

HealthFlex Plan Options—Exhibit B

Plan Sponsor name _____

HealthFlex # _____ UMC ID # _____

Part 1 – Medical/Pharmacy

Please indicate which benefit option will be the default option for eligible participants (i.e., the benefit option that will cover an eligible participant who makes no election, if applicable).

- B1000 H2500 with HSA C2000 with HRA
 H2000 with HSA H5000 with HSA C3000 with HRA

Part 2 – Premium Credit (Monthly)

Plan Sponsor elects to fund a premium credit that their participants will use to purchase their health coverage. Plan Sponsor may provide a \$0 premium credit for one or more categories defined below.

The Plan Sponsor elects to treat Deacons as *clergy* or *lay* for premium credit purposes. Please select one: Clergy Lay

Plan Sponsor elects to fund the *same amounts* for all active and retired clergy, lay participants and their surviving dependents.

	Individual Coverage	Individual + 1 Coverage	Individual + Family Coverage
All	\$	\$	\$

OR

Plan Sponsor elects to fund *different amounts* for active and retired clergy, lay participants and their surviving dependents, as follows:

	Individual Coverage	Individual + 1 Coverage	Individual + Family Coverage
Active Clergy	\$	\$	\$
Active Lay—Conference	\$	\$	\$
Active Lay—SPU	\$	\$	\$
Pre-65 Retiree Clergy	\$	\$	\$
Pre-65 Retiree Lay	\$	\$	\$
Surviving Dependents of Clergy	\$	\$	\$
Surviving Dependents of Lay—Conference	\$	\$	\$
Surviving Dependents of Lay—SPU	\$	\$	\$
Leave of Absence—Medical	\$	\$	\$
Leave of Absence—Personal	\$	\$	\$

Note: Individuals on continuation coverage will be assigned a premium credit of \$0 for all tiers.

Part 3 – Dental Plan Options

Please indicate which dental benefit option will be the default option for eligible participants (i.e., the benefit option that will cover an eligible participant who makes no election, if applicable). *Dental HMO option cannot be designated as the default due to lack of HMO availability in certain ZIP codes.*

- No Coverage Dental PPO Dental Passive PPO 2000

Note: Individuals on continuation coverage are not eligible for dental coverage.

Part 4 – Vision

The default vision option will always be Exam Core. Participants will be able to choose between Exam Core, Full Service, or Premier vision plans.

Note: *Individuals on continuation coverage are only eligible for the Exam Core option.*

Part 5 – Flexible Spending Accounts (FSAs)

Active participants in HealthFlex Exchange are allowed to contribute to HealthFlex flexible spending accounts.

Part 6 – Medicare Secondary Payer Small Employer Exception

Check one box to indicate if the Plan Sponsor desires to elect to participate in the Small Employer Exception to the Medicare Secondary Payer rules for which the Plan has submitted an election to the Centers for Medicare and Medicaid Services (CMS). **Please note:** This does not eliminate the need to complete the necessary forms contained in the *Medicare Secondary Payer/Small Employer Exception Administrative Guidelines*, distributed under separate cover and also found in *Appendix F to the HealthFlex Plan Sponsor Manual*.

- Yes—Plan Sponsor elects to participate in the Small Employer Exception
 - Plan Sponsor chooses Via Benefits for their MSP participants
 - With HRA contribution
 - With **no** HRA contribution
 - Plan Sponsor elects to participate in the Small Employer exception with their own sponsored retiree plan (not Via Benefits)
- No—Plan Sponsor elects not to participate in the Small Employer Exception

- Notes:**
1. *Medicare Secondary Payer Small Employer Exception participants in Via Benefits are not eligible for auxiliary benefits through HealthFlex (vision, dental and behavioral health).*
 2. *Wespath must administer the CMS approval process for all Plan Sponsors that elect to participate in the Small Employer Exception.*
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Part 7 – Signatures

(Print name of Plan Sponsor) _____ has selected the Plan benefit options indicated above in this *Exhibit B* to the HealthFlex Plan Sponsor Adoption Agreement dated _____, to become effective on _____, 20 ____ and remain in effect until further notice.

Print name of authorized representative _____

Title _____ Date _____

- I understand that checking this box and typing my name on the e-mail that accompanies this document (sent from the work address of this authorized individual) constitutes a legally binding signature. In addition, by entering my name above and checking this box, I certify that I am authorized to execute this Adoption Agreement on behalf of the Plan Sponsor.

Accepted by Wespath:

Print name of authorized representative _____ Title _____

Authorized signature _____ Date _____