SALARY REDUCTION AGREEMENT

for

Cornerstone Behavioral Healthcare

August 1, 2023

to

July 31, 2024

The Flexible Benefit Plan allows you to make your contribution toward your benefits with pre-tax dollars. These dollars are not subject to FICA, federal or state taxes. Once you have made your election, you may not change your election unless you experience a change in status. You may be able to change your benefit election when:

- You experience a change in your legal marital status;
- A child is born to you or you adopt a child; or your spouse or dependent dies;
- Your spouse either gets a job or loses a job;
- You or your spouse take or return from an unpaid leave of absence, a strike or lockout;
- Your health insurance cost or coverage changes significantly because of your spouse's employment (for example, your spouse's employer has open enrollment);
- A change in your or your spouse's work status (such as changing from part-time to full-time);
- You or your spouse's worksite changes which impacts your eligibility (such as moving out of an HMO service area);
- You, your spouse or dependent gain or lose eligibility;
- Your or your spouse's plan either adds or eliminates a benefit option;
- You, your spouse or dependent becomes entitled to Medicare or Medicaid.
- You become covered under the Exchange.

Note: To be permitted, any change in election must be consistent with the status event that has occurred.

	CONTRIBUTION *Bi-Weekly Pay Period*		YOUR CHOICE
MEDICAL INSURANCE	*Harvard Pilgrim POS HSA 7000*		
Employee	**44.62**		____
Employee & Spouse	**292.54**		____
Employee & Children	**255.35**		____
Family	**565.25**		____
		I am declining Medical insurance	____
DENTAL INSURANCE	*Delta Dental*		
Employee	**-**		____
Employee + 1	**14.47**		____
Family	**37.23**		____
		I am declining Dental insurance	____

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above for the plan year. I understand this agreement will remain in effect until the end of the plan year unless one of the events listed in the Summary Plan Description occurs, in which case I may revoke or change this agreement as provided in the **Summary Plan Description**. I further understand that in the event the cost of a benefit I have selected for the plan year changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

The plans covered by this agreement are: **Health & Dental Insurance**. I understand the above agreement.

Employee Name (please print) Social Security Number

Address City State Zip

Employee Signature Date