CITIZENS MEMORIAL HOSPITAL

FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION
&
PLAN DOCUMENT

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FLEXIBLE BENEFITS PLAN
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CITIZENS MEMORIAL HOSPITAL
FLEXIBLE BENEFITS PLAN
PLAN DOCUMENT

The following document will act as the Plan Document (Plan) for the Citizens Memorial Hospital Flexible Benefits Plan. This Plan has been established by the Employer and Plan Sponsor and became effective as amended on January 1, 2013. The Summary Plan Description (SPD) is a separate Document and along with the Plan Document is available to any Plan Member.

Section 1
INTRODUCTION

1.1 Creation and Title. The Employer hereby amends its cafeteria plan under the terms and conditions set forth in this document. The Plan is to be known as Citizens Memorial Hospital Flexible Benefits Plan.

1.2 Effective Date. The provisions of the Plan as amended shall be effective as of January 1, 2013.

1.3 Purpose. The purpose of the Plan is to allow employees to select among cash compensation and certain nontaxable benefits, namely coverage under one or more benefits programs maintained by the Employer. The Employer intends that the Plan qualifies as a cafeteria plan under Section 125 of the Code, and that the benefits provided under the Plan be eligible for exclusion from Federal income tax.

Section 2
PARTICIPATION

2.1 Eligibility. Each Employee, as defined in Section 7, shall be eligible to participate in the Plan so long as the Participant is a full-time employee working at least 36 hours per week or 20 hours per week for part time employees, employed by the Employer as of his or her Entry Date and meets the eligibility requirements. Employees who meet the eligibility requirements may enroll in the Plan at Open Enrollment. New Employees hired during the Plan Year who meet the eligibility requirements will be eligible in the Plan on the first day of the month following their date of hire.

2.2 Commencement of Participation. An Eligible Employee shall become a Participant in the Plan after providing the Plan Administrator with an executed Benefits Enrollment Form setting forth the Benefits to be made available to the Eligible Employee for the immediately following Plan Year. As part of the Benefits Enrollment Form, the Participant shall also execute a Salary Reduction

Agreement, which authorizes the Employer to withhold from the Participant's Compensation an amount the Participant elects to have contributed to the Plan. The Participant must, before the end of the first Plan Year of participation and, before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Form. Each new Benefits Enrollment Form shall specify the type and amount of Benefits to be made available to the Participant for the immediate following Plan Year.

2.3 Term of Participation. Each Participant shall be a Participant in the Plan for the entire Plan Year after the Participant's Entry Date. A Participant shall cease to be a Participant in the Plan on the earliest of:

(a) the date the Participant dies, resigns or terminates employment with the Employer, subject to the provisions of Section 2;

(b) the date the Participant fails to make required contributions under the Plan;

(c) the date the Participant ceases to be an Employee; or

(d) the date the Plan terminates.

2.4 Participation by Rehired Employees. Each Participant in the Plan who separates from service with the Employer shall suspend participation under this Plan for the period from the date of termination to the last day of the Plan Year in which the termination occurred. During such period of suspension, any contributions pursuant to a Salary Reduction Agreement shall cease. Participation in the Plan shall terminate on the first day of the next Plan Year, provided the terminated Employee has not been rehired by the Employer on such date. If a terminated Employee should later be rehired by the Employer in the same Plan Year as the Plan Year in which he or she separated from service, such Employee may elect to resume participation in the Plan under the terms of the Benefits Enrollment Form in force on the date of termination of employment.

2.5 HIPAA Portability. Notwithstanding any other provisions in this Article III, any Employee who becomes eligible under the Health Portability and Accountability Act of 1996("HIPAA") for coverage by an Accident or Health benefit under the Plan shall be allowed to participate in the Plan, so long as such Employee complies with the provisions set out in HIPAA.

2.6 COBRA Continuation Coverage. Under COBRA, This Section 2 shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Notwithstanding any other provisions in this section, any Participant, Spouse or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse or Dependent complies with the provisions set out in COBRA.

The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

2.7 **Family and Medical Leave Act.** Under the FMLA, the provisions of this section shall not be available to Employees for such Plan Years in which the Employer has 50 or fewer Employees. For Plan Years in which the Employer has more than 50 Employees, the Employer must make FMLA leave available to Employees for up to 12 weeks in connection with the birth or adoption of a child, or to care for a close relative, or because of a serious health condition of the Employee. The Employer waives the requirement that employees pay their cost of continued coverage while on FMLA leave.

Section 3
PARTICIPANTS' ACCOUNTS AND PAYMENT OF BENEFITS

3.1 **Participants' Benefit Accounts.** The Plan Administrator shall establish separate Benefits Accounts based on the Benefits selections made by each Participant. Contributions shall be credited to the proper Benefits Accounts of each Participant. Each Benefits Account shall be designated as a "Premium Account" or as a "Reimbursement Account".

3.2 **Premium Account.** A "Premium Account" is an account established with the intent of paying for premium-type benefits pursuant to an insurance policy issued by an insurance company, or a contract with a health maintenance or preferred provider organization to provide medical, psychological or psychiatric, prescription drugs, or other qualified benefits under Section 125.

3.3 **Reimbursement Account.** A "Reimbursement Account" is an account established with the intent of providing reimbursement of allowable expenses pursuant to a medical or dependent care reimbursement plan offered by the Employer.

3.4 **Payment of Benefits.** The Plan Administrator shall pay the Benefits authorized under the Plan other than insurance benefits administered by a third-party benefit provider. Payment shall be made by the Employer, (or the designated Plan Administrator), in a timely manner upon receipt of a Premium Notice from the Benefit Provider providing such benefit. In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

(a) Executor of the Estate of the deceased Participant,
(b) Spouse,
(c) Family member held responsible for payment of deceased's medical bills,
(d) Spouse of dependent with COBRA continuation rights.

3.5 Heroes Earnings Assistance and Relief Tax Act of 2008 (referred to as the HEROES or HEART Act). The Act and permits distributions from a health flexible spending accounts for certain US military reservists. A “qualified reservists distribution” is defined as any distribution to an employee of all or a portion of the balance in the employee’s health FSA if: 1) the employee was ordered or called to active duty for a period in excess of 179 days or for an indefinite period; and 2)such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made for the Plan Year which includes the date of such order or call. The disbursements will be made to those Participants who qualify in accordance with the regulation language of the Act.

Section 4
CONTRIBUTIONS

4.1 Source of Contributions. The Employer shall contribute amounts deemed necessary to meet its obligations under the Plan. Contributions to the Plan for the Plan Year shall be limited to the amounts determined by the Benefits Enrollment Form entered into by Participants for the Plan Year.

Contributions to the Plan shall be made to, and all Plan assets shall be held in such accounts or funds as the Employer deems appropriate.

4.2 Changes in Participant's Benefits Enrollment. No Participant in the Plan shall be allowed to alter or discontinue the Participant's elected Benefits under the Plan during a Plan Year except when due to and consistent with a Status Change.

Upon the occurrence of a Status Change, the Participant may file a new Benefits Enrollment form, which will serve to revoke the Participant's previous Benefits Enrollment Form. The new Benefits Enrollment Form, if determined by the Plan Administrator to be timely submitted and consistent with the Status Change, shall be effective prospectively and apply only to those Benefits accruing to the Participant, the Participant's Spouse or the Participant's Dependents after the effective date of the new Benefits Enrollment Form. With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" shall mean submitted no later than the last day of such special enrollment period. With respect to any other change in election, the Plan Administrator shall determine if the new Benefits Enrollment Form has been timely submitted consistent with the nature of the Status Change. The Participant's Benefits Enrollment Form for a given Plan Year shall terminate and Benefits under the Plan shall cease upon the date a Participant is no longer eligible to participate under the terms of this Plan.

4.3 Increases or Decreases in Premiums. Should a third party benefit provider, such as an Insurance Company, increase or decrease premiums for any health

benefits being offered under this Plan during the Plan Year, any Participant participating in such benefit shall have his premium contributions increased or decreased automatically in an amount sufficient to pay for such increase or decrease. However, in the case of an increase in premium, if there is a similar benefit offered under the Plan at the time of said increase, the Participant may select such similar benefit rather than pay the increase.

4.4 Maximum Contribution. The Maximum Contribution any individual can make under this Plan is an amount equal to the sum of the costs for each of the highest cost premium-type Benefit Options offered under the Plan in each Benefit Category plus the sum of the deferrals made to Reimbursement-type Benefit programs under this Plan. The term "Benefit Option" refers to any category of Benefits offered under this Cafeteria Plan in which the Participant has the opportunity to choose one benefit from several different Options in that category. The term "Benefit Category" refers to any category of Benefits offered under this Plan.

4.5 Nondiscrimination. The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated individuals from participation in the Plan or limiting the contributions made with respect to certain highly compensated participants if, in the Plan Administrator's review and judgment, such actions serve to assure that the Plan does not violate the applicable nondiscrimination rules.

Section 5
PLAN ADMINISTRATION

5.1 Plan Administrator. The Plan Administrator shall be responsible for the administration of the Plan.

5.2 Plan Administrator's Duties. In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator shall have the following rights, duties and powers:

(a) to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

(b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;

(c) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;

(d) to develop appellate and review procedures for any Participant, Spouse, Dependent or designated beneficiary denied benefits under the Plan;

(e) to provide the Employer with such tax or other information it may require in connection with the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of Section 125 of the Code.

5.3 Information to be Provided to Plan Administrator. The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator might reasonably request to insure the proper and efficient administration of the Plan.

5.4 Decision of Plan Administrator Final. Subject to applicable State or Federal law, and the provisions of Section 5, below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

5.5 Review Procedures. In cases where the Plan Administrator denies a benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish in

writing to said party the reasons for the denial of benefits. The written denial shall be provided to the party within 30 days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 180 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his final decision on the reviewed claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

5.6 Extensions of Time. In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any Participant, Spouse, Dependent or designated beneficiary may need to appeal a claim, upon proper application to the Plan Administrator.

5.7 Rules to Apply Uniformly. The Plan Administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

5.8 Indemnity. The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law and over and above any liability coverage contracts or directors and officers insurance, any officer or director of the Employer, designated by the Employer or the Plan Administrator who has been employed, hired or contracted to assist in the fulfillment of the administration of this Plan. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties over and above those paid by any liability or insurance contract.

Section 6
GENERAL PROVISIONS

6.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant, Spouse, Dependent or designated beneficiary was or might have been entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with

Section 125 of the Code or any other provision of the Code applicable to the Plan.

6.2 Nonassignability. Any benefits to any Participants under this Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents and designated beneficiaries. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

6.3 Medical Child Support Orders. The Plan Administrator shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which

(i) relates to the provision of child support related to health benefits for a child of a Participant of a group health plan

(ii) is made pursuant to a state domestic relations law and

(iii) creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

The Plan Administrator shall promptly notify the Participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Any such Qualified Medical Child Support Order, (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO shall not require the Plan to provide any type or form of benefit, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Reconciliation Act of 1993 (OBRA '93).

Upon determination of a Qualified Medical Child Support Order, the Plan must

recognize the QMCSO by providing benefits for the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions. A copy of the Plan's QMCSO is available, upon request, at no charge from the Plan Administrator.

6.4 Not an Employment Contract. By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

6.5 Participant Litigation. In any action or proceeding against the Plan, or the administration thereof, employees or former employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their registered representatives shall be the sole source for service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

6.6 Addresses, Notice and Waiver of Notice. Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefitting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

6.7 Required Information. Each Participant, Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

6.8 Severability. In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

6.9 Applicable Law. The Plan shall be construed under the laws of the State, to the extent not preempted by any Federal law.

Section 7
DEFINITIONS

As used in this Plan Document, the following terms shall have the following meanings:

7.1 **"Affiliate Employer"** means any employer which adopts the Plan with the approval of Citizens Memorial Hospital.

7.2 **"Benefits"** mean cash and the various qualified benefits under Section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan, including, but not limited to, health insurance, vision care, dental, medical reimbursement and dependent care reimbursement.

7.3 **"Benefits Accounts"** mean the accounts established by the Plan Administrator under the Plan for each Participant's Benefits for purposes of administering the Plan.

7.4 **"Benefits Enrollment Form"** means the form or forms, including a Salary Reduction Agreement, evidencing an Eligible Employee's selections from among the various Benefits and the amount to be contributed towards various Benefits for a Plan Year.

7.5 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

7.6 **"Compensation"** means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not included the in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Code.

7.7 **"Dependent"** means an individual who is a dependent within the meaning of Section 152(a) of the Code of a Participant or a former Participant in the Plan. With the changes allowed under PPACA, the Plan considers Dependent children through the end of the tax year in which the Dependent turns 26.

7.8 **"Effective Date"** shall be as amended January 1, 2013.

7.9 **"Eligible Employee"** means an Employee, as defined in Section 7.10 below, who has met the Eligibility requirements of the Plan set out in Section 2.

7.10 **"Employee"** means an individual employed by the Employer, who is a Full-Time employee who regularly works at least 36 hours per week or part time employee who works at least 20 hours per week except for: (1) employees covered by a collective bargaining agreement, (2) employees who are self-employed individuals as defined in section 401 C of the Internal Revenue Code (including sole proprietors and partners in a partnership), and (3) employees who own (or are ,considered to own within the meaning of section 318 of the Internal Revenue Code) more than 2 percent of the outstanding stock of an S corporation or stock possessing more than 2 percent of the total combined voting power of all stock of such corporation.

7.11 **"Employer"** means Citizens Memorial Hospital or any of its affiliates, successors or assignors which adopt the Plan.

7.12 **"Entry Date"** means for each Eligible Employee, the first day of the Plan Year.

7.13 **"Participant"** means any Employee who has met the eligibility requirements of Section 2 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Benefits Enrollment Form.

7.14 **"Plan"** means Citizens Memorial Hospital Flexible Benefits Plan, as described herein.

7.15 **"Plan Administrator"** means the Employer or such other person or committee

as may be appointed by the Employer to administer the Plan.

7.16 **"Plan Year"** means the 12-consecutive-month period beginning on January 1st and ending on December 31st.

7.17 **"Salary Reduction Agreement"** means the agreement by an Employee authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of making contributions toward Benefits under the Plan.

7.18 **“Short Plan Year”** means the initial Plan Year would be less than 12 months if the Plan is established mid-year. This Plan does not have a Short Plan Year.

7.19 **"Spouse"** means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

7.20 **"Status Change"**

(a) With regards to the election to participate in the Plan and elections for benefits other than Health, Status change shall mean a change in status such as the marriage or divorce of the Participant; the adoption, birth, or death of a child or other Dependent of the Participant or the Participant's Spouse; the emancipation or coming of age of a child of the Participant so that the child is no longer eligible as a Dependent under the Plan; the employment of the Participant's Spouse; or such other event as may qualify as a change in status in the opinion of the Plan Administrator.

(b) With regards to elections for Health benefits, Status Change shall mean events that change an Eligible Employee's legal marital status, number of dependents, the Eligible Employee, Spouse or dependents employment status, work schedule, residence or work site, an event that causes an Eligible Employee's Dependent to satisfy or cease to satisfy the requirements for coverage, and such other events as provided in code or Regulation.

(c) Additional Special Enrollment Rights: This Plan will permit employees and Dependents which are eligible but not enrolled for coverage to enroll in two additional circumstances:

1. The employee’s or Dependent’s Medicaid or CHIPRA coverage is terminated as a result of loss of eligibility and the employee requests coverage under the Plan within 60 days after the termination, or
2. The employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIPRA, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

Executed this ______________day of ___________________ ,____________.

Employer: Citizens Memorial Hospital

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Approved by

CITIZENS MEMORIAL HOSPITAL
FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

We would like to welcome you as a participant to your employers Flexible Benefits Plan. This summary explains how the US Treasury and IRS have made it possible for individuals like you to set payroll dollars aside for Medical or Dependent Care purposes, before taxes are taken out. This document acts as a summary of the benefit and rules for your Flexible Benefits Plan. This is only a summary as there is also a Plan Document available to each plan member outlining details of the Plan.

PLAN PURPOSE

The Citizens Memorial Hospital Flexible Benefits Plan is a benefit program that allows you to use benefit dollars in a cost effective manner which best suits your needs. Section 125 of the Internal Revenue Code permits Citizens Memorial Hospital to offer you the chance to get involved in designing your personalized benefit plan on a tax-favored (pretax) basis.

WHO IS ELIGIBLE TO ENROLL IN THE PLAN

Each Employee shall be eligible to participate in the Plan so long as the Participant is employed by the Employer as of his or her Entry Date and is considered a full-time employee who works at least 36 hours a week or a part-time employee who works at least 20 hours per week. Employees who meet the eligibility requirements may enroll in the Plan at Open Enrollment. New Employees hired during the Plan Year who meet the eligibility requirements will be eligible in the Plan the first day of the month following the date of hire.

HOW TO ENROLL

After you become eligible, you must select which benefits you would like to purchase through the Plan. Your decision must be made during the month preceding the Plan Year for which it will be in effect. Each year, Citizens Memorial Hospital will provide you with a written election form that will enable you to identify the benefits in which you wish to participate and the portion of your compensation reduction that may be applied to provide each benefit.

If for some reason, as a newly eligible employee, you fail to complete an election form, then you will be deemed to have elected cash compensation to the extent permissible. If you are already a Plan participant and you fail to complete an election form for the upcoming Plan Year, then you will not be eligible to participate in either Spending Account.

You may build a completely new plan each year. Keep in mind that your choices are in effect for the entire Plan Year. *Only under special circumstances,* such as changes in

status, changes in the cost of coverage under the plan, and certain other events, may you apply to change your selected benefits. Generally, the change must be consistent with the change event, to the extent that it is necessary or appropriate as a result of the change.

Special circumstances also include cost and coverage changes to a health plan, such as a significant increase in the cost of your coverage, a significant decrease in or cessation of your coverage or a significant change in your health coverage or your spouse's attributable to your spouse's employment. For these instances, however, only a change to another health plan with similar coverage is permitted. Think about your needs carefully because the benefits you choose but do not use cannot be converted to cash or accumulated from year to year.

If you should terminate your employment and stop your elections under this Plan, you may, if rehired, begin to participate in the Plan again after re-satisfying the eligibility requirements. However, you may not make a new election which is effective during the Plan Year in which your service with Citizens Memorial Hospital was terminated.

If, for any reason, you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax payment of premiums until the next Plan Year.

WHEN YOU ARE ELIGIBLE TO ENROLL

As an eligible employee, you may enroll in the Plan during Open Enrollment or for a new hire, can be enrolled for eligibility the first day of the month following the date of hire.

SCHEDULE OF FLEXIBLE BENEFITS

Benefits may be purchased through the Flexible Benefits Plan with pretax income. Details relative to the cost per pay for each benefit and the minimum and maximum amounts you may contribute to the Spending Accounts are provided by Citizens Memorial Hospital on the enrollment form.

The benefits from which you may choose include:

- premium payroll deduction
- a medical spending account
- a dependent care spending account

Each benefit under the Flexible Benefits Plan has separate rules governing benefits and plan administration. These rules are explained in more detail in the Plan Document which has been prepared solely for the purpose of each particular benefit. A copy of all this information is available from the Director of Human Resources of Citizens Memorial Hospital.

OPTIONAL BENEFITS

Briefly, the Optional Benefits from which you may choose are as follows:

1. Premium Payroll Deduction

You may purchase coverage for yourself and your family through the Flexible Benefits Plan. You may pay for this coverage using pretax dollars that are automatically deducted per pay period. See Schedule A for those plans that qualify.

2. Medical Spending Account

There are some expenses you know you'll have to pay for in the coming year; for instance, new eye glasses, medical and dental care expenses not covered by the health plan. Normally you'd pay for expenses like these with after-tax income. And, because taxes reduce the value of your dollar, you'd have to earn considerably more than $100 to pay for $100 of expenses.

3. Dependent Care Account

There are dependent care expenses you may know will occur during the year, perhaps care for a child or an incapacitated dependent adult while you are at work. Through your Dependent Care Account you can deduct those expenses from your payroll check before taxes.

If you are eligible to participate, the Citizens Memorial Hospital Flexible Benefits Plan allows you to contribute pretax income to create special accounts in order to reimburse yourself on a pretax basis for payment of certain medical and dependent care expenses. It's like getting a discount on these bills since you don't have to earn as much money to pay for them. The money you contribute to spending accounts by automatic payroll deduction is not subject to federal or Social Security taxes but, depending on your residence, may be subject to state and local income taxes.

How Medical and Dependent Care Spending Accounts Work

You may establish spending accounts for two separate categories of predictable expenses medical and dependent care. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be paid for with pretax pay, deposited on a per pay basis to the spending account you have elected.

Maximum Employee Contribution: The maximum annual deduction allowed is $2,500 per Plan Year for the Medical Spending Account and $5,000 (or $2,500 if married and filing single) per Plan Year for the Dependent Care Spending Account. The Internal Revenue Code Section 125 states that these balances cannot be combined or used for purposes other than for which they were originally intended.

To receive reimbursement, you must complete a claim form and submit it along with

your paid bills to the Benefits Supervisor of Citizens Memorial Hospital or the designated claims administration representative. Once the claims administrator receives the claims all claims will be processed for reimbursement on a weekly basis. Upon submission of a claim to your Medical Spending Account, you will be reimbursed the full amount of your eligible expenses up to your elected Medical Spending Account pretax deferral amount. However, you must have accumulated a sufficient credit balance in your Dependent Care Account in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent weeks as more dollars are contributed from your pay to your Dependent Care Account.

The Medical Spending Account

Under this category are expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary," or prescribed by a licensed physician to qualify. Covered expenses *do not include* premiums paid for other health plan coverage, including plans maintained by the employer of your spouse or dependents, or expenses for non-reconstructive cosmetic surgery.

One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs, because the tax law requires unused amounts in your spending accounts to be forfeited at the end of each Plan Year.

Over-the-counter (OTC) medicines or drugs are not eligible for reimbursement unless the medicine or drug is prescribed by a physician regardless of whether a prescription is required to obtain the item (Insulin does not require a prescription). Your VISA Debit Card can not be used for OTC medicines or drugs, therefore, you will need to purchase the item and submit the receipt along with a copy of the prescription for reimbursement. OTC items other than medicines or drugs are still eligible expenses that can be purchased with the VISA Debit Card and will not require a prescription (bandages, contact lens solution, etc.).

The Dependent Care Spending Account

Dependents are defined for this purpose as children up to age 13, handicapped children or adults, or elderly individuals who rely upon you for financial support and are eligible to be claimed as an exemption on your federal tax return. If dependent care is required to enable you (or a spouse or single person) to work, these expenses may be eligible for reimbursement. Included are payments to child care centers, nursery schools, kindergarten and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after-school care and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), or a non-relative, as long as such a person is reporting payments as income, is also eligible.

Be aware that you may be able to take a federal tax credit for eligible expenses up to $3,000 (for one dependent) or $6,000 (for more than one dependent). The credit equals 30% of expenses, reduced by one percentage point (but not to drop below 20%) for each $2,000 (or fraction) by which your adjusted gross income exceeds $10,000. Any amounts deferred to a Dependent Care Spending Account will reduce dollar-for-dollar the maximum allowable expense under the tax credit.

Spending Accounts - Other Facts to Consider

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible spending accounts:

Annual Election Only: Compensation redirection authorized for both medical and dependent care expense reimbursement is in effect for the entire year unless you have are a mid year enrollee or have a change in family status-such as marriage, divorce, death of a child or spouse, adoption or birth of a child, termination or commencement of your spouse's employment, the switching from part-time to full-time employment status or the reverse by you or your spouse or the taking of an unpaid leave of absence by you or your spouse.

Use All of Election: You must use all of the funds in your spending accounts by the end of the Plan Year or the unused funds will remain in the Plans account for the Plan Administrator to use for administrative fees. The balances cannot be combined or carried over into the next year, or converted to cash. So, if you choose to open a Medical or Dependent Care Spending Account, it is wise to be conservative in your estimate of future reimbursable expenses.

Grace Period For Filing A Claim: You will receive a statement towards the end of the year to remind you how much money is left in your account. This money must be used for expenses incurred before the end of the Plan Year or be forfeited.

The Plan Year is January 1st - December 31st. Citizens Memorial Hospital has agreed to allow a 2 ½ month extension for claims, therefore, claims must be incurred and submitted by the following March 15th.

Services must be incurred during the Plan Year and while you are active on the Flexible Spending Account. Employees who terminate employment during the Plan Year will be given until the end of the month in which he or she is terminated to submit claims that incurred prior to the end of the month of their termination.

ABOUT TAXES

Social Security taxes are not deducted from the amount you pay in premiums on a pretax basis. This could result in a small reduction in the Social Security benefit you receive at retirement. This is because Social Security benefits are based on what you earned while you were working, up to the Taxable Wage Base (TWB). The TWB is

adjusted annually. If your compensation is above the TWB, your Social Security benefit is not likely to be affected. If you are below the TWB, the benefit would be reduced. The tax advantages you gain through the Flexible Benefits Plan may offset any possible reduction in Social Security benefits.

FUTURE OF THE FLEXIBLE BENEFITS PLAN

The Flexible Benefits Plan is based on Citizens Memorial Hospital understanding of the current provisions of the Internal Revenue Code. Citizens Memorial Hospital reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

HEROES EARNINGS ASSISTANCE AND RELIEF TAX ACT OF 2008 (referred to as the HEROES or HEART Act)

The Act permits distributions from health flexible spending accounts for certain US military reservists. A "qualified reservists distribution" is defined as any distribution to an employee of all or a portion of the balance in the employee's health FSA if: 1) the employee was ordered or called to active duty for a period in excess of 179 days or for an indefinite period; and 2)such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made for the Plan Year which includes the date of such order or call. The disbursements will be made to those Participants who qualify in accordance with the regulation language of the Act.

FAMILY AND MEDICAL LEAVE

If your Employer has more than 50 employees in a given year, you may be entitled under the federal Family and Medical Leave Act (FMLA) to up to 12 work-weeks of unpaid, job-protected leave in any l2-month period. You may be eligible if you have worked for Citizens Memorial Hospital, for at least one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a newborn child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent) or a personal serious health condition.

As a participant in the medical part of the Flexible Benefits Plan, you have while on leave under the FMLA the option to continue your health benefits on the same terms and conditions as immediately prior to your taking FMLA leave. You and your eligible dependents shall remain covered under this plan while you are on FMLA leave as if you still were at work. Your coverage will be maintained until you return to work or, if earlier, you notify Citizens Memorial Hospital that you will not return to work. If you choose not to remain covered under the plan while on FMLA leave, and subsequently return to work before or at the end of FMLA leave, you and your eligible dependents shall immediately become covered under the plan without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave. More details on your FMLA rights and benefits while on FMLA leave are in the Citizens Memorial Hospital employee handbook.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified. A copy of the QMCSO is available, upon request, at no charge from the Plan Administrator.

MATERNITY AND NEWBORN COVERAGE

Since this Plan offers maternity and newborn coverage, you are advised that under federal law, this Plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from this Plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods.

OTHER INFORMATION

The information furnished herein constitutes the Summary Plan Description required by federal law. To comply with the law, the following additional information is also furnished. Note: Dependent care assistance plans are not covered under the Employee Retirement Income Security Act (ERISA).

Name of Plan: Citizens Memorial Hospital Flexible Benefits Plan

Participants: The plans provide benefits for all employees of Citizens Memorial Hospital who meet the eligibility requirements described herein.

Plan Administrator: Citizens Memorial Hospital
1500 N. Oakland Ave.
Bolivar, MO 65613
(417) 326-6000

Employer Tax Identification Number (EIN): 43-1142176

Agent for Service: Citizens Memorial Hospital
1500 N. Oakland Ave.
Bolivar, MO 65613
(417) 326-6000

Plan Year: January 1st- December 31st

Plan Definition and Funding: This is a Section 125 flexible benefits plan classified as a "cafeteria" plan by the Internal Revenue Code. It includes a Section 105 Health Flexible Spending Account, classified by the Department of Labor as a "welfare" plan, and a Section 129 Dependent Care Flexible Spending Account. The FSA Plan is funded by employee contributions.

Insurance Issuer: Citizens Memorial Hospital
1500 N. Oakland Ave.
Bolivar, MO 65613
(417) 326-6000

Not a Contract of Employment: No provision of the Plan is to be considered a contract of employment between you and Citizens Memorial Hospital or a Participating Employer. Citizens Memorial Hospital's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

ERISA RIGHTS STATEMENT: The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all employer-sponsored group benefit programs conform to standards set by Congress. An employee who is a Participant in the Plan is entitled to certain rights and protections under ERISA, which provides that all Participants will be entitled to: (1) examine, without charge, at the Plan Administrator's office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; (2) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report. Plan records are kept on a Plan Year basis.

In addition to creating rights for plan Participants, ERISA imposes duties upon those responsible for the operation of the Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of Participants and Beneficiaries. If a claim for a benefit under the Plan is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to

have the claim reviewed and reconsidered.

Under ERISA, there are steps the Employee covered under the Plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay the person up to $100 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the Employer's control.

If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Employee covered under the Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the claimant is successful, the court may order the person sued to pay these costs and fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

This is a Summary Plan Description only. Your specific rights to benefits under the plan are governed solely, and in every respect, by Citizens Memorial Hospital. Flexible Benefits Plan Document, a copy of which is available from the Human Resources Department upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document shall govern.

SCHEDULE A

CITIZENS MEMORIAL HOSPITAL

FLEXIBLE BENEFITS PLAN
APPROVED PLANS FOR EMPLOYEE CONTRIBUTION

Benefit Options	***Employee Contributions***
Medical Spending Account	Employee's designated salary reduction and allocation subject to the limitations set forth on Schedule B, for the employer's group health plan.
Dependent Care Spending Account	Employee's designated salary reduction and allocation subject to the limitations set forth on Schedule B.

Premium Deductions:

A list of the Participants pre-taxed premiums are provided to the Participants at their Enrollment/Hire date as well as at their annual benefits meeting. These premiums may include non-employer sponsored premiums as approved by the Employer. Participants may also request a copy of their pre-taxed premiums from their human resource department at any time during the Plan Year.

Note: The Employee contributions necessary to obtain the coverage's set forth in this Schedule A above will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period. The Employee contribution required to obtain coverage under any of the above will be the maximum elected contributions required for coverage under such options.

SCHEDULE B

CITIZENS MEMORIAL HOSPITAL

FLEXIBLE BENEFITS PLAN
EMPLOYEE CONTRIBUTION LIMITATIONS

Premium Deductions:

A list of the Participants pre-taxed premiums are provided to the Participants at their Enrollment/Hire date as well as at their annual benefits meeting. These premiums may include non-employer sponsored premiums as approved by the Employer. Participants may also request a copy of their pre-taxed premiums from their human resource department at any time during the Plan Year.

Medical Spending Account Maximum:
Annual Employee Contribution Maximum: $2,500

Dependent Care Account Maximum:
Annual Employee Contribution Maximum: $5,000 or $2,500 if married and filing single