BUD MAHAS
CONSTRUCTION INC

Employee Benefits Packet – 2019

Employee Name:_____

Group Health Plan and information _____

Health Insurance Application (due within 60 days of employment or during open enrollment) _____

Health Savings Account Election and Change Form (due yearly by 12/15 or when you want to change your contribution) _____

Cafeteria Plan information _____

Cafeteria Plan Election Form (due yearly by 12/15) _____

Profit Sharing / 401k / Roth 401k (see instructions for online management on this account at the end of the packet) _____

Benefit Comparison _____

See our benefits web page for other information on these benefits

www.budmahas.com/careers/benefits

BUD MAHAS
CONSTRUCTION INC

Group Health Plan
Hourly Workers
January 1, 2011

1) This plan supercedes the plan dated September 1, 2009. This plan in no way forms a guarantee or contract for employment between the employee and Bud Mahas Construction, Inc.

2) All workers will be eligible for health insurance coverage on the 1st of the month following the 60th calendar day after employment began. All employees are subject to medical underwriting requirements of the plan in place at the time of eligibility. To be eligible, employment must be continuous, full time (average 30 hours per week) for the 60 day period.

3) The employee is responsible to submit the application or other paperwork in a timely manner the group health underwriter requires. If applications are not submitted when the underwriter requires, or if the eligible employee waives coverage, the employee must wait until the next open enrollment period before entering the plan.

4) The cost of the premium not paid by the company is to be paid by the employee through payroll deduction on a weekly basis. The insurance coverage is through the end of the month in which your employment is terminated. In any month employment is terminated, the employee is responsible for the full month premium (i.e. if you terminate the first week of the month, you have coverage for the rest of the month and you pay a full month premium).

5) The employee's cost of health insurance is detailed as follows. The cost of insurance is subject to change in December of each year.

	Select Med Plus	Select Care Plus
Employee premium cost (per month)	$50 / employee only $300 / employee and children $300 / employee and spouse $400 / employee and family	$70 / employee only $340 / employee and children $355 / employee and spouse $475 / employee and family

6) At the discretion of management, the company will contribute an amount to the H.S.A. account of employees participating in this group health plan. Contributions will be made at the for those employed on the first and last day of the calendar quarter. The annual contribution will be prorated based on the number of months of insurance coverage during the calendar year under this plan.

7) The company will continue to pay the employee's premium in accordance with paragraphs 4 & 5 as long as the employee works at least 150 hours (35 hours per week) each month. In any month the hours worked drops below 150, the company may hold the employee responsible for the entire premium through payroll deduction.

selecthealth

selecthealth℠
BENEFIT ASSURANCE COMPANY

P.O. Box 30192 Salt Lake City, UT 84130-0192 801-442-5038/800-538-5038 **selecthealth.org**

Medical Enrollment Form and Instructions Large Employer

You must read all instructions before completing and signing the Enrollment Form as it contains terms for agreement. If you need help, contact a Human Resources/Personnel representative at your place of employment or Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038.

SECTION A. EMPLOYEE INFORMATION

Complete this section with all of the requested information about yourself (the employee applying for coverage).

SECTION B. EMPLOYEE AND DEPENDENT INFORMATION

Complete this section with all of the requested information about you and your dependent(s).

- If your dependent child is older than the age limit specified in the agreement with SelectHealth℠/SelectHealth Benefit Assurance Company℠ (SelectHealth BAC) and your employer, but still eligible for coverage because of a physical or mental disability, you must attach proof of the dependent's disability to this form.
- If you or your eligible dependents have other health insurance you must complete the Secondary Medical Coverage Form (COB) to facilitate accurate coordination of benefits with other carriers, when necessary.
- If you or your eligible dependents have had health insurance coverage within the last 63 days, your Pre-Existing Condition Waiting Period (if applicable) may be partially or completely waived. You must give SelectHealth/SelectHealth BAC proof of prior coverage, such as a Certificate of Creditable Coverage, ID Card, Explanation of Benefits (EOB), etc., for each applicant. You have the right to request a Certificate of Creditable Coverage from your prior plan. If necessary, SelectHealth/SelectHealth BAC will assist in obtaining such certificates.

If your spouse is added, he or she may only be deleted from your coverage in the following circumstances:

- During your employer's next open enrollment period;
- When proof of a legal divorce or annulment is given to SelectHealth/SelectHealth BAC; or
- When your spouse agrees by signing the Employee Change Form (if allowed by your employer's eligibility rules).

SECTION C. EMPLOYEE AGREEMENT AND SIGNATURE

You must read and understand the following information. After you have read and agreed to the following terms of this form, sign under "Section C. Employee Agreement and Signature." Otherwise, this application and enrollment may not be valid.

- I hereby apply for membership in SelectHealth℠/SelectHealth BAC℠ for the persons listed on this application (herein referred to as applicants) and agree to submit premiums as required by SelectHealth/SelectHealth BAC or authorize my employer to deduct from my earnings the necessary contributions, if any, required of me. I accept the terms of the group agreement between my employer and SelectHealth/SelectHealth BAC and appoint my employer to act as an agent on my behalf. I understand that said agreement is on file with the employer and SelectHealth/SelectHealth BAC and is available for my inspection. I understand that any intentional material misrepresentation in answering the questions on this application or nonpayment of premiums, deductibles, or copays/coinsurance may result in recision or cancellation of my coverage and that of my dependents.

SECTION D. WAIVER OF COVERAGE

Complete and sign this section if you wish to waive healthcare coverage at this time.

You and your dependents may not be eligible to enroll in this program again until the next open enrollment period established by your employer and SelectHealth/SelectHealth BAC unless you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage. You may, in the future, be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and any dependent child(ren) newly acquired by such marriage, birth, adoption, or placement for adoption if you request enrollment within 31 days after the marriage or the date of birth, adoption, or placement for adoption.

SECTION E. EMPLOYER USE ONLY

An authorized representative of the employer group must complete this section. NOTE: The first two items below only apply if employees are to be credited for previously satisfied Pre-Existing Condition Waiting Periods.

- Employee's Current Payroll Status – Indicates the current employment classification of the subscriber. Note, for example, if he or she is an active employee, on an approved leave of absence, retired, etc.
- Comments – This section may be used to communicate any other pertinent information to SelectHealth/SelectHealth BAC.
- Employer's Signature – A representative of the employer must sign and date this section to validate the form.

Medical Enrollment Form (See reverse side for instructions)

I am (Please check one):

- ❑ A new enrollee
- ❑ Switching from another SelectHealth plan (list plan) _____
- ❑ Switching from another carrier (list carrier) _____

Please make selection(s) below (Form is not complete unless a box is checked!)

- ❑ Select Care Plus℠ HealthSave
- ❑ Select Med Plus℠ HealthSave

A. EMPLOYEE INFORMATION (Please print legibly)

Employee Legal Name (Last, First, Initial) _____ Employer Name _____

Mailing Address _____ Full-Time Hire Date _____

City _____ State _____ ZIP _____ E-mail Address _____

Street Address (if different) _____ City _____ State _____ ZIP _____

Home Ph# (_____)_____ Work Ph# (_____)_____ Marital Status ❑ Single ❑ Legally Married ❑ Separated ❑ Divorced

Are you enrolling because of a special enrollment event? ❑ Yes ❑ No
If yes, check all that apply ❑ Birth/adoption ❑ Marriage ❑ Loss of other coverage

Carrier _____ Date Coverage Began _____ Date Coverage Ended _____
You must give proof of prior coverage to SelectHealth/SelectHealth BAC as soon as reasonably possible.

Are you adding a dependent because of a court or administrative order? ❑ Yes ❑ No If yes, please attach a copy of the notice with this form.

B. EMPLOYEE AND DEPENDENT INFORMATION

Complete this section in full. List yourself and all eligible dependents (spouse and children) you wish to be covered. List children in order of age. List the relationship of all children and dependents to the employee in the "Relationship" column. If you need more space, use another Enrollment Form (available from SelectHealth).

LEGAL NAME OF MEMBER TO BE COVERED (LAST, FIRST, MIDDLE INITIAL)	SEX	DATE OF BIRTH (MM/DD/YY)	RELATIONSHIP	SOCIAL SECURITY#
YOURSELF	M/F			
	M/F			
	M/F			
	M/F			
	M/F			
	M/F			

Are you and/or your ex-spouse required to pay your dependent's medical expenses in a divorce decree? ❑ Yes ❑ No

If yes, you must attach a copy of the divorce decree with this Enrollment Form. You should include the first page of the decree, the signature page, and any other portion(s) of the decree that specifies responsibility for dependent coverage.

Will you or any of your dependent(s) have other health insurance in addition to this plan? ❑ Yes ❑ No (If yes, complete COB Form)

C. EMPLOYEE AGREEMENT AND SIGNATURE

This section requires that you turn to the reverse of this form and read the information in "Section C. Employee Agreement and Signature."
I hereby certify that I have read, understand, and agree to the terms outlined in "Section C. Employee Agreement and Signature" on the reverse side of this Enrollment Form. After your employer has checked and approved this form, please keep a copy for your records.

Employee Signature _____ Date _____

D. WAIVER OF COVERAGE

I have been given the opportunity to enroll and choose to waive such coverage. I have read the information in "Section D." on the front of this Enrollment Form and understand the consequences of my choice to waive coverage. Reason for waiving: (check one box)

- ❑ I already have health insurance through _____ (Insurance Company Name) _____ Employee Signature
- ❑ I do not want to buy any health insurance at this time

E. EMPLOYER USE ONLY (Employer, please provide the following information where applicable to this employee)

If using HealthEquity® (SelectHealth's preferred vendor) for account administration, employees must complete the HSA Enrollment & Authorization to Disclose Health Information to HealthEquity Form.

PEC Waiting Period _____ (Date) through _____ (Date) Subgroup Name _____ Class Name _____

Employee's Medical Plan Effective Date _____ Employee's Current Payroll Status _____

Comments _____

Employer Signature _____ Date _____

Health Savings Account

ELECTION AND CHANGE FORM 2019

You must be a participant in the Company's group insurance plan to participate in the Health Savings Account benefit. New employees complete this form to initiate set up of your Health Savings Account. Existing employees complete this form to elect deductions into 2019 or to make changes to your existing election.

Employee Information

Name

Application and Agreement

☐ I elect to have $_____ withheld from **each payroll check** and added to my Health Savings Account. This is in addition to the amount the company will contribute for me to the Health Savings Account.[1] This election may be changed or rescinded at any time. Ten days notice is required to effect the change. Refer to chart below for maximum contribution amounts.

I understand this plan in no way forms a guarantee or contract for employment between myself and Bud Mahas Construction, Inc.

_____ _____

Signature Date

The company contributions for 2019 are as follows:

	Single	Family
Per year, prorated for partial year	$1,000.00	$2,750.00
Per quarter[1] [2]	$250.00	$687.50

Maximum contribution above company contribution

	Single	Family
Per year	$2,500.00	$4,250.00
Per week	$48.07	$81.73

Annual catch up if over 55 can be added to the above amounts

Per year (per individual over 55)	$1,000.00
Per week	$19.23

[1] Refer to paragraph 6 of the Medical Insurance Plan dated January 1, 2011 for restrictions.

[2] Contributions will be made at the beginning of each calendar quarter for those employed on the first and last day of the previous calendar quarter. The annual contribution will be prorated based on the number of months of insurance coverage during the calendar year under this plan.

FLEXIBLE SPENDING ACCOUNTS

Your employer offers two types of Flexible Spending Accounts (FSAs):
Health Care and Dependent Day Care
These accounts provide a way to pay for certain types of expenses on a pre-tax basis.

The IRS released new guidance modifying the longstanding "use it or lose it" rule for Health FSAs. The new rule allows taxpayers to carryover up to $500 of their unspent FSA funds to the following plan year. You may now elect a Health FSA of at least $500 without worry of losing it!

Health Care FSA

- ✓ You may use the FSA even if your family is not enrolled in your employers benefit plan.
- ✓ A Health Care FSA is a great way to save for out-of-pocket health care expenses, because you contribute a small amount each pay period, rather than all at once.
- ✓ The money you contribute from each paycheck is deducted before taxes – no federal, state or SSN taxes will be withheld from any of those dollars – saving you up to 30 cents for each dollar.
- ✓ Make sure to spend any amounts above $500 by the last day of your plan year. You may submit expenses for the current Plan Year during the grace period of 90 days.

Dependent Day Care FSA

- ✓ You can still contribute up to $5,000 into your Dependent Day Care FSA each year. If you are married, both you and your spouse must work, and you and your spouse must each earn at least $5,000 per year, unless your spouse is a full-time student.
- ✓ If you are married and you and your spouse file separate tax returns, the maximum contribution is $2,500 per person.
- ✓ Dependents eligible for care can be your children up to age 13 or any other dependents (including a parent or in-law) who are not able to care for themselves because of a disability and who spend at least eight hours per day in your home.
- ✓ If required by law, a dependent care facility must be registered or licensed for you to receive reimbursement under the FSA program.
- ✓ If you employ an independent child care provider, you must provide their SSN or tax ID number and issue them a 1099 in order for you to receive reimbursement.

What you **NEED TO DO…….**

- ✓ Check out the online Calculator at myRSC.com to estimate what to contribute to your FSA this year.
- ✓ Complete a new election form for 2019

BUD MAHAS
CONSTRUCTION INC

2019 CAFETERIA PLAN ELECTION FORM

EMPLOYEE INFORMATION

First Name	Last Name	Soc. Sec. #
Address	**City & State**	**Zip Code**

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Annual Elections	Annual Election	Per-Pay-Period Deduction
Medical Reimbursement Account – FSA Maximum = $2,700		
Dependent Care Reimbursement Account Maximum = $5,000		

AUTHORIZATION: By signing this form I acknowledge that I am authorizing the company to deduct equal amounts from my paychecks to collect the designated pre-tax amount indicated above. I recognize that these selections constitute a deliberate binding decision on my part that shall not be changed until the enrollment period for the next plan year or if I experience a change in status.

Signature_____ Date_____

P.O. Box 510566 Salt Lake City, UT 84151-0566 WATS: 800-748-4423 *Tel.: (801) 521-8777 Fax: (801) 521-8780 www.wasatchbenefit.com

BUD MAHAS CONSTRUCTION INC

Bud Mahas Construction, Inc.
401(k) Profit Sharing Plan

Savings Rate Election

MAHAS

Step 1: Enter Your Information and Authorization

Name:_____ SSN:_____
Address:_____ Birth Date:____/____/____
_____ Hire Date:____/____/____

You must complete either Step 2a or 2b, and then Step 3.

Step 2a: Contribution Election

I DO WANT TO PARTICIPATE: I elect to contribute to the Plan according to my elections below. If I am not yet eligible, contributions will begin being deducted on the first payroll after the start date below and after I have met the Plan's eligibility requirements. Amounts will be deducted from my pay and contributed to the plan as follows.

I understand that the sum of my Employee Pretax 401(k) and Employee Roth 401(k) contributions may not exceed $19,000 for the calendar year 2019, plus if I am age 50 by 12/31/2019 I am eligible to contribute an additional $6,000. I also understand that the total of all contributions to the plan may not exceed 100% of eligible compensation. I am also aware that the amounts designated below may be reduced by the Plan Administrator to comply with IRS regulations.

Election/Contribution Type	Applies To	Elections	Effective/Start Date
☐ Employee Pretax 401(k)	Each Pay Period	$_____ or _____ % (1% to 100%)	_____
☐ Employee Roth 401(k)	Each Pay Period	$_____ or _____ % (1% to 100%)	_____

Step 2b: Non-Participation/Suspension

_____ **I DO NOT WANT TO PARTICIPATE**: I do not wish to contribute to the Plan at this time or I am suspending my contributions. I understand that I may reconsider my decision at a future date.
Initial Here

Step 3:Your Authorization

I hereby authorize deductions from my pay for any contributions required by my elections. I confirm the above elections and understand the terms of the Plan (as stated in the Summary Plan Description that I have received) Further, I understand that if I have not provided Investment Elections, my future deposits will be invested in the MetLife Stable Value Fund. I understand that I may reconsider my decision at any future date.

Your Signature _____ **Date** _____

DISCLOSURE STATEMENT: You must notify Steve Wise within 15 days of receipt of your quarterly statement in which this transaction has occurred, if during that period there is an error in your directive change indicated above. Your Employer and NWPS will not be liable for any loss to your account, if not contacted within the 15-day period stated above.

Please return completed forms to Steve Wise

_____ _____
Plan Administrator Approval Signature Plan Administrator Approval Date

BUD MAHAS CONSTRUCTION INC

Bud Mahas Construction, Inc.
401(k) Profit Sharing Plan

Investment Election Form

MAHAS

Step 1: Enter Your Information

Name:_____ SSN:_____

Step 2: Select Your Investment Style (for all future deposits and current positions)

☐ I want to invest based on my risk tolerance (go to step 3a and then to step 4)
☐ I want to create my own mix of investments using the Plan's options (go to step 3b and then to step 4)

Step 3a: Choose Your Investment Strategy Based on Risk Tolerance (for all future deposits and current positions)

Select a *single* option from the list below by placing a check mark (✓) in the box next to the selection of your choice. Once you've made your selection, go straight to Step 4.

☐ Conservative
☐ Moderate
☐ Growth

Step 3b: Select Your Own Investment Strategy (for all future deposits and current positions– Must total 100%)

You should only complete this section if you are comfortable making investment decisions and you are willing to commit the time and effort necessary to manage your investments. Enter the percentage you want to invest in each option below, making certain that the total is equal to 100%.

Investment Model / Risk Tolerance
_____ % Conservative
_____ % Growth
_____ % Moderate

Stable Value / Money Market
_____ % MetLife Stable Value

Fixed Income
_____ % PIMCO Total Return A
_____ % Templeton Global Bond Adv

Domestic Equity
_____ % American Century Equity Income Inv
_____ % Boston Trust Small Cap
_____ % Heartland Value Plus
_____ % Segall Bryant & Hamill Small Cap GrInstl
_____ % T. Rowe Price New America Growth Adv
_____ % Vanguard 500 Index Inv
_____ % Virtus Ceredex Mid-Cap Value Equity I

International / Global Equity
_____ % American Funds New Perspective R4
_____ % Thornburg International Value R4
_____ % Wasatch Emerging Mrkts Small Cap

Alternatives
_____ % Rydex Basic Materials A
_____ % Van Eck Global Hard Assets A
_____ % Virtus Duff & Phelps Real Estate Sec A

100 % **Total**

Step 4: Authorization

By my signature below, I authorize the elections made above. I also understand that if I do not provide Investment Elections, my future deposits and current positions will be invested in the MetLife Stable Value Fund. Please note that your current positions as well as your future deposits to the plan will be invested as indicated.

Your Signature _____ **Date** _____

Please return completed forms to Steve Wise

_____ Plan Administrator Approval Signature

_____ Plan Administrator Approval Date

BUD MAHAS CONSTRUCTION INC

Bud Mahas Construction, Inc.
401(k) Profit Sharing Plan

Designation of Beneficiary

MAHAS

Step 1: Enter Your Information and Authorization

Name:_____ SSN:_____

Marital Status: (check one)
☐ Married / ☐ Single / ☐ Separated

Is there a Domestic Relations Order Pending?
(check one:) ☐ Yes / ☐ No

Step 2: Enter Your Acknowledgements/Authorizations

By my signature below:

- I understand that I have the right to change or revoke the primary beneficiary designation with the approval of my spouse (if married) subject to receipt by the Plan Administrator of my written designation prior to my death.
- I understand that I may change or revoke my contingent beneficiary designation at any time subject to receipt by the Plan Administrator.
- I understand that if I am married, I must designate my spouse as my only primary beneficiary unless my spouse consents in writing in Step 4. If I am single and marry at a later date, I understand that my spouse will automatically become my only primary beneficiary. I understand that if I do not want my spouse to be my only primary beneficiary, I and my spouse may designate a different primary beneficiary.
- I hereby authorize the Plan Administrator to provide for payment of any Death Benefits as directed by the Plan if my primary and contingent beneficiaries fail to survive me.
- I understand that my Beneficiary Designation shall become effective without further notice upon receipt by the Plan Administrator and is made subject to all of the terms and conditions of the Plan.
- I hereby revoke any prior designation and do hereby direct that, upon my death, any benefit payable with respect to my account under the Plan shall be paid to the **primary beneficiary** named in Step 3. If I should die and no primary beneficiary is alive to receive any benefit payable from the Plan, I hereby direct that such benefit shall be paid to the **contingent beneficiary** named in Step 3.
- I understand that it is my responsibility to complete this form and that I cannot rely on my will, prenuptial agreement, separation agreement, property settlement agreement or court order to specify who will inherit my account, because the Plan does not use any of these documents to distribute death benefits.
- I understand that it is important to review how I have designated my Beneficiary Designation periodically – particularly when my life situation changes (e.g., by marriage, divorce, the birth or adoption of a child, or the death of a beneficiary).
- I understand that if I do not designate a beneficiary before the date of my death, my entire account will be distributed according to the terms of the Plan.
- I understand that if my children are my beneficiaries, and they are minors: (1) the Plan generally will not transfer money directly to a minor and a court will have to appoint a trustee or guardian to receive the money; and (2) I should consider choosing a trustee (person or institution) now, and naming my children's trust as my beneficiary.
- I understand that I should consult with a tax advisor before naming a trust as a beneficiary, to be sure that the selection is appropriate and within the IRS Guidelines.
- I understand that all death benefit payments will be disbursed proportionally from all accounts in the plan and that any outstanding plan loans (if applicable) at the time of my death will become taxable income to my estate and not to my beneficiary.

Participant Signature _____ **Date** _____

Note: Be certain to fill out and return both pages, as the entire form must be completed.

Step 3: Designate Your Beneficiary(ies)

By my signature below, I hereby designate the following beneficiary(ies) for my Plan benefits:

a: Primary Beneficiary(ies)

Name(s) and Contact Information	Relationship	Birth Date	Social Security Number	Share (Must total 100%)

b: Contingent Beneficiary(ies)

Name(s) and Contact Information	Relationship	Birth Date	Social Security Number	Share (Must total 100%)

(Attach additional sheets of paper if more space is required. Each category must total 100%.)

Participant Name _____ **SSN** _____

Participant Signature _____ **Date** _____

Step 4: Spousal Consent *(***Only required if married/separated, and spouse is not sole primary beneficiary***)*

I hereby acknowledge that my spouse has designated a Primary Beneficiary in place of me. I understand that by consenting to this designation, I am foregoing both present and future rights to these benefits if my spouse dies. I further understand my consent is irrevocable unless my spouse revokes the Primary Beneficiary designation on this form. By my signature below, I approve the designation made.

NOTARIZATION OF SPOUSE'S SIGNATURE:

_____
Spouse's Signature

STATE OF _____)

COUNTY OF _____)

On this _____ day of _____, 20_____, before me, the undersigned Notary Public, personally appeared known to me to be the person whose signature is subscribed as the spouse to the foregoing Beneficiary Election document, who acknowledged that he/she executed the same for the purposes herein contained.

WITNESS my hand and official seal.

_____
Notary Public

My Commission Expires: _____

Please return completed forms to Steve Wise for Approval

_____ _____

Plan Administrator Approval Signature | Plan Administrator Approval Date

Note: Be certain to fill out and return both pages, as the entire form must be completed.

BUD MAHAS
CONSTRUCTION INC

Benefits Comparison

				Contribution made by:		
Benefit	**Enroll or Annual Election**	**Taxation**	**Forfeit balance?**	**Company**	**Employee**	**Website**
Profit Sharing	Enter when hired. Investment elections should be made	Contributions are not taxed. Taxed on distribution. IRS penalty for early distribution.	Balance vests according to schedule. Fully vested after 6 vesting years.	Yes	No	www.401save.com
401k / Roth 401k	Annual contribution election required	Contributions are made pre-tax for 410, Roth is after tax. Taxed on distribution. IRS penalty for early distribution.	No, 100% vested	Yes, will match employee up to 4%	Yes, when elected	www.401save.com
Health Insurance	Enroll within 60 days of hire or during open enrollment	Employer contribution not taxed, employee portion is pre-tax.	N/A	Portion	Portion	www.myuhc.com
Health Savings	Annual contribution election required	Employer contribution not taxed, employee portion is pre-tax.	Never	Yes	Yes, when elected	www.optumbank.com
Cafeteria Plan	Annual contribution election required	Contributions are pre-tax.	$500 may be rolled to the next year	No	Yes, when elected	www.myrsc.com