Episcopal Diocese of Western North Carolina

PREMIUM ONLY PLAN (POP Plan)

It is the intent that this plan shall qualify as a Section 125 plan of IRC, as amended from time to time. The purpose of the plan is to allow employees the opportunity to elect to pay the portion of medical insurance premium costs, for which they are responsible, either on a pre-salary reduction basis, or through a post-tax salary deduction. The plan is effective from January 1, 2016 through December 31 of each year until the plan has been discontinued in writing. All employees working 30 hours per Week as of January 1 of each year and who contribute toward the cost of coverage may elect to participate. Employees must enroll before each plan year.

Money set aside in the premium only plan will automatically be used by Episcopal Diocese of Western North Carolina to pay premiums for everyone enrolled in the organization's health insurance policy.

The maximum amount of the employee contribution is limited to the difference between the total plan costs and the amount contributed by the organization. Since this amount may change periodically, the organization does not specify an annual maximum in this document. Episcopal Diocese of Western North Carolina will automatically increase or decrease the amount of your salary reduction to correspond with changes in the cost of premiums. You will be notified of any change in premium cost as soon as possible.

New employees are allowed to participate once they have satisfied the waiting period for health insurance coverage. At Such time, employees will be provided with an election form for use in communicating their decision to contribute on either a pre-tax or post-tax salary deduction basis. Elections will apply until the end of the plan year.

Participation terminates on the earlier of the plan year end or the participant ceases to be an employee. Participant may not change coverage amounts unless there has been a qualifying change in family status.

Episcopal Diocese of Western North Carolina

Employer Signature: _____ Adoption Date: _____

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Premium Only Plan Election Form

Name:

Social Security Number:

1. Enrollment Type (Check One): Effective Date is January 1 or the first of the month following your date of hire or the date the enrollment form is signed, if later. You cannot be reimbursed for expenses incurred prior to the Effective Date.

- ☐ Annual Open Enrollment for Annual plan effective January 1.
- ☐ New Hire Enrollment for (effective date*) through December 31, 200X
- ☐ Revised Enrollment due to Employment Status Change for (effective date*) through December 31, 200X
- ☐ Revised Enrollment due to Family Status Change for (effective date*) through December 31, 200X

2 . Election and Contribution:

I am enrolling in (check as many as apply):

- ☐ Premium Only Plan: Money set aside in this account will be used to pay the Cost Of your health insurance premiums. I elect salary reduction in the amount necessary to satisfy the required contribution I am expected to pay toward the cost Of coverage for which I am eligible under the Organization' s group insurance plan. I understand that this is a pre-tax Option and my Social Security Benefits may be reduced as a consequence of this election.

- ☐ I do not wish to elect salary reduction, please take the necessary Contribution as a post tax salary deduction.

- ☐ I do not wish to elect the coverage for which I am eligible and certify that I and/or my dependents are covered under another insurance plan

3. Authorization and Agreement: The required Contribution amount will be taken in equal installments on an annual basis from my paychecks while I am enrolled in this plan.
I understand that this authorization is irrevocable until the next election period unless I have a change in family status and the change I wish to make to my election is consistent with that change in status as specified in the Internal Revenue Code and regulations. All Changes must be reported and a new election form must be completed within 30 days of the change.

Employee Signature: _____ Date: _____