The BESTflex℠ Plan

Enrollment Guide

Enroll in the BESTflex℠ Plan to get a tax-advantaged benefit that just works.

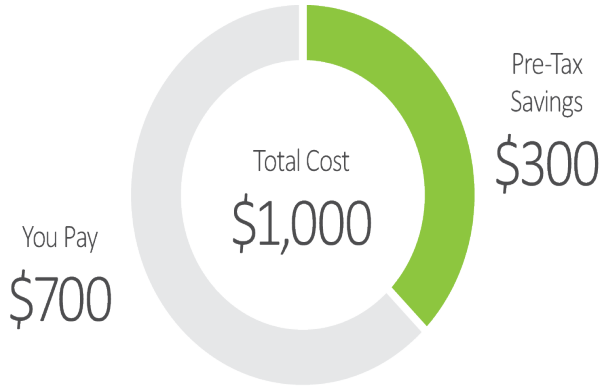
Use ***tax-free dollars*** to pay for eligible health care and daycare expenses.

How the BESTflex Plan Works

The BESTflex Plan is an easy way for you to save money on eligible expenses. With the BESTflex Plan, a portion of your paycheck is deposited in one or more Flexible Spending Accounts (FSAs) on a pre-tax basis. You can then use these funds to pay for out-of-pocket eligible expenses, which may include health or dependent care expenses.

How does the BESTflex Plan save me money?

The contributions that you make to your FSA are exempt from Federal, State, and FICA payroll taxes. This means that you save approximately 30%* on your eligible expenses, making a $100 eligible expense cost you about $70.



*These tax examples are broad approximations of tax liability. Your specific savings depend on your tax bracket. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all BESTflex Plan matters and are subject to change.

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Flexible Spending Accounts

You may participate in any BESTflex Plan accounts available under your employer's plan design, as long as you are eligible to participate. The most common options are the Health Care FSA and Dependent Care FSA.

Health Care FSA

There are two types of Health Care FSAs: a standard health FSA and a limited health FSA. With both Health Care FSAs, you choose how much pre-tax money you would like to contribute to the FSA, up to the annual limit.

Standard health FSA

A standard health FSA allows you to pay for eligible medical, vision, and dental expenses that are not covered by another health plan.

Limited health FSA

A limited health FSA allows you to pay for eligible vision and dental expenses that are not covered by another health plan. A limited health FSA is a great option if you (or your spouse, if you're married) contribute to a Health Savings Account (HSA) because you can participate in both of these plans at the same time.

Dependent Care FSA

A Dependent Care FSA allows you to set aside pre-tax funds to pay for daycare expenses for children or other eligible dependents. You (and your spouse, if you're married) must be working, looking for work, or be a full-time student to use this account. When you enroll in this plan, you choose how much pre-tax money you would like to contribute to the FSA, up to the annual limit.

When you enroll in a Dependent Care FSA, you pay for your eligible daycare expenses out-of-pocket and then are reimbursed after completing a claim form. Claims for reimbursement can be submitted through your online account or on our mobile app.

Using the FSA

When paying for eligible products and services, your Benefits Card* is the most convenient way for you to access your Health Care FSA funds. Your Benefits Card is a prepaid debit card that uses funds directly from your benefits plan. You can also pay for your eligible expenses out-of-pocket and then be reimbursed. For reimbursement, you must submit a claim form through your online account or on our mobile app.

Filing Claims

We make filing claims easy and we offer three options: **Mobile, Online** or via a paper **Claim Form.**

Our mobile app, EBC Mobile, lets you file a claim using your phone to take and submit pictures of receipts/expense documentation at home or on the go. Filing a claim for any eligible health care or dependent care expense doesn't get any easier. Complete a few lines on a simple form, upload your receipt using your phone's camera and tap ***Submit***. EBC Mobile makes filing claims smart, simple, and secure!

Online Account

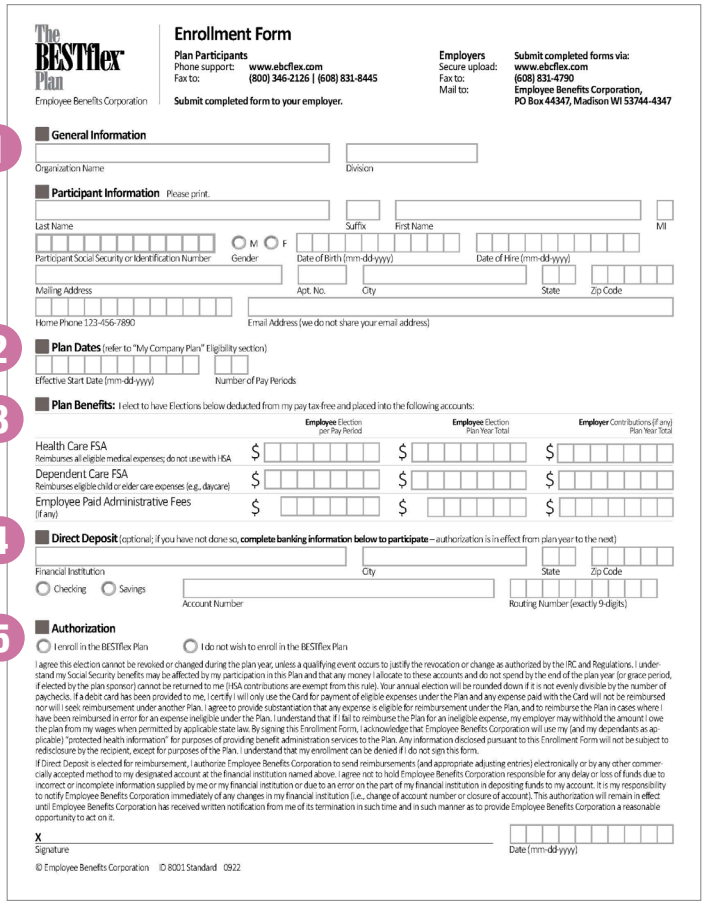
Once you enroll in the BESTflex Plan, register your online account at www.ebcflex.com. In your online account, you will be able to:

- View and file claims
- Review account balance(s)
- Monitor the status of your claims
- Access forms and information regarding the operation of your plan
- Update personal information
- View a detailed account history

How to Enroll in the BESTflex Plan:

Enrollment in the BESTflex Plan

We help you set aside the right amount of money for eligible health care and dependent care expenses. Referencing your *Eligible Expenses List* and using the worksheets we've created, you'll arrive at a solid estimate of how much money you should contribute to the plan and help alleviate concerns about forfeiting any contributions.



The BESTflex Plan
Employee Benefits Corporation

Enrollment Form

Plan Participants
Phone support: www.ebcflex.com
Fax to: (800) 346-2126 | (608) 831-8445
Submit completed form to your employer.

Employers
Secure upload: www.ebcflex.com
Fax to: (608) 831-4790
Mail to: Employee Benefits Corporation, PO Box 44347, Madison WI 53744-4347

1 **General Information**
Organization Name | Division

Participant Information Please print.
Last Name | Suffix | First Name | MI
Participant Social Security or Identification Number | Gender M F | Date of Birth (mm-dd-yyyy) | Date of Hire (mm-dd-yyyy)
Mailing Address | Apt. No. | City | State | Zip Code
Home Phone 123-456-7890 | Email Address (we do not share your email address)

2 **Plan Dates** (refer to "My Company Plan" Eligibility section)
Effective Start Date (mm-dd-yyyy) | Number of Pay Periods

3 **Plan Benefits:** I elect to have Elections below deducted from my pay tax-free and placed into the following accounts:

	Employee Election per Pay Period	Employee Election Plan Year Total	Employer Contributions (if any) Plan Year Total
Health Care FSA — Reimburses all eligible medical expenses; do not use with HSA	$	$	$
Dependent Care FSA — Reimburses eligible child or elder care expenses (e.g., daycare)	$	$	$
Employee Paid Administrative Fees (if any)	$	$	$

4 **Direct Deposit** (optional; if you have not done so, **complete banking information below to participate** – authorization is in effect from plan year to the next)
Financial Institution | City | State | Zip Code
Checking Savings | Account Number | Routing Number (exactly 9-digits)

5 **Authorization**
I enroll in the BESTflex Plan | I do not wish to enroll in the BESTflex Plan

I agree this election cannot be revoked or changed during the plan year, unless a qualifying event occurs to justify the revocation or change as authorized by the IRC and Regulations. I understand my Social Security benefits may be affected by my participation in this Plan and that any money I allocate to these accounts and do not spend by the end of the plan year (or grace period, if elected by the plan sponsor) cannot be returned to me (HSA contributions are exempt from this rule). Your annual election will be rounded down if it is not evenly divisible by the number of paychecks. If a debit card has been provided to me, I certify I will only use the Card for payment of eligible expenses under the Plan and any expense paid with the Card will not be reimbursed nor will I seek reimbursement under another Plan. I agree to provide substantiation that any expense is eligible for reimbursement under the Plan, and to reimburse the Plan in cases where I have been reimbursed in error for an expense ineligible under the Plan. I understand that if I fail to reimburse the Plan for an ineligible expense, my employer may withhold the amount I owe the plan from my wages when permitted by applicable state law. By signing this Enrollment Form, I acknowledge that Employee Benefits Corporation will use my (and my dependants as applicable) "protected health information" for purposes of providing benefit administration services to the Plan. Any information disclosed pursuant to this Enrollment Form will not be subject to redisclosure by the recipient, except for purposes of the Plan. I understand that my enrollment can be denied if I do not sign this form.

If Direct Deposit is elected for reimbursement, I authorize Employee Benefits Corporation to send reimbursements (and appropriate adjusting entries) electronically or by any other commercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it.

X _____ Signature | Date (mm-dd-yyyy)

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(Sample Enrollment Form shown; your form may differ slightly)

*Some employers may choose not to offer the Benefits Card. Refer to My Company Plan for details about your specific plan.

Follow enrollment instructions from your employer. If you receive an enrollment form, complete these steps:

1. **Enter General and Personal Information.** Enter all of your information, including an email address if you have one. Providing your email ensures that you get updates on your plan quickly.
2. **Enter Plan Dates.** Enter the date you start the plan (the Effective Start Date) and the number of paychecks per year from which your elections are deducted (Number of Pay Periods). Enrollment is for one plan year, usually consisting of 12 calendar months or less.
3. **Enter BESTflex Plan Benefits.** Enter your annual election for your plan selections under the *Plan Benefits* section. Choose the amount you'd like deducted from each paycheck (Employee Deduction per Pay Period) and multiply that amount by the Number of Pay Periods to determine your Plan Year Total.
   Do this for each FSA in which you are enrolling and total the form.
   If you receive contributions from your employer, add the Employer Contribution Plan Year Total.
4. **Complete Direct Deposit Information.** You have the option of having your reimbursement deposited directly into your personal checking or savings account. To authorize the direct deposit feature of the BESTflex Plan, provide the financial account information requested on the enrollment form. If you already have direct deposit information on file with us, it is not necessary to provide it again. The direct deposit feature will carry over to your new plan year.
5. **Authorize Enrollment and Direct Deposit.** First, indicate whether you want to participate in the BESTflex Plan. Then sign and date the form and return it to your employer.
   If you choose to not enroll in the BESTflex Plan FSAs, you must sign and date the form anyway. Your eligible employer-provided insurance premiums will still be deducted from your pay on a pre-tax basis.

What Happens After I Enroll?

Your employer will begin making payroll deductions according to your elections and you can then use your FSA benefits in accordance with your *Summary Plan Description* and *My Company Plan*. Check your pay stub to ensure these amounts are correct.

Once your plan year starts, activate your online account at **www.ebcflex.com.**

Review My Company Plan

My Company Plan, the appendix to your *Summary Plan Description (SPD),* describes the specific details and features of your company's BESTflex Plan. Use the information in *My Company Plan* to aid in completing your enrollment.

My Company Plan Contains:

A. BESTflex Plan Dates, including the date your employer started its BESTflex Plan (Original Plan Date) and the start and end dates of your employer's current BESTflex Plan (My Company's Plan Year)

B. Eligibility definitions

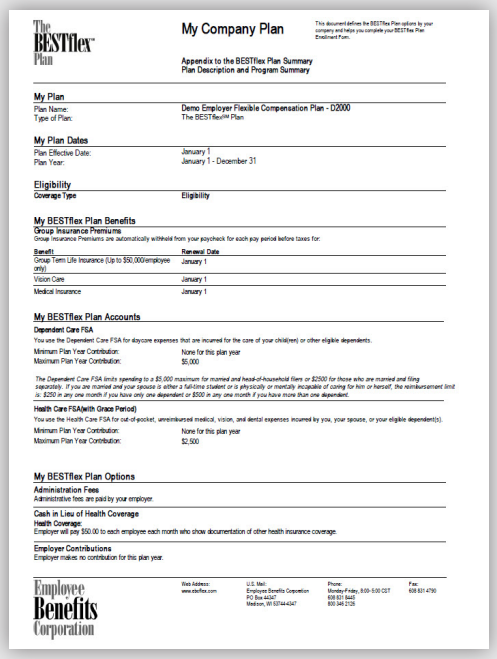
C. Group Insurance Premiums, the types of premiums deducted from your paycheck on a pre-tax basis

D. The Health Care and Dependent Care FSA contribution limits, the maximum amount you can contribute to each account

E. Plan Amendments, if any

F. Company Information regarding who to contact within your Company

G. Legal Information defining the relationship between your employer and Employee Benefits Corporation



The BESTflex Plan

My Company Plan

This document defines the BESTflex Plan options by your company and helps you complete your BESTflex Plan Enrollment Form.

Appendix to the BESTflex Plan Summary
Plan Description and Program Summary

My Plan

Plan Name:	Demo Employer Flexible Compensation Plan - D2000
Type of Plan:	The BESTflex℠ Plan

My Plan Dates

Plan Effective Date:	January 1
Plan Year:	January 1 - December 31

Eligibility

Coverage Type	Eligibility

My BESTflex Plan Benefits

Group Insurance Premiums

Group Insurance Premiums are automatically withheld from your paycheck for each pay period before taxes for:

Benefit	Renewal Date
Group Term Life Insurance (Up to $50,000/employee only)	January 1
Vision Care	January 1
Medical Insurance	January 1

My BESTflex Plan Accounts

Dependent Care FSA

You use the Dependent Care FSA for daycare expenses that are incurred for the care of your child(ren) or other eligible dependents.

Minimum Plan Year Contribution:	None for this plan year
Maximum Plan Year Contribution:	$5,000

The Dependent Care FSA limits spending to a $5,000 maximum for married and head-of-household filers or $2500 for those who are married and filing separately. If you are married and your spouse is either a full-time student or is physically or mentally incapable of caring for him or herself, the reimbursement limit is $250 in any one month if you have only one dependent or $500 in any one month if you have more than one dependent.

Health Care FSA(with Grace Period)

You use the Health Care FSA for out-of-pocket, unreimbursed medical, vision, and dental expenses incurred by you, your spouse, or your eligible dependent(s).

Minimum Plan Year Contribution:	None for this plan year
Maximum Plan Year Contribution:	$2,500

My BESTflex Plan Options

Administration Fees
Administrative fees are paid by your employer.

Cash in Lieu of Health Coverage
Health Coverage
Employer will pay $50.00 to each employee each month who show documentation of other health insurance coverage.

Employer Contributions
Employer makes no contribution for this plan year.

Employee Benefits Corporation

Web Address: www.ebcflex.com
U.S. Mail: Employee Benefits Corporation PO Box 44347 Madison, WI 53744-4347
Phone: Monday-Friday, 8:00-5:00 CST 608 831 8445 800 346 2126
Fax: 608 831 4790

My Company Plan is available online at www.ebcflex.com.