EMPLOYEE ADMINISTRATIVE SERVICES, INC.

ENROLLMENT PERIOD/PLAN YEAR: JANUARY 1, 2024 THROUGH DECEMBER 31, 2024

FLEXIBLE SPENDING PLAN ELECTION

EMPLOYER NAME: _____

Employee Name: _____ Date of Birth: _____

Address: _____

Marital Status: _____ Sex: _____ Contact Phone: _____

☐ I decline to participate in the employer sponsored Flex Plan. I have been given the opportunity to participate, and the benefits of the Plan have been explained to me. I understand that I may only participate at the beginning of the next **Plan Year**.

☐ I elect to participate in the employer sponsored Flex Plan. I agree to and understand that:

Elections cannot be changed during the Plan Year unless there is a change in the family status (marriage, divorce, death of a spouse or child, birth or adoption of a child or a change in spouse's condition of employment: i.e., becomes employed, unemployed, or changes employers).

Salary reduction for the Medical and Dependent Care Expense Reimbursement programs will be credited to my "Flexible Spending Account" and the employer will reimburse me during the Plan Year as I submit paid documentation for incurred expenses, for approved un-reimbursed medical and/or dependent care expenses. I further understand that any amount remaining in my "benefit bank" as of March 2025 will be forfeited to the employer.

The opportunity to change my benefit elections for the following Plan Year will be given to me prior to each Plan Year. ***Benefit selections will continue from one Plan Year to the next without completing a new election form.*** However, if I wish to make a change or decline further participation for the next Plan Year, a new election form is required.

The employer may have to reduce or cancel the amount of my salary reduction or otherwise modify this agreement to satisfy new provisions of the Internal Revenue Code as they may occur during the plan year. Should I terminate my employment and the reimbursements I have received are greater than the amount that has been deposited into my Flexible Spending Account, I agree to reimburse the difference to People Lease.

Having selected the benefits checked below, I hereby elect to be reimbursed for the indicated expenditures and authorize my employer to reduce my gross compensation per pay period in the total amount stated below in conformity with Section 125 of the Internal Revenue Code.

Un-reimbursed Medical/Dental/Vision Expenses *(Not to exceed $3,200 for the 2024 Plan Year)*$_____

Dependent Child Care Expenses *(Not to exceed $5,000 for the 2024 Plan Year)* $ _____

Employee Signature: _____ Date:_____

**************************************FOR OFFICE USE ONLY**************************************

Total number of pay periods remaining in 2024 (12, 24 or 48)

Divide the Total Annual Eligible Expenses amount by the number of pay periods in 2024 to get your pay period election.

$_____(*Deducted per period/Medical*)
$_____*(Deducted per period/Dependent care)*

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2024 Dental Plan Benefits

Employee Cost	
Members/Coverage	**Monthly Rate**
Employee Only	$29.99
Employee and 1 Dependent	$58.62
Employee and Family	$86.15

Plan Summary	In-Network	Out-of-Network
Coverage		
Deductible	$50 First Year; Max 3 per family; $25 Second Year; Max 3 per family	$50 First Year; Max 3 per family; $25 Second Year; Max 3 per family
Deductible waived for A services	Waived	Waived
Calendar Year	$1,500	$1,500
Class A - Preventive	100%	100%
Class B - Basics	80%	80%
Class C - Major Restorative	50%	50%
Class D - Orthodontia	50%	50%
Network Negotiated Fee	Negotiated Fee	90%
Orthodontia Maximum	$1,000	$1,000
Clear Align Ortho	Included	Included
Additional Cleanings	1 additional cleaning based on specific medical conditions	1 additional cleaning based on specific medical conditions
Preventive Benefits	**Frequency**	
Oral Examination	2 per 12 months	
Cleanings	2 per 12 months	
Fluoride Treatment	2 per 12 months, Under age 19	
Space Maintainers	Maximum 1 time per tooth, Under age 14	
Sealants	1 per 24 months, Under age 16	
Bitewing Radiographs	1/12 Adult, 2/12 Child	
Full Mouth Radiographs	1 in 60 months	
Basic Benefits	**Frequency**	
Root Canals	Maximum 1 time per tooth	
Pulp Capping		
Pulp Therapy		
Pulpotomy	Dependent children under age	
Restorations (Amalgams And Anterior Resin)	1/36 Adult, 1/12 Child	
Restorations (Posterior Resin)	1/36 Adult, 1/12 Child	
Periodontal Maintenance	2 per calendar year	
Periodontics Non-Surgical	1 per quadrant per 24 months	
Emergency Palliative Treatment		
Endodontics - Vital		
Simple Extractions		
Anesthesia		

Continued on back

2024 Dental Plan Benefits Continued

Major Benefits	Frequency
Crowns	1 per tooth in 5 calendar years
Inlays	1 per tooth in 5 calendar years
Bridges	1 per tooth in 5 calendar years
Bridge Repairs	6 months must have passed since initial placement
Crown Repairs	6 months must have passed since initial placement
Dentures	1 per tooth in 5 calendar years
Denture Repairs	6 months must have passed since initial placement
Implants	1 per tooth in 5 calendar years
Periodontics Surgical	1 per quadrant per 36 months
Onlays	1 per tooth in 5 calendar years
Prefabricated Stainless Steel Crowns	1 per tooth in 5 calendar years
Oral Surgery	
Surgical Extraction	
Orthodontia	**Frequency**
Orthodontic	Child Only, under age 19

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2024 Vision Plan Benefits

Employee Cost	
Members/Coverage	**Monthly Rate**
Employee Only	$7.51
Employee and Spouse	$12.81
Employee and Child(ren)	$13.48
Employee and Family	$19.81

In-Network Benefits (Network Available at www.davisvision.com)	
Service Type	**Frequency**
Eye Examinations with Dilation (as necessary)	Once Every 12 months
Spectacle Lenses	Once Every 12 months
Frame	Once Every 12 months
Contact Lens (In lieu of eyeglasses)	Once Every 12 months
In Network	
Eye Examination	$10
Retinal Imaging	$39
Spectacle Lenses	$10
Non-elective (visually required) Contact Lens Evaluation, Fitting & Follow-Up Care	$0
Eyeglass Benefit - Frame	
Frame Allowance (Retail)	Up to $130 Up to $180 at VisionWorks
Additional Pairs	30% discount on additional pairs at select retailers
Davis Vision Frame Collection (in Lieu of Allowance)	**Member Co-Pays**
Fashion level/Designer level/Premier level	$0 / $0 / $25
Eyeglass Benefits - Spectacle Lenses	Member Co-Pays
Clear plastic lenses in any RX (Single Vision, Bifocal, Trifocal, Lenticular)	$0
(Single Vision, Bifocal, Trifocal, Lenticular)	
Tinting of Plastic Lenses	$0
Scratch Resistant Coating	$0
Polycarbonate Lenses (Children/Adults)	$00/$30
Digital Single Vision (Intermediate)	$30
Ultraviolet Coating	$12
Blue Light Filtering	$15
Anti-Reflective (AR) Coating (Standard/Premier/Ultra/Ultimate)	$35/$48/$60/$85
Progressive Lenses (Standard/Premier/Ultra/Ultimate)	$50/$90/$140/$175
High Index Lenses	$55
Polarized Lenses	$75
Plastic Photochromic Lenses	$65
Scratch Protection Plan: Single Vision/Multifocal Lenses	$20/$40
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lens Material Allowance Plus a 15% discount on any overage	Up to $130 plus 15% discount
Collection Contact Lenses Benefit (in Lieu of Contact Lens Material Allowance)	
Materials Disposable: up to	4 boxes/multi-packs
Planned Replacement: up to	2 boxes/multi-packs
Evaluation, Fitting & Follow Up Care	$0

Continued on back

2024 Vision Plan Benefits Continued

Out-of-Network Reimbursement Allowance Schedule:	
Eye Examination	Up to $ 40
Frame	Up to $ 50
Lenses - Single Vision	Up to $ 40
Lenses - Bifocal/Progressive	Up to $ 60
Lenses - Trifocal	Up to $ 80
Lenses - Lenticular	Up to $100
Elective Contact Lenses	Up to $105
Visually Required Contact Lenses	Up to $225

Enroll in (check all that apply): ____ Dental ____ Vision

Change Type: ☐ Add ☐ Term ☐ Update

Employee Information (as appears on payroll)

_____ _____ _____

First Name **M.I.** **Last Name**

_____

Street Address

_____ _____ _____ _____

City **State** **Zip** **Phone Number**

_____-____-_____ ____/____/____ M / F _____

Social Security # **Date of Birth** **Gender (Circle One)** **Email Address**

Spouse Information

Enroll in (check all that apply): ____ Dental ____ Vision

_____ _____ _____

First Name **M.I.** **Last Name**

____/____/____ _____-____-_____ M / F

Date of Birth **Social Security #** **Gender (Circle One)**

Dependent Information

Enroll in (check all that apply): ____ Dental ____ Vision

_____ _____ _____

First Name **M.I.** **Last Name**

____/____/____ _____-____-_____ M / F

Date of Birth **Social Security #** **Gender (Circle One)**

_____ _____ _____

First Name **M.I.** **Last Name**

____/____/____ _____-____-_____ M / F

Date of Birth **Social Security #** **Gender (Circle One)**

**Use additional sheets to add more dependents

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

Signature of Enrollee _____ Date:_____

Scan the QR Code below to see the Aflac Insurance Plans

Aflac helps with expenses health insurance doesn't cover, so you can care about everything else.

Or, visit your benefits page at:
www.aflacenrollment.com/PeopleLease/U54312215304

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