



Servant HR, Inc. Plan Detail Sheet



Plan Year: January 1, 2010 through December 31, 2010

Eligibility:

The Plan is effective **January 1, 2010**. You are eligible to participate, *subject to any IRS guidelines*, if you are a *regular employee working at least 30 hours per week*. Your election will become effective on January 1, or for new employees that join the Company during 2010 or in subsequent plan years, on the first of the month following thirty (30) days of service.

Maximum Elections:

	Medical Expenses	Dependent Care
Maximum (per year)	\$ 5,000.00	\$ 5,000.00*
Minimum (per year)	\$ 250.00	\$ 250.00

**If you are married and filing separately, your childcare maximum election is \$2,500.00.*

Annual Elections:

Your annual plan elections are irrevocable for the plan year. Please consider your medical and dependent care expenses carefully prior to electing coverage under each plan. If you do not incur enough eligible expenses to equal your elections, some of your contributions may be forfeited.

Open Enrollment:

If you do not elect to participate on your initial eligibility date, you may do so during the next annual open enrollment period. Open enrollment will normally occur several months prior to the end of the Plan Year. All open enrollment changes are effective for the next upcoming Plan Year following the close of open enrollment. You may elect to change your salary deferral amount for your Medical Flexible Spending Arrangement (MED FSA) and/or your Dependent Care Assistance Program Flexible Spending Arrangement (DCAP FSA) during open enrollment. If you have deductions towards your employer's group health plans, these deductions will be automatically deducted on a pre-tax basis unless you opt out and pay this with after-tax income.

Status Changes:

Mid-year you may change your elections **only** if you experience a qualifying event, subject to certain plan restrictions. Please call 125MAX for details and to receive a Change of Status Form.

Per Paycheck Elections:

Your FULL annual election/s will be spread evenly over the appropriate pay periods in this Plan Year. Should you become eligible mid-year, your annual election/s will be divided by the number of remaining paychecks in the Plan Year.

Eligible Claims:

Many health care expenses, including copays, Rx, dental, vision, and over-the-counter medicines are eligible for reimbursement. Dependent care expenses that enable both parents to be gainfully employed are also eligible for reimbursement. The IRS establishes the guidelines for claims eligibility. Your eligible MED FSA claims must be incurred during the plan year and after your participation effective date. If you terminate employment, medical claims must be incurred prior to your termination date, unless you qualify for, and elect MED FSA COBRA.

If you elect the DCAP FSA benefit and you terminate, you will have the entire *plan year (see below) to submit for work-related expenses incurred during the plan year to clear your account.

Reimbursements:

Claims are adjudicated and processed by 125MAX. Reimbursements will be itemized on your pay stub and included in your normal paycheck as a non-taxable reimbursement for those non-debit card related claims. These reimbursements are received in addition to your normal compensation. If your employment is terminated, any reimbursements owed (from claims submitted), will be mailed to you in a separate reimbursement check

Claim Filing:

Claims, *not paid with your debit card*, need to be submitted **by 12:00pm PST, ten (10) days** prior to the pay date in which you want the reimbursement. Claims may be submitted as they are incurred or they may be bundled and filed on a periodic basis. All claims for the Plan Year must be received by **March 31st** (Run-Out Period) after the Plan year-end.

Debit Card:

All New MED FSA participants will receive a debit card for your Medical Flexible Spending Arrangement. If you are an existing debit card holder, do not destroy your card. It will be reloaded with your 2010 MED FSA annual election.

Additional:

This Plan Detail Sheet provides a brief summary of several important elements of your Pre-tax Flexible Benefits Plan. Additional details may be found in the User's Guide from the Participant's Kit you will receive after enrolling in the 125MAX plan. For full plan details, rules, and restrictions, please refer to the Summary Plan Description.



125MAX Flex Expenses Eligible For Reimbursement (not exhaustive)

Medical

- Acupuncture
- Ambulance
- Artificial limbs
- Braille books and magazines
- Chiropractic visits
- Closed Caption TV equipment
- Contact Lenses, solutions and cleaners
- Contraceptives
- Deductibles
- Dental expenses
- Dentures
- Dermatologists
- Diagnostic fees
- Eyeglasses
- Handicapped car controls
- Hearing devices and batteries
- Infertility treatments
- Insulin
- Laboratory fees
- Non-prescription medications (over-the-counter)
Examples: Advil, Claritin, Nicorette, Tylenol, etc.
- Obstetrical expenses
- Orthodontia
- Orthopedic shoes
- Osteopaths
- Oxygen
- Pap smears
- Physical therapy
- Physician prescribed weight loss
- Podiatrists
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Radial/Laser eye surgery
- Seeing Eye dog and its upkeep
- Smoking cessation programs
- Special education for the handicapped
- Special blend vitamins by prescription
- Sterilization fees
- Support Braces- Letter of Medical Necessity Required
- Surgical expenses
- Therapeutic Care for drug or alcohol addiction
- TMJ-related expenses
- Well-baby care
- Wheelchairs

Dependent Care

- Care of a dependent child (12 years and under)
- Care of a dependent adult or child living in the home who is unable to care for themselves due to disability
- Day care center expenses
- Housekeeping Fees (if part is attributed to dependent care)
- Pre-School
- Summer day camp expenses
- YMCA fees (for day care)

This is only a partial list of the most commonly claimed eligible **medical** expenses. For a complete listing, go to IRS Publication 502 at: <http://www.irs.gov/pub/irs-pdf/p502.pdf>
Please note: Flex Plans reimburse based on when the expense is incurred, not when paid. Health insurance premiums and HMO premiums MAY qualify for credit on your tax return, but are not allowed to be reimbursed through the 125MAX Flex plans. Also, some items in Pub 502 are tax deductible only and not reimbursable through the Flex plan.

Please check with your 125MAX representative.



125MAX Flex Expenses Ineligible For Reimbursement (not exhaustive)

Medical

- Bottled water
- Cosmetic prescription drugs (Propecia, Rogaine, etc.)
- Cosmetic surgery procedures (unless necessary to eliminate a deformity, personal injury or disease)
- Food items
- Dental Veneers
- Expenses for food, clothing or entertainment
- Marriage/Group Counseling
- Prescription drugs for cosmetic purposes
- Teeth bleaching/whitening kits
- Vitamins and Dietary Supplements
- Premiums for individual coverage or coverage by spouse's employer

Dependent Care

- Care for a dependent over age 12
- Outside care of dependent when there is a stay-at-home spouse
- Child support payments
- Overnight camp expenses
- Tuition for a child in kindergarten or higher grade



125MAX Eligible Expense Estimator Worksheet

Flexible Spending Accounts (FSA) offer many benefits to employees by providing a simple way to gain tax savings. Participating in an FSA allows you to contribute, on a pre-tax basis through payroll deduction, to a medical and/or dependent care account. When you incur eligible expenses, as outlined by the IRS, you may then request reimbursement from your account(s). The reimbursements you receive from these accounts remain tax-free when they are paid to you in your paycheck as a non-taxable reimbursement.

MED FSA

Use this worksheet to estimate eligible medical expenses that you and your qualifying dependents may incur during the 2010¹ Plan Year (January 1, 2010 – December 31, 2010). This list is not all-inclusive of eligible expenses but contains some of the most common ones.

Annual Family Health Care Expenses	Estimate for 2010 ¹	Amount Paid in 2009
Medical expenses (office visits, emergency or urgent care, surgery, lab work, therapy)	\$	\$
Prescription drug expenses (copayments for home delivery or coinsurance for retail prescriptions)	\$	\$
Over-the-Counter (OTC) medications (refer to the listing of OTC eligible expenses)	\$	\$
Vision care expenses (exams, lenses, frames, contact lenses, cleaners, etc.)	\$	\$
Dental/orthodontia expenses (braces, cleanings, fillings, dentures, extractions, etc.)	\$	\$
Hearing care expenses (exams, hearing aids)	\$	\$
Braille books and magazines, specialized telephones or televisions for the hearing or sight impaired (additional cost above regular cost for item)	\$	\$
Tuition fees to a special school for a child with learning disabilities	\$	\$
Certain other eligible health care expenses that may not be covered by insurance (wheelchair purchase and maintenance, transportation costs essential to medical care, drug/alcohol treatment programs, guide dog, lead paint removal, nursing services, medically necessary weight loss programs)	\$	\$
Total: Use as a contribution-level guideline for 2010¹ Contribution maximum: \$5,000	\$	\$

DCAP FSA

Use this worksheet to estimate your eligible child and dependent care expenses during the 2010¹ Plan Year (January 1, 2010 – December 31, 2010). This is not an all-inclusive listing of eligible expenses but contains some of the most common ones.

Annual Dependent Care Expenses	Estimate for 2010 ¹	Amount Paid in 2009
Dependent care center fees (qualifying child or adult day care)	\$	\$
Nursery school fees (excluding Kindergarten)	\$	\$
Before-/After-school care	\$	\$
Private sitter (for expenses incurred while you, and spouse, if married, work)	\$	\$
Certain other eligible dependent care expenses	\$	\$
Total: Use as a contribution-level guideline for 2010¹ Contribution maximum: \$5,000	\$	\$

¹ Or when you become eligible for this Flex Plan.



Employee Annual Tax Savings Estimator

A. Employee portion of Group Insurance _____ per month
(not reimbursable) X 12 = \$ _____

B. Eligible out-of-pocket Medical Expenses:

Co-Pays \$ _____
Deductibles \$ _____
Prescriptions \$ _____
Non-Prescription Drugs \$ _____
Eye exams & surgery \$ _____
Dental \$ _____
Orthodontia \$ _____
Other \$ _____

Total \$ _____

C. Dependent Care Expenses \$ _____

Total Expenses \$ _____

(Estimated taxes saved) _____ x _____ %
multiply by your tax bracket percentage – average is 28%

Potential Employee Yearly Savings \$ _____



Enrollment Form

Medical and/or Dependent Care Flexible Spending Arrangement



PLAN YEAR: January 1, 2010 – December 31, 2010

Employee Data

Employer Name: SERVANT HR, INC.					
Employee Name:			Social Security Number:		
Mailing Address:			Daytime Phone:		
City, State, Zip:			Evening Phone:		
E-mail Address:			Date of Hire:		
May 125MAX communicate with you via email? (i.e. HIPAA Privacy Notice, EOBs, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No					
List All Tax Dependents (spouse, children, etc.) <input checked="" type="checkbox"/> = full-time student					
Name	Relationship	Date of Birth	Name	Relationship	Date of Birth
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

Type of Election and Current Coverage

Type of Election:	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Family Status Change	<input type="checkbox"/> New Hire
New Hire (only)	Date of Eligibility:	First Contribution (payroll date):	
Current Health Coverage (Check all that Apply) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other:			

Participant's Flexible Spending Arrangement Request

Please indicate desired participation for the current Plan Year. This election may not be changed during the Plan Year unless a qualified family status event occurs.

Medical Expenses

I **do** wish to participate I **do not** wish to participate

Plan Year Election: \$ _____

Plan Year Maximum: \$ 5,000.00

Plan Year Minimum: \$ 250.00

This election is for eligible medical expenses for you and/or your spouse and dependents. For example; acupuncture, co-pays, glasses, prescription drugs, and over-the-counter medicines.

Premium contributions **should not** be counted.

For plan information, on-line web access, debit card info, please visit our website at: www.125max.com.

Dependent Care Expenses

I **do** wish to participate I **do not** wish to participate

Plan Year Election: \$ _____

Plan Year Maximum: \$ 5,000.00

Plan Year Minimum: \$ 250.00

***If you are married and filing separately, your childcare maximum election is \$2,500.00.**

This election is for eligible dependent care expenses (daycare, childcare, or elder care). This election **should not** be used for medical expenses for your dependents. You must actually be at work while your eligible dependent is provided care. If you are married, both you and your spouse must be working while care is provided to your eligible dependent. Generally, one of the following eligibility guidelines must be satisfied.

* Your spouse must be working outside the home (if you are married); or

* You must be a single parent; or

* Your spouse must be a full-time student at least five months during the year while you are working; or You are divorced and the child is in your custody.

Employee Certification

I have read and understand the 125MAX Medical and/or Dependent Care Flexible Spending Arrangement Plan guidelines as outlined in the Enrollment Packet and I understand the restrictions that apply to eligible expense reimbursement requests. *Further, I understand that the above salary reduction request which will be allocated to my Flexible Spending Arrangement will be forfeited according to current plan provisions and tax laws if I do not incur and appropriately submit any eligible expenses within the Plan Year.* I certify the above information to be true and that the dependents that I intend to claim expense reimbursements for are legally dependent on me for their support as defined by current tax law. I agree to have my compensation reduced by the amounts indicated above. I understand that my election to reduce my compensation could affect my Social Security benefits and other wage-based social insurance programs. I further understand that the deduction elections indicated above will remain in effect for the entire Plan Year and cannot be changed or revoked unless I experience a qualified change in family status as defined by the law. I understand that my signature on this enrollment form constitutes a formal salary reduction agreement between my Employer and me.

Date: _____ Participant Signature: _____