CAERUS INSURANCE LLC

PREMIUM ONLY PLAN

PURPOSE

The Caerus Insurance LLC Premium Only Plan (the "Plan") is adopted by Caerus Insurance LLC effective March 30, 2023. The purpose of the Plan is to allow Employees of Caerus Insurance LLC and other Participating Employers, to choose between at least one permitted taxable benefit, such as cash compensation from existing income and at least one qualified benefit such as health care coverage under medical plan(s) sponsored by the Company.

Caerus Insurance LLC intends that the Plan qualify as a "cafeteria plan" under section 125 of the Internal Revenue Code of 1986 ("Code") as amended, and that the Medical Insurance Benefits that an Employee elects to receive under the Plan be eligible for exclusion from the Employee's income for federal income tax purposes.

Although this Plan has been reduced to writing in order to comply with section 125 of the Code, the Plan shall also serve as an amendment to each of the health plans described in Schedule A affected by its provisions in order to permit the benefits of this Plan to be fully implemented.

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Section 1

DEFINITIONS

The words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context, and pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

"Adoption Agreement" means the written agreement by which an Affiliated Company adopts this Plan.

"Affiliated Company" means:

A. any company which is a member of a controlled group of corporations with the Employer within the meaning of section 1563(a) of the Code, determined without regard to sections 1563(a) (4) and (e) (3) (C);
B. all organizations under common control with the Employer within the meaning of section 414 (c) of the Code:
C. all organizations which are included with the Employer in an affiliated service group within the meaning of section 414 (m) of the Code; or
D. any other entity required to be aggregated with the Employer pursuant to regulations under section 414 (o) of the Code.

"Beneficiary" means the person, persons or trust designated by written revocable designation filed with the Plan Administrator by the Participant to receive payments under this Plan, including the Participant and any dependents of a Participant.

"Cash" for purposes of section 125, cash means cash from current compensation (including salary reduction), payment for annual leave, sick leave, or other paid time off, severance pay, property, and certain after-tax employee contributions.

"Change in Status" has the meaning described in Section 4.3.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986 as amended, and the same as may be amended from time to time.

"Dependent" has the meaning described in Section 2.8.

"Effective Date" means March 30, 2023.

"Eligible Employee" means any non-union Employee regularly scheduled to work 40 or more hours per week for a Participating Employer.

"Employee" means an individual that the Employer classifies as a common-law employee, leased employee, or full time life insurance salesmen, and who is on the Employer's W-2 payroll, but does not include the following: (a) individuals classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means Caerus Insurance LLC and any other business organization which succeeds to its business and elects to continue this Plan.

"Enrollment Period" means the calendar month preceding the beginning of any Plan Year.

"Entry Date" means the first day following completion of 90 consecutive days of active employment as an Eligible Employee.

"ERISA" means the Employee Retirement Income Security Act of 1974, and the same as may be amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Highly Compensated Employee" means any Employee defined as such in section 414(q) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Key Employee" means any Employee defined as such in section 416(I) (l) of the Code.

"Medical Insurance Benefits" means a health care coverage option, available from time to time under the Plan, as set forth in Schedule A hereto.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 2.

"Participating Employer" means Caerus Insurance LLC and any Affiliated Company that adopts this Plan with the consent of the Employer. As of the Effective Date, the Employer is the only

Participating Employer.

"Plan" means the Caerus Insurance LLC Premium Only Plan which is described herein and as amended from time to time, and which is intended to constitute a separate, written Plan for the exclusive benefit of Eligible Employees.

"Plan Number" or "PN" assigned by Caerus Insurance LLC is 501.

"Plan Sponsor" means Caerus Insurance LLC ("Employer").

"Plan Year" means the twelve-month period commencing each January 1 and ending on the subsequent December 31.

"Premium Payment Benefits" means the amount set aside for Medical Insurance Benefits under Section 3.2 and credited to the Participant's Premium Only Account.

"Premium Only Account" means the account established in each Participant's name as provided under Section 3.2 and which is used to record the allocation of Premium Payment Benefits for the expenditure of the Medical Insurance Benefits elected by a Participant.

"Premium Expense" means the expense identified with the Medical Insurance Benefits elected by a Participant in accordance with Section 3.2.

"Qualified Benefits" For purposes of section 125, Qualified Benefit means benefits excludible from an employee's gross income under a specific provision of the Code and must not defer compensation, except as specifically allowed in section 125(d)(2)(B), (C) or (D). Examples of qualified benefits include the following: group-term life insurance on the life of an employee (section 79); or employer-provided accident and health plans. A cafeteria plan may also offer long-term and short-term disability coverage as a qualified benefit (see section 106). See paragraph (q) in Sec. 1.125-1 for nonqualified benefits.

"QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

"Salary Reduction Agreement" means a voluntary agreement whereby an Employee agrees to reduce his compensation for the forthcoming Plan Year (or, if the agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year) for purposes of obtaining the Medical Insurance Benefits offered by the Plan.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

Section 2

PARTICIPATION IN THE PLAN

2.1 Eligibility to Participate. Each Eligible Employee may elect to participate in the Plan if the Individual satisfies all of the following: (a) is an Employee of a Participating Employer; (b) is working 40 or more hours per week; and (c) has been employed by the Employer for 90 consecutive days. Eligibility shall also be subject to the additional requirements, if any, specified in the Medical Insurance Plan.

Self-employed individuals are not eligible to participate in the Plan. New proposed regulations make clear that:

- sole proprietors,
- partners,
- directors of corporations, and
- 2-percent shareholders of an S corporation

are not employees for purposes of this Plan. (C Corporation owners who are employees and a director of the Corporation are eligible to participate in the Plan in their capacity as an Employee).

2.2 Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing a Salary Reduction Agreement under which the Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if such Salary Reduction Agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year). The Salary Reduction Agreement shall be governed by Section 3 hereof. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

An Eligible Employee's spouse or dependents can only receive benefits through the Plan if they are named on an Eligible Employee's qualifying policy. Eligible Employee's spouse or dependents can not participate in the Plan independently.

2.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of:

A. the date on which the Plan terminates;
B. the date on which he ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for periods on the terms and subject to the restrictions described in Section 6.4;

C. the first day of any Plan Year for which he has elected not to participate in the Plan;

D. the date on which he revokes his election and elects not to participate in Medical Insurance Benefits, on account of and consistent with a change in family status in accordance with Section 4.3; or

E. the date on which he fails to make a contribution in accordance with Section 3.5.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

Notwithstanding the foregoing, a former Eligible Employee who is absent by reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Participating Employer may direct.

2.4 Recommencement of Participation. If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.2. Notwithstanding the above, an election to participate in the Premium Payment Module will be reinstated only to the extent that coverage under the Medical Insurance Plan (here, major medical insurance) is reinstated. If an Employee becomes ineligible for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 2.1 before again becoming eligible to participate in the Plan.

2.5 FMLA Leaves of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical Insurance Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require participants to continue all Medical Insurance Benefit coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are

required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Medical Insurance Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Medical Insurance Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Medical Insurance Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Medical Insurance Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return

from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

2.6 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 4.4(d) will apply.

2.7 Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period during which he or she is in "uniformed service." The manner in which such payments are made shall be determined by the Plan Administrator, in a manner similar to Section 2.5 (regarding the payment of contributions with respect to FMLA Leave). A Participant whose coverage under the group health insurance plan is terminated on account of his or her being in "uniformed service," and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical savings account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service."

2.8 Definition of Dependent. Any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (1) a dependent is defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) a dependent means any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) a dependent means any child to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year), is treated as a dependent of both parents.

The definition of "Dependent" has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA). An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following qualifying criteria now apply to be a "dependent child":

1) The individual has a specific family type relationship to the taxpayer
2) The individual does not provide more than half of his or her own support
3) The individual has the same place of residence as the taxpayer for more than half of the year
4) The individual does not turn age 19 (24 if a full-time student)*, by the end of the Plan Year

In addition, the following qualifying criteria apply to be a "dependent relative":

1) The individual has a specific family type relationship to the taxpayer
2) The individual is not a qualifying child of any other taxpayer
3) The individual receives more than half of his or her support from the taxpayer
4) The individual's annual gross income is less than the Section 151 limit (this criteria does not apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by Employer dependent children may be covered by either spouse, but not by both.

*NOTE: the Internal Revenue Service (the "IRS") Notice 2010-38 (the "Notice") provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Treasury regulations have been amended retroactively to March 30, 2010, to allow both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid by (or reimbursed to) the employee for such coverage to be excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. This coverage is provided to such adult child (as defined in Code § 152(f)(1)) regardless of whether the child satisfies the other requirements listed above. The Notice provides important guidance and further clarifications with regard to these issues.

Section 3

BENEFITS AND METHODS OF FUNDING

3.1 Benefits Offered. When first eligible or during the Open Enrollment Period as described under Section 2.2, Participants will be given the opportunity to elect Premium Payment Benefits, as described in Section 6. See Schedule A for a complete description of available benefits and refer to specific insurance premium rate sheets for individual maximum elective contribution.

3.2 Premium Payment Benefits. Upon proper election by a Participant in accordance with Section 3.3 herein, there shall be credited to each Participant's Premium Only Account any Premium Payment Benefits that correspond to the Participant's Salary Reduction Agreement determined in accordance with Section 3.3 hereof. Such Premium Payment Benefits shall not exceed the Premium Expense of the Medical Insurance Benefits elected, set forth in Schedule A attached hereto, as it may be revised by the Employer from time to time. The Participant's Premium Payment Benefits shall be credited as and when such sum is redirected from the Participant's compensation pursuant to the Salary Reduction Agreement then in effect. The Premium Payment Benefits shall be used to pay all or part of the Premium Expense of the Medical Insurance Benefits that the Participant has designated pursuant to Section 3.3. The Premium Expense paid on behalf of any Participant shall be a charge to the balance of his Premium Only Account. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

3.3 Election of Benefits. An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits after eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the date in which participation will commence.

Each Eligible Employee shall submit to the Employer, before the close of the Enrollment Period for each Plan Year, or when Employee first becomes eligible, a Salary Reduction Form identifying the Medical Insurance Benefits to be provided by the Employer to or on behalf of the Eligible Employee. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 4.4.

Each election under this Section 3.3 may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of Section 125 of the Code. If

an Eligible Employee separates from service with a Participating Employer during a period in which he is covered under Medical Insurance Benefits, the Employer may terminate the remaining portion of Medical Insurance Benefits coverage provided by the Plan. Any Participant or newly Eligible Employee who fails to execute an appropriate Salary Reduction Agreement during the Enrollment Period shall be deemed to have elected cash compensation (regular income) to the extent permissible.

3.4 Provision of Benefits. The Participating Employer shall provide the Medical Insurance Benefits the Participant has elected under the Plan. Eligibility for Premium Payment Benefits shall be subject to the additional requirements specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

3.5 Employer and Employee Contributions.

Employer Contributions. For Employees who elect Premium Payment Benefits, the Employer will contribute a portion of the Contributions (if applicable) as provided in the open enrollment materials furnished to Employees and/or on Election Form/Salary Reduction Agreement.

Employee Contributions. Employees who elect any of the Premium Payment Benefits, may pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement, or may pay with after-tax deductions.

If a Participant does not have sufficient Premium Payment Benefits to pay for the Medical Insurance Benefits elected, the Participating Employer is authorized to withhold the additional amounts from a Participant's pay on an after-tax basis to the extent required for said Medical Insurance Benefits.

Participants are required to increase or decrease their payments under the terms of the Plan and as required by the Plan Administrator, if there is an increase or decrease in the premium payments required by an independent, third party provider in order to maintain any Medical Insurance Benefits.

Notwithstanding the foregoing, Medical Insurance Benefits shall cease to be provided to a Participant if said Participant fails to make a contribution required under the terms of the Plan.

3.6 Nondiscrimination. Contributions and benefits under the Plan shall not discriminate in favor of Highly Compensated Employees; nor shall the aggregate cost of the Medical Insurance Benefits provided to Key Employees exceed 25% of the aggregate of such cost for the Medical Insurance Benefits provided to all Employees under the Plan. The Employer may limit or deny any

Employee's Salary Reduction Agreement to the extent necessary to avoid any such discrimination.

3.7 Insurance Contracts. Any dividends or retroactive rates or other refunds which may become payable under any Medical Insurance Benefits due to actuarial error in rate calculation shall be the exclusive property of and shall be retained by a Participating Employer.

3.8 Using Salary Reductions to Make Contributions. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits and for the purposes of this Plan and the Code, are considered to be Employer contributions. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

For those Participants who elect to pay their share of the Contributions for any of the Medical Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

3.9 Funding the Plan. All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Section 4

IRREVOCABILITY OF ELECTIONS AND EXCEPTIONS

4.1 Irrevocability of Elections. Except as described in this Article 4, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options.

4.2 Procedure for Making New Elections if Exception to Irrevocability Applies.

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 2.1 or during the Open Enrollment Period under Section 2.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.4(d) through 4.4(i), within 30 days after the events described in such Sections, or within 60 days for loss of Medicaid or CHIP coverage or notice of eligibility for a Premium Assistance Subsidy). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 4.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

4.3 Change in Status Defined. A Participant may make a new election upon the occurrence of certain events as described in Section 4.4, including a Change in Status, for the applicable Module. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

4.4 Events Permitting Exceptions to Irrevocability Rule for All Benefits. A Participant may change an election as described below upon the occurrence of the stated events for the applicable Module of this Plan:

(a) *Open Enrollment Period* - A Participant may change an election during the Open Enrollment Period in accordance with Section 2.2.

(b) *Termination of Employment* - A Participant's election will terminate under the Plan upon

termination of employment in accordance with Sections 2.3 and 2.4, as applicable.

(c) *Leaves of Absence* - A Participant may change an election under the Plan upon FMLA leave in accordance with Section 2.5 and upon non-FMLA leave in accordance with Section 2.6.

(d) *Change in Status* - A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 2.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a

result of divorce, annulment, or legal separation).

IRS Notice 2010-38 states that the applicable Treasury Regulations have been amended retroactively to March 30, 2010, to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, to include becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) *HIPAA Special Enrollment Rights* - If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or
- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment

attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

- a Participant or their Dependent becomes eligible for a Premium Assistance Subsidy (60 day special enrollment period provided by CHIP Reauthorization Act effective April 1, 2009).
- a Participant or their Dependent loses Medicaid or CHIP coverage (60 day special enrollment period provided by CHIP Reauthorization Act effective April 1, 2009).

(f) *Certain Judgments, Decrees and Orders* - If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid* - If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid, but coverage for the unaffected Participants may not be canceled or reduced. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(h) *Change in Cost* - For purposes of this Section 4.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are

considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); and (b) Employees who are otherwise eligible under Section 2.1 may elect the Benefit Package Option that has decreased in cost (such as

the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(i) *Change in Coverage* - The definition of "similar coverage" under Section 4.4(h) applies also to this Section 4.4(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either

prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 4.4(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 2.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively

change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s). Beginning April 1, 2009, employees and dependents are permitted to enroll in the Employer's group health insurance plan within 60 days of the loss of Medicaid or CHIP coverage.

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

A Participant entitled to change an election as described in this Section 4.4 must do so in accordance with the procedures described in Section 4.2.

4.5 Election Modifications For HSA Benefits May Be Changed Prospectively at Any Time

As set forth in Section 7.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Package Option election changes can occur as a result of a change in HSA election except as otherwise described in this Section 4. A Participant entitled to change an election as described in this

Section 4.5 must do so in accordance with the procedures described in Section 4.2.

4.6 Election Modifications Required by Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 5

PLAN ADMINISTRATOR

5.1 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination.

5.2 Powers of the Plan Administrator. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit

consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

5.3 Reliance on Participant, Tables, etc. The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

5.4 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

5.5 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

5.6 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

5.7 Bonding. The Plan Administrator shall be bonded to the extent required by ERISA.

5.8 Insurance Contracts. The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such

amounts are less than aggregate Employer contributions toward such insurance.

5.9 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

5.10 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

Section 6

PREMIUM ONLY PLAN MODULE

6.1 Benefits. The only Medical Insurance Benefits that are offered under the Premium Payment Module are benefits under the Medical Insurance Plan providing major medical benefits and other ancillary benefits outlined in Schedule A. Notwithstanding any other provision in this Plan, the Medical Insurance Benefits outlined in Schedule A are subject to the terms and conditions of the Medical Insurance Plans, and no changes can be made with respect to such Medical Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Module by electing to pay for his or her share of the Contributions for Medical Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Module and to pay for his or her share of the Contributions, if any, for Medical Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Section 4), such election is irrevocable for the duration of the Period of Coverage to which it relates. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

6.2 Contributions for Cost of Coverage. The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Medical Insurance Benefits Provided Under the Medical Insurance Plan. Medical Insurance Benefits will be provided by the Medical Insurance Plan(s), not this Plan. The types and amounts of Medical Insurance Benefits, the requirements for participating in the Medical Insurance Plan, and the other terms and conditions of coverage and benefits of the Medical Insurance Plans are set forth in the Medical Insurance Plans. All claims to receive benefits under the Medical Insurance Plans shall be subject to and governed by the terms and conditions of the Medical Insurance Plan(s) and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical Insurance Benefits and COBRA. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the

opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

Section 7

MISCELLANEOUS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time. The Employer may amend this Plan retroactively to enable the Plan to qualify as a cafeteria plan under section 125 of the Code. No amendment shall deprive any Participant or Beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made; and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their Beneficiaries, except as may be specifically authorized by statute or regulation.

7.2 Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Participating Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

7.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a Qualified Medical Child Support Order pursuant to Section 609 of ERISA and Section 7.4 hereof.

7.4 Facility of Payment. If the Employer deems any person incapable of receiving benefits to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by a Participating Employer to disburse it, whose receipt shall be a complete acquittance therefore. Such payments shall, to the extent thereof, discharge all liability of the Participating Employer.

7.5 Proof of Claim. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Plan Administrator may require either directly to the Plan Administrator or to any person delegated by him/her.

7.6 Status of Benefits. The Employer believes that this Plan is in compliance with section 125 of the Code and that it provides certain benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be

available. Any Participant, by accepting benefits under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

7.7 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Oregon to the extent not preempted by any federal law.

7.8 Source of Benefits. The Participating Employer and any insurance company contracts purchased or held by a Participating Employer shall be the sole sources of benefits under the Plan. No Employee or Beneficiary shall have any right to, or interest in, any assets of the Participating Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or Beneficiary.

7.9 No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to, purposes other than the exclusive benefit of Participants or their Beneficiaries, or for defraying reasonable expenses of administering the Plan.

7.10 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

7.11 Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and Beneficiary.

7.12 Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

7.13 Information to be Furnished. Participants shall provide the Employer and/or Participating Employer with such information and shall complete and sign such forms and documents, as may reasonably be requested from time to time for the Purpose of administration of the Plan.

Executed March 30, 2023

CAERUS INSURANCE LLC

By:_____ Witness:_____

Tracey Borra

CAERUS INSURANCE LLC

Schedule A

MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

Group Health Insurance
Dental Insurance

*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment and in Schedule B. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

Caerus Insurance
Premium contribution detail
Monthly Pay Cycle
October 1, 2023 to September 30, 2024

Providence Connect 2800			
	Total	**Employer monthly**	**Employee monthly**
	Premium	**Contribution**	**Contribution**
Single	$452.75	$452.75	$0.00
Single + Spouse	$905.50	$452.75	$452.75
Family	$1,290.35	$452.75	$837.60
Single + Children	$837.60	$452.75	$384.85

Providence Balance 2500			
	Total	**Employer monthly**	**Employee monthly**
	Premium	**Contribution**	**Contribution**
Single	$520.95	$452.75	$68.20
Single + Spouse	$1,041.90	$452.75	$589.15
Family	$1,484.70	$452.75	$1,031.95
Single + Children	$963.75	$452.75	$511.00

Providence Advantage Access Dental			
	Total	**Employer monthly**	**Employee monthly**
	Premium	**Contribution**	**Contribution**
Single	$44.40	$44.40	$0.00
Single + Spouse	$88.80	$44.40	$44.40
Family	$126.55	$44.40	$82.15
Single + Children	$79.65	$44.40	$35.25

Some monthly employee premium contributions are not divisible by two, so a .01 rounding is included in employer cost

This page is provided as a guide to employee premium contributions. Confirm rates used with carrier contracted rates

Employee contributions may be taken on a pre-tax basis provided compliance and eligibility criteria are met

Employer pays 100% for employee and 0% for dependents for the Connect Medical plan

Employees can choose Balance with premium contributions

Employer pays 100% for employee and 0% for dependents on the dental plan

PROVIDENCE Health Plans

Oregon 2022 Small Group Rates

Print Date:: 6/12/2022
Print Time:: 6:00:09 PM
Group Numb 116922

Caerus Insurance

Effective Date: 10/1/2022

Total Enhanced Plans (Providence Signature Network)

Plan	Medical						Prescription Drug						Rates			
✓= Deductible Waived	PCP Copay	Spec Copay	In-Network Coinsurance	Out-of-Network Coinsurance	Deductible	Out-of-pocket Maximum	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	EE Tier	ES Tier	EF Tier	EC Tier
Total Enhanced 7400 Silver	$45✓	$65✓	35%	40%	$7,400	$8,700	$0✓	$15✓	$65✓	40%✓	50%✓ with $200 per script cap	50%✓	$476.15	$952.30	$1,357.05	$880.90
Total Enhanced 5500 Gold	$20✓	$40✓	20%	40%	$5,500	$7,500	$0✓	$10✓	$40✓	30%✓	50%✓ with $200 per script cap	50%✓	$520.55	$1,041.10	$1,483.55	$963.00
Total Enhanced 4500 Gold	$20✓	$40✓	20%	40%	$4,500	$7,500	$0✓	$10✓	$40✓	30%✓	50%✓ with $200 per script cap	50%✓	$542.10	$1,084.20	$1,545.00	$1,002.90
Total Enhanced 3500 Gold	$20✓	$40✓	20%	40%	$3,500	$7,500	$0✓	$10✓	$40✓	30%✓	50%✓ with $200 per script cap	50%✓	$558.90	$1,117.80	$1,592.85	$1,033.95
Total Enhanced 2500 Gold	$20✓	$40✓	20%	40%	$2,500	$7,500	$0✓	$10✓	$40✓	30%✓	50%✓ with $200 per script cap	50%✓	$577.95	$1,155.90	$1,647.15	$1,069.20
Total Enhanced 1500 Gold	$20✓	$40✓	30%	40%	$1,500	$7,500	$0✓	$10✓	$40✓	30%✓	50%✓ with $200 per script cap	50%✓	$595.10	$1,190.20	$1,696.05	$1,100.95
Total Enhanced 1000 Gold	$20✓	$40✓	30%	40%	$1,000	$7,500	$0✓	$10✓	$40✓	30%✓	50%✓ with $200 per script cap	50%✓	$615.40	$1,230.80	$1,753.90	$1,138.50
Total Enhanced 500 Platinum	$10✓	$25✓	10%	30%	$500	$3,500	$0✓	$10✓	$25✓	30%✓	50%✓ with $200 per script cap	50%✓	$707.25	$1,414.50	$2,015.65	$1,308.40
Total Enhanced 250 Platinum	$10✓	$25✓	10%	30%	$250	$3,500	$0✓	$10✓	$25✓	30%✓	50%✓ with $200 per script cap	50%✓	$735.60	$1,471.20	$2,096.45	$1,360.85

- Most comprehensive coverage, with platinum, gold and silver options
- Broadest provider network access with Providence Signature Network
- Deductible is waived for in-network diabetic supplies such as needles, lancets, test strips and glucose monitoring.
- No deductible for in-network doctor and specialist visits, emergency room, urgent care, lab, x-ray and vision. Express Care Virtual covered in full.
- Combined in-network and out-of-network deductible and out-of-pocket maximum
- Pharmacy included, no deductible for most prescriptions; Mail order maintenance medications have a 2 copay for 90 day benefit
- Chiropractic manipulation & acupuncture included, no deductible, $25 copay to in-network providers, visit limits of 20 (chiropractic) and 12 (acupuncture) per calendar year
- Pediatric dental, and pediatric and adult vision (12/12/12) included

Tier Key: EE = Employee Only, ES = Employee + Spouse, EF = Employee + Spouse + Child(ren), EC = Employee + Child(ren)

PROVIDENCE Health Plans

Oregon 2022 Small Group Rates

Print Date:: 6/12/2022
Print Time:: 6:00:09 PM
Group Numb 116922

Balance Plans (Providence Signature Network)

Plan	Medical						Prescription Drug						Rates			
✓= Deductible Waived	PCP Copay	Spec Copay	In-Network Coinsurance	Out-of-Network Coinsurance	Deductible	Out-of-pocket Maximum	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	EE Tier	ES Tier	EF Tier	EC Tier
Balance 8700 Bronze	$75✓	$100✓	0%	0%	$8,700	$8,700	$0✓	$35✓	0%	0%	0%	0%	$429.85	$859.70	$1,225.05	$795.20
Balance 8000 Bronze	$75✓	$100✓	50%	50%	$8,000	$8,700	$0✓	$35✓	50%	50%	50% with $200 per script cap	50%	$435.55	$871.10	$1,241.30	$805.75
Balance 6000 Silver	$40✓	$60✓	35%	50%	$6,000	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$472.50	$945.00	$1,346.65	$874.15
Balance 4500 Silver	$40✓	$60✓	35%	50%	$4,500	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$485.40	$970.80	$1,383.40	$898.00
Balance 3500 Silver	$40✓	$60✓	40%	50%	$3,500	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$494.95	$989.90	$1,410.60	$915.65
Balance 2500 Gold	$40✓	$60✓	30%	50%	$2,500	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$520.95	$1,041.90	$1,484.70	$963.75
Balance 1500 Gold	$30✓	$50✓	20%	50%	$1,500	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$588.70	$1,177.40	$1,677.80	$1,089.10
Balance 750 Gold	$30✓	$50✓	20%	50%	$750	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$628.05	$1,256.10	$1,789.95	$1,161.90

- A balance of cost saving features and first dollar coverage for the most commonly used services
- Broadest provider network access with Providence Signature Network
- No referrals required
- No deductible for in-network doctor and specialist visits, urgent care and vision. Express Care Virtual covered in full.
- Separate in-network and out-of-network deductibles and out-of-pocket maximums
- Pharmacy included, no deductible for most prescriptions; Mail order maintenance medications have a 2 copay for 90 day benefit
- Chiropractic manipulation & acupuncture included, no deductible, $25 copay to in-network providers, visit limits of 20 (chiropractic) and 12 (acupuncture) per calendar year
- Pediatric dental, and pediatric and adult vision (12/24/24) included
- SHOP certified; dental plans cannot be purchased with SHOP certified plans if the employer is applying for the small business tax credit

Tier Key: EE = Employee Only, ES = Employee + Spouse, EF = Employee + Spouse + Child(ren), EC = Employee + Child(ren)

PROVIDENCE Health Plans

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Caerus Insurance

Effective Date: 10/1/2022

HSA Qualified Plans (Providence Signature Network)

Plan	Medical						Prescription Drug						Rates			
✓= Deductible Waived	PCP Coinsurance	Spec Coinsurance	In-Network Coinsurance	Out-of-Network Coinsurance	Deductible	Out-of-pocket Maximum	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	EE Tier	ES Tier	EF Tier	EC Tier
HSA Qualified 7000 Bronze	0%	0%	0%	0%	$7,000	$7,000	0%	0%	0%	0%	50% with $200 per script cap	50%	$423.55	$847.10	$1,207.10	$783.55
HSA Qualified 6000 Bronze	50%	50%	50%	50%	$6,000	$7,000	0%	50%	50%	50%	50% with $200 per script cap	50%	$426.00	$852.00	$1,214.10	$788.10
HSA Qualified 4500 Silver	30%	30%	30%	50%	$4,500	$6,750	0%	30%	30%	30%	50% with $200 per script cap	50%	$439.85	$879.70	$1,253.55	$813.70
HSA Qualified 3500 Silver	30%	30%	30%	50%	$3,500	$6,750	0%	30%	30%	30%	50% with $200 per script cap	50%	$484.20	$968.40	$1,379.95	$895.75
HSA Qualified 2500 Silver	30%	30%	30%	50%	$2,500	$6,750	0%	30%	30%	30%	50% with $200 per script cap	50%	$508.35	$1,016.70	$1,448.80	$940.45
HSA Qualified 1500 Gold	20%	20%	20%	50%	$1,500	$6,000	0%	20%	20%	20%	50% with $200 per script cap	50%	$545.90	$1,091.80	$1,555.80	$1,009.90

- Health Savings Account qualified plans
- Broadest provider network access with Providence Signature Network
- No referrals required
- Separate in-network and out-of-network deductibles and out-of-pocket maximums
- Preventive care, prenatal care, pediatric vision and adult vision exams covered without deductible
- Integrated enrollment and claims with our banking partner, HealthEquity when this service is selected (no additional charge)
- Pharmacy, chiropractic manipulation and acupuncture included, subject to deductible; Mail order maintenance medications have a 2 copay for 90 day benefit
- HSA formulary includes safe harbor medications that are deductible waived, subject to applicable tier cost share
- Pediatric dental, and pediatric and adult vision (12/24/24) included
- SHOP certified; dental plans cannot be purchased with SHOP certified plans if the employer is applying for the small business tax credit

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PROVIDENCE Health Plans

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Choice Plans (Choice Network)

Plan	Medical						Prescription Drug						Rates			
✓= Deductible Waived	PCP Coinsurance	Spec Coinsurance	In-Network Coinsurance	Out-of-Network Coinsurance	Deductible	Out-of-pocket Maximum	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	EE Tier	ES Tier	EF Tier	EC Tier
Choice 8700 Bronze	$75✓	$100✓	0%	0%	$8,700	$8,700	$0✓	$35✓	0%	0%	0%	0%	$397.80	$795.60	$1,133.75	$735.95
Choice 7200 Silver	$50✓	$70✓	40%	50%	$7,200	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$413.00	$826.00	$1,177.05	$764.05
Choice 6000 Silver	$40✓	$60✓	35%	50%	$6,000	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$437.65	$875.30	$1,247.30	$809.65
Choice 4900 Silver	$40✓	$60✓	35%	50%	$4,900	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$446.05	$892.10	$1,271.25	$825.20
Choice 3800 Silver	$45✓	$65✓	40%	50%	$3,800	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$454.15	$908.30	$1,294.35	$840.20
Choice 2800 Gold	$40✓	$60✓	30%	50%	$2,800	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$477.35	$954.70	$1,360.45	$883.10
Choice 1500 Gold	$30✓	$50✓	25%	50%	$1,500	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$534.95	$1,069.90	$1,524.60	$989.65
Choice 750 Gold	$30✓	$50✓	25%	50%	$750	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$569.85	$1,139.70	$1,624.05	$1,054.20

- Providence's exclusive Choice medical home network available to employees working or residing in the Choice service area
- For gold and silver plans the first three PCP/BH visits are covered in full
- Referrals required & care coordinated through the medical home for all in-network coverage
- No deductible for in-network or referred office visits, urgent care and vision. Express Care Virtual and Express Care Retail Health Clinic visits covered in full.
- Separate in-network and out-of-network deductibles and out-of-pocket maximums
- Pharmacy included, no deductible for most prescriptions; Mail order maintenance medications have a 2 copay for 90 day benefit
- Chiropractic manipulation & acupuncture included, no deductible, $25 copay to in-network providers, visit limits of 20 (chiropractic) and 12 (acupuncture) per calendar year.
- Pediatric dental, and pediatric and adult vision (12/24/24) included
- New: SHOP certified; dental plans cannot be purchased with SHOP certified plans if the employer is applying for the small business tax credit

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Connect Plans (Connect Network)

Plan	Medical						Prescription Drug						Rates			
✓= Deductible Waived	PCP Copay	Spec Copay	In-Network Coinsurance	Out-of-Network Coinsurance	Deductible	Out-of-pocket Maximum	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	EE Tier	ES Tier	EF Tier	EC Tier
Connect 8700 Bronze	$75✓	$100✓	0%	0%	$8,700	$8,700	$0✓	$35✓	0%	0%	0%	0%	$377.30	$754.60	$1,075.30	$698.00
Connect 7200 Silver	$50✓	$70✓	40%	50%	$7,200	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$391.75	$783.50	$1,116.50	$724.75
Connect 6000 Silver	$40✓	$60✓	35%	50%	$6,000	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$415.15	$830.30	$1,183.20	$768.05
Connect 4900 Silver	$40✓	$60✓	35%	50%	$4,900	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$423.05	$846.10	$1,205.70	$782.65
Connect 3800 Silver	$45✓	$65✓	40%	50%	$3,800	$8,700	$0✓	$20✓	$65✓	50%✓	50% with $200 per script cap	50%	$430.75	$861.50	$1,227.65	$796.90
Connect 2800 Gold	$40✓	$60✓	30%	50%	$2,800	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$452.75	$905.50	$1,290.35	$837.60
Connect 1500 Gold	$30✓	$50✓	25%	50%	$1,500	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$507.40	$1,014.80	$1,446.10	$938.70
Connect 750 Gold	$30✓	$50✓	25%	50%	$750	$8,200	$0✓	$15✓	$50✓	50%✓	50% with $200 per script cap	50%	$540.45	$1,080.90	$1,540.30	$999.85

- Providence's exclusive Connect medical home network available to employees residing in Multnomah, Clackamas, Washington and Hood River counties as well as Yamhill county (zip code 97132 only)
- For gold and silver plans the first three PCP/BH visits are covered in full
- Referrals required & care coordinated through the medical home for all in-network coverage
- No deductible for in-network or referred office visits, urgent care and vision. Express Care Virtual and Express Care Retail Health Clinic visits covered in full.
- Separate in-network and out-of-network deductibles and out-of-pocket maximums
- Pharmacy included, no deductible for most prescriptions; Mail order maintenance medications have a 2 copay for 90 day benefit
- Chiropractic manipulation & acupuncture included, no deductible, $25 copay to in-network providers, visit limits of 20 (chiropractic) and 12 (acupuncture) per calendar year.
- Pediatric dental, and pediatric and adult vision (12/24/24) included
- New: SHOP certified; dental plans cannot be purchased with SHOP certified plans if the employer is applying for the small business tax credit

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PROVIDENCE Health Plans

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Caerus Insurance

Standard Plans (Providence Signature Network)																
Plan	Medical						Prescription Drug						Rates			
✓= Deductible Waived	PCP Copay	Spec Copay	In-Network Coinsurance	Out-of-Network Coinsurance	Deductible	Out-of-pocket Maximum	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	EE Tier	ES Tier	EF Tier	EC Tier
Providence Oregon Standard Bronze Plan	$50✓	$100✓	0%	0%	$8,700	$8,700	$20✓	$20✓	$0	0%	0%	0%	$420.75	$841.50	$1,199.15	$778.40
Providence Oregon Standard Silver Plan	$40✓	$80✓	30%	50%	$3,650	$8,550	$15✓	$15✓	$60✓	50%✓	50%✓	50%✓	$481.05	$962.10	$1,371.00	$889.95
Providence Oregon Standard Gold Plan	$20✓	$40✓	20%	50%	$1,500	$7,300	$10✓	$10✓	$30✓	50%✓	50%✓ with $500 per script cap	50%✓ with $500 per script cap	$612.10	$1,224.20	$1,744.50	$1,132.40

- State of Oregon mandated plans
- Broadest provider network access with Providence Signature Network
- Separate in-network and out-of-network deductibles and out-of-pocket maximums
- Pharmacy included, no deductible for most prescriptions (Excludes Bronze); Mail order maintenance medications have a 2 copay for 90 day benefit
- Pediatric vision included
- Providence dental plans cannot be purchased with Standard Plans for employers applying for the small business tax credit (SHOP)

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PROVIDENCE Health Plans

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Dental Plans

Plan	Benefits							Rates			
	Deductible	*Annual Benefit Maximum*	*In-Network Preventive*	*In-Network Basic*	*In-Network Major*	*OON Reimbursement*		*EE Tier*	*ES Tier*	*EF Tier*	*EC Tier*
Essential Dental	$50	$1,000	Covered In Full✓	20%	50%	MAC		$33.35	$66.65	$95.00	$59.80
Essential Access Dental	$50	$1,000	Covered In Full✓	20%	50%	90th UCR		$39.90	$79.80	$113.75	$71.60
Advantage Access Dental	$25	$1,500	Covered In Full✓	20%	50%	90th UCR		$44.40	$88.80	$126.55	$79.65
Preventive Dental	$0	N/A	Covered In Full✓	Not Covered	Not Covered	MAC		$10.75	$21.20	$32.25	$21.80

- No waiting periods
- Preventive Services do not apply to the annual maximum benefit
- Endodontics, periodontics and oral surgery are covered under Class II Basic Services
- Broad in and out-of-network provider access
- Ortho is not a covered service

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Caerus Insurance

Spending Accounts			
Account Type	*Employee Set-Up Fee*	*Employer Set-Up Fee*	*Monthly Administration Fee*
Health Savings Account	Free	No Additional Charge	No Additional Charge
Health Reimbursement Account	Free	$250-$500	$3.45 per employee
Flexible Spending Account	Free	$250-$500	$3.45 per employee
Limited Flexible Spending Account (paired with an HSA)	Free	Free	$1.95 per employee

- Optional account administration through banking partner HealthEquity
- Automated HSA and HRA enrollment through Providence Health Plan when paired with HealthEquity
- Integrated enrollment, billing and claims administration when choosing HealthEquity
- Manage contributions and view reporting from HealthEquity employer portal
- View integrated claims, pay providers, request reimbursement and obtain tax information via HealthEquity employee portal
- 24/7 customer service

Employee Assistance Program		
Group Size	*Structure*	
2-50 Employees	Up to 3 sessions per issue	No additional charge

- The EAP is offered to ALL employees and their dependents, up to age 26 regardless of their enrollment status
- Additional onsite services are available to employers for an additional cost

Caerus Insurance

Effective Date: **10/1/2022**

Plan Requirements

1) Choice/Connect may be offered on a stand-alone basis. Out-of-area (OOA) dependents (spouse or domestic partner, child, step-child or legally adopted child) not living with the employee may enroll as an OOA dependent by completing the OOA dependent enrollment section of the Choice/Connect form.
Out of area dependents cannot remain on the standard Connect plan.

2) Dependents must enroll in the same benefit option as the employee.

Multiple Plan Option Requirements

1) Available for all small employers.

2) The employer must contribute a minimum of 50% of the employee only rate of the lowest premium plan chosen. If a dollar amount contribution is chosen, the amount must at least equal 50% of the employee only rate of the lowest premium plan chosen.

3) A small employer with 1-4 enrolled employees may choose up to two small group plans. A small employer with 5 or more enrolled employees may choose up to three small group plans.

4) At time of sale plans without enrollment will not be offered. The exception is when the plan without enrollment is the lowest cost plan.

5) There are no restrictions on plan pairings.

Additional Underwriting Requirements

1) An eligible Oregon Small Group employer is an employer having an average of at least one but not more than a combined total of 50 full-time (FT) and full time equivalent (FTE) employees during the preceding calendar year and who employs at least one benefit eligible employee on the first day of the plan year.
2) The employer must have at least one common law employee that is enrolled in the plan, and offers the group health plan to all benefit eligible employees.
3) The employer must be located in the Providence Health Plan Oregon service area.
4) The employer must have at least 50% of enrolling employees working or residing in Oregon and Washington state
5) Choice products are available to employers located in Oregon Counties of Baker, Benton, Clackamas, Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Umatilla, Union, Wallowa, Washington and Yamhill.
6) Connect products are only available to employers located in Clackamas, Multnomah, Hood River, Yamhill (zip code 97132 only) and Washington counties. Employees who enroll on these plans must work or reside in these same counties.
7) Products are offered on a sole carrier basis.
8) The employer may determine hours worked for benefit eligibility between 17.5 and 40 hours per week.
9) 75% of benefit eligible employees must enroll or show proof of other valid coverage. There is no minimum participation requirement for dependents.
10) Valid waivers include those waiving for other group or individual coverage. Waivers for other types of coverage are subject to underwriting review.
11) The employer must contribute a minimum of 50% to the employee only rate of the least expensive plan offered to employees.
12) Employee only contracts are available.
13) The employer must elect a probationary period from the following: (1) Date of hire (2) Day immediately following 30, 60 or 90 days (3) First of the month following DOH, 30 or 60 days.
14) Dependents are eligible for coverage up to age 26.
15) If an employer offers different benefits to different classes of employees, all other contract provisions such as contribution, probationary period and hourly requirements must be the same for all employees, regardless of class.
16) Premium is due on or before the first of the month for which coverage is provided. Payment at time of enrollment does not constitute coverage without UW approval.

Open Enrollment Period

1) If an employer does not meet the minimum contribution or participation requirements, they may only enroll during the period of November 15th through December 15th, for a January 1st effective date.
2) If an employer does not meet our contribution or participation requirements at renewal, we may decline to renew.

Dental Guidelines

1) Dental enrollment and eligibility must match medical enrollment.
2) Providence dental plans are only offered on a sole carrier basis and cannot be offered to a group with another dental carrier in place.
3) Employer can only choose one Providence dental plan.
4) Dental can only be purchased in conjunction with a medical plan through Providence.

This proposal is to be used for illustrative purposes only and is not an offer or contract. Providence Health Plan small group quotes are for the use of appointed agents only. The final rates will be determined by Providence Health Plan in writing when the final requirements, including receipt of Group Size Determination Form demonstrating the quoted business is a valid Oregon Small Employer, have been received and reviewed by the Underwriting department. Final rates will be based on (among other things): the most recent approved state filing for the requested final effective date of coverage, the final plan design selected, ages of those applying for coverage, number of family members issued coverage, zip code of the employer business. This document highlights some of the benefits available under these plans.