Maine Media Workshops
Flexible Benefit Plan
Summary Plan Description
For The
Flexible Benefit Plan
Medical Flexible Spending Account
Dependent Care Flexible Spending Account

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Maine Media Workshops
Flexible Benefit Plan
SUMMARY PLAN DESCRIPTION

GENERAL INFORMATION ABOUT THE PLAN

Maine Media Workshops (the "Employer") is pleased to sponsor an employee benefit program known as the **Maine Media Workshops Flexible Benefit Plan** (the "Plan") for you and your fellow employees. It is so-called because it lets you choose from several different benefit programs (which we refer to herein as "Benefit Options") according to your individual needs, and allows you to reduce your pay before taxes ("Pre-tax Contributions") to pay for the Benefits Options that you choose by entering into a salary reduction agreement with your Employer (NOTE: Some state taxes may continue to apply). This Plan helps you because the Benefit Options you elect are nontaxable (i.e., you save social security and income taxes on the amount of your salary reduction). Alternatively, you may choose to pay for any of the available benefits with after-tax payroll deductions to the extent set forth in your enrollment materials.

This Plan has three components:

- **A Flexible Benefit Plan Component.** The Flexible Benefit Plan Component allows you to pay your share of Benefit Options with Pre-tax Contributions.
- **The Medical Flexible Spending Account ("Medical FSA")**. The Medical FSA allows you to use a specified amount of Pre-tax Contributions to be used for reimbursement of Eligible Medical Expenses. The Medical FSA is intended to qualify as a Code Section 105 self-insured medical reimbursement plan.
- **The Dependent Care Spending Account ("Dependent Care FSA").** The Dependent Care FSA allows you to use a specified amount of Pre-tax Contributions for reimbursement of Dependent Care Expenses. The Dependent Care FSA is intended to qualify as a Code Section 129 dependent care assistance plan.

Each of the three components is summarized in this document. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary. For example, you can find the identity of the Third Party Administrator, the Employer, and the Plan Administrator in the Plan Information Summary as well as the Plan Number and any applicable contact information. Each summary and the attached Appendices constitute the Summary Plan Description for the Maine Media Workshops Flexible Benefit Plan. The SPD (collectively, the Summary Plan Description or "SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a plan document into which the SPD has been incorporated. However, if there is a conflict between the official plan document and the SPD, the plan document will govern. Certain terms in this Summary are capitalized. Capitalized terms reflect important terms that are specifically defined in this Summary or in the Plan Document into which this SPD is incorporated. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator (who is identified in the Plan Information Summary).

Maine Media Workshops

FLEXIBLE BENEFIT PLAN COMPONENT SUMMARY

Q-1. What is the purpose of the Flexible Benefit Plan?

The purpose of the Flexible Benefit Plan is to allow eligible employees to pay for Benefit Options with Pre-tax Contributions. The Benefit Options to which you may contribute with Pre-tax Contributions under this Flexible Benefit Plan are described in the Plan Information Summary. Rules regarding Pre-tax Contributions are described in more detail below.

Q-2. Who can participate in the Flexible Benefit Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who (i) satisfies the Plan's Eligibility Requirements and (ii) is also eligible to participate in at least one of the Benefit Options will be eligible to participate in this Plan. If you meet these requirements, you may become a Participant on the Flexible Benefit Plan Eligibility Date. The Eligibility Requirements and Eligibility Date are described in the Plan Information Summary. Those employees who actually participate in the Plan are called "Participants". (See below for instructions on how to become a Participant.) You may use this Plan to pay for Benefit Options covering only yourself and your dependents as defined in Code Section 152 (except as otherwise defined in Code Section 105 for health plan purposes, Code Section 21 for Dependent Care FSA benefits, and Code Section 223 for Health Savings Account purposes). The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Options. In other words, if you are eligible to participate in this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options. For details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Options, please refer to the plan summary for each Benefit Option. If you do not have a summary for a Benefit Option, you should contact the Plan Administrator for information on how to obtain a copy.

Q-3. When does my participation in the Flexible Benefit Plan end?

Your coverage under the Flexible Benefit Plan ends on the earliest of the following to occur:

- The date that you make an election not to participate in accordance with this Flexible Benefit Plan Summary;
- The date that you no longer satisfy the Eligibility Requirements of this Plan or all of the Benefit Options;
- The date that you terminate employment with the Employer; or
- The date that the Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will ***automatically*** cease, and you will not be able to make any more Pre-tax Contributions under the Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g., a severance arrangement where the former employee is permitted to continue paying for a Benefit Option out of severance pay on a pre-tax basis). If you are rehired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections if you are rehired or become eligible again more than 30 days after your employment terminated or you otherwise lost eligibility (subject to any limitations imposed by the Benefit Option(s)). If you are rehired or again become eligible within 30 days, your Plan elections that were in effect when you terminated employment

or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4. How do I become a participant?

If you have otherwise satisfied the Eligibility Requirements, you become a Participant by signing an individual Flexible Benefit Enrollment Form (sometimes referred to as an "Election Form") on which you agree to pay your share of the cost of the Benefit Options that you choose with Pre-tax Contributions. You will be provided with a Flexible Benefit Enrollment Form on or before your Eligibility Date. You must complete the form and submit it to the Plan Administrator or the Third Party Administrator (per the instructions provided on or with your Flexible Benefit Enrollment Form) during one of the election periods described in **Q-6** below. You may also enroll during the year if you previously elected not to participate and you experience an event described below that allows you to become a participant during the year. If that occurs, you must complete an election change form during the Election Change Period described in **Q-8** below. The Third Party Administrator is identified in the Plan Information Summary.

In some cases, the Employer may *require* you to pay your share of the Benefit Option coverage that you elect with Pre-tax Contributions. If that is the case, your election to participate in the Benefit Option(s) will constitute an election under this Plan. NOTE: Although coverage under a Benefit Option may be retroactively effective the Pre-tax Salary Reduction elections made under this plan are typically effective on a prospective basis only.

You may be required to complete a Flexible Benefit Enrollment Form via telephone or voice response technology, electronic communication, or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5. What are tax advantages and disadvantages of participating in the Flexible Benefit Plan?

You save both federal income tax and FICA (Social Security) and state income taxes (to the extent permitted by applicable state law) by participating in the Plan. Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-6. What are the election periods for entering the Flexible Benefit Plan?

The Flexible Benefit Plan has three election periods: (i) the "Initial Election Period," (ii) the "Annual Election Period," and (iii) the "Election Change Period", which is the period following the date you have a Change in Status Event (described below). The following is a summary of the Initial Election Period and the Annual Election Period. The Election Change Period is described in Q-8 below.

6a. What is the Initial Election Period?

The Initial Election Period is the period following the date that you first satisfy the Eligibility Requirements. The enrollment material provided to you by the Employer (or its designee) will identify the Initial Election Period. If you make a Pre-tax Contribution election during the Initial Election Period, your Pre-tax Contributions begin as of the first pay period coinciding with or next following the date that your election is received or the date that you satisfy the Eligibility Requirements, whichever is later. Generally, the Pre-tax Contributions will only relate to Benefit Option coverage provided on and after the election is received

(i.e. the election is prospectively effective); however, if you are eligible for Benefit Option coverage on the date of hire and you are provided no more than 30 days to make your election during the Initial Election Period, then the Pre-tax Contributions may relate to the coverage beginning on and after the date of hire (i.e. the election is retroactively effective). Regardless, the effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options. **NOTE: The election that you make during the Initial Election Period (whether to make Pre-tax Contribution Elections or not) is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you experience one of the enumerated events and provide proper notice of such event as set forth in Q-8 below.**

6b. What is the Annual Election Period?
The Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status Event described below. If you fail to complete, sign and file a Flexible Benefit Enrollment Form during the Annual Election Period, you may be deemed to have elected to continue participation in the Plan with the same Benefit Option elections that you had on the last day of the Plan Year in which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election." Alternatively, the Plan Administrator may deem you to have elected not to participate in the Plan for the next Plan Year if you fail to make an election during the Annual Election Period). The consequences of failing to make an election under this Plan during the Annual Election Period are described in the Plan Information Summary. **Special Rule for Flexible Spending Account elections and Health Savings Account elections (if applicable): Evergreen Elections do not apply to Flexible Spending Account elections or Health Savings Account elections. Consequently, you must make an election each Annual Election Period in order to participate in the Flexible Spending Accounts or to contribute to a Health Savings Account offered under the Plan during the next Plan Year.**

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary Appendix.

Q-7. How is my Benefit Option coverage paid for under this Plan?

You may be *required* to pay for any Benefit Option coverage that you elect with Pre-tax Contributions. Alternatively, your Employer may allow you to pay your share of the contributions with after-tax contributions. The enrollment material you receive will indicate whether you have to pay with Pre-Tax Contributions or whether you have an option to choose to pay with after-tax contributions.

When you elect to participate both in a Benefit Option and this Plan, an amount equal to your share of the annual cost of those Benefit Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use Pre-tax Contributions (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Options you choose with Employer Contributions. The amount of Employer Contributions that is applied by the Employer towards the cost of the Benefit Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion. The Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during

the Plan Year, and such other factors that the Employer deems relevant. In no event will any Employer Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in the Plan Information Summary.

The Employer may provide you with Employer Contributions over which you have discretion to allocate the contributions to one or more Benefit Options available under the Plan. These elective employer contributions are called "Flexible Credits" or "Benefit Credits". The Flexible or Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

Q-8. Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Plan during the Plan Year. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Plan or under all of the Benefit Options that you have chosen. Second, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

- You experience a "Change in Status Event" that affects your eligibility under this Plan and/or a Benefit Option; or
- You experience a significant cost or coverage change; and
- You complete and submit a written Election Change Form within the Election Change period described in the Plan Information Summary.

Change in Status Events and Cost or Coverage Changes recognized by this Plan, and the rules surrounding election changes in the event you experience a Change in Status Event or Cost or Coverage Change are described in the Election Change Appendix attached to this SPD.

Third, an election under this Plan may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the applicable federal income tax law.

If coverage under a Benefit Option ends, the corresponding Pre-tax Contributions for that coverage will automatically end. No election is needed to stop the contributions. Note: There are special election change rules for Health Savings Account (if applicable) elections made under the Plan. Please refer to the attached Health Savings Account Appendix (if applicable).

Q-9. What happens to my participation under the Flexible Benefit Plan if I take a leave of absence?

The following is a general summary of the rules regarding participation in the Flexible Benefit Plan (and the Benefit Options) during a leave of absence. The specific election changes that you can make under this Plan following a leave of absence are described in the Election Change Appendix and the rules regarding coverage under the Benefit Options during a leave of absence will be described in the Benefit Option summaries. If there is a conflict between the Election Change Appendix/Benefit Option Summaries and this Q-9, the Election Change Appendix or Benefit Option summary, whichever are applicable, controls.

- If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the Employer will continue to maintain your Benefit Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA (e.g.,

the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

- Your Employer may elect to continue all health coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).
- In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

    - With after-tax dollars while you are on leave,
    - You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave pay by making a special election to that effect before the date such pay would normally be made available to you. However, pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year (except as otherwise permitted by law).
    - By other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave).

The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator. The Election Change Appendix will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

- If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan and the Benefit Option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.
- The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.
- If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.
- If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Option offered under this Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-10. How long will the Flexible Benefit Plan remain in effect?

Although the Employer expects to maintain the Flexible Benefit Plan indefinitely, it has the right to modify or terminate the Flexible Benefit Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Q-11. What happens if my request for a benefit under this Flexible Benefit Plan (e.g. an election change or other issue germane to Pre-tax Contributions) is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Maine Media Workshops
Flexible Benefit Plan

MEDICAL FSA COMPONENT SUMMARY

Q-1. Who can participate in the Medical FSA?

Each Employee who satisfies the Medical FSA Eligibility requirements and who is eligible to participate in the Employer's major medical plan is eligible to participate on the Medical FSA Eligibility Date. The Medical FSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the Medical FSA's Eligibility requirements, you become a participant in the Medical FSA by electing Medical Care Reimbursement benefits during the Initial or Annual Election Periods described in the Flexible Benefit Plan Summary. Your participation in the Medical FSA will be effective on the date that you make the election or your Medical FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Medical FSA elections.

You may also become a participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year (see **Q-8** of the Flexible Benefit Plan Summary for more details regarding mid-year election changes and the effective date of those changes).

Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the Medical FSA, Eligible Dependents are the following:

(i) Your legal Spouse (determined in accordance with federal law) and
(ii) any other individuals who would qualify as a Dependent under Code Section 105(b).

An individual is a "dependent" for purposes of Code Section 105(b) if the individual satisfies any of the following criteria: (i) the individual is a dependent for income tax purposes under Code Section 152 (i.e. qualifies you for a personal exemption); (ii) the individual would qualify as your dependent under Code Section 152 but for the fact that (A) the individual has income in excess of the exemption amount (applicable to "Qualifying Relatives" as defined in Code Section 152), (B) you are a dependent of another taxpayer, or (C) the individual is married and files a joint return with his or her spouse; or (iii) the individual is a "child" as defined by Code Section 152(f)(1) who will not turn age 27 during the year (i.e. through the end of the calendar year in which the "child" turns age 26). An individual qualifies as a child as defined by Code Section 152(f)(1) if he/she is any of the following: (i) natural child; (ii) adopted child or child "placed with you for adoption" (iii) step child or (iv) child placed with you by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. In addition, a child to whom Section 152(e) applies (i.e. a child of divorced or separated parents) is considered a dependent of both parents for the purpose of the Medical FSA without regard to who claims the child as a dependent on his or her tax return.

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Medical FSA, the Medical FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Medical FSA does not otherwise provide. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment,

decree or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Medical Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

NOTE: Your participation in this Medical FSA could disqualify your spouse from establishing and making and/or receiving tax-favored contributions to a Health Savings Account.

Q-3. What is my "Medical Care Account"?

If you elect to participate in the Medical FSA, the Employer will establish a "Medical Care Account" to keep a record of the reimbursements to which you are entitled as well as the Pre-Tax Contributions you elected to pay for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Medical FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4. When does coverage under the Medical FSA end?

Your coverage under the Medical FSA ends on the earlier of the following to occur:

- The date that you elect not to participate in accordance with the Flexible Benefit Plan Summary;
- The last day of the Plan Year unless you make an election during the Annual Election Period;
- The date that you no longer satisfy the Medical FSA Eligibility Requirements;
- The date that you terminate employment; or
- The date that the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage (as described in Q-16 below) under the Medical FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on earliest of the following to occur:

- The date your coverage ends;
- The date that your dependents cease to be eligible dependents (e.g. you and your spouse divorce);
- The date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Medical FSA.

You and/or your covered dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail below.

Q-5. Can I ever change my Medical FSA election?

You can change your election under the Medical FSA in the following situations:

- *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
- *Following a Change In Status Event.* You may change your Medical FSA election during the Plan Year only if you experience an applicable Change in Status Event. See **Q-8** of the Flexible Benefit Plan Summary for more information on election changes. **NOTE: You may not make Medical FSA election changes as a result of any cost or coverage changes.**

Q-6. What happens to my Medical Care Account if I take an approved leave of absence?

Refer to the Flexible Benefit Plan Summary and the Election Change Appendix to determine what, if any, specific changes you can make during a leave of absence. If your Medical FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Medical FSA at either a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or b) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Medical FSA coverage was not in effect are not eligible for reimbursement under this Medical FSA.

Q-7. What is the maximum annual Medical Care Reimbursement that I may elect under the Medical FSA, and how much will it cost?

You may elect any annual reimbursement amount subject to the maximum annual Medical Care Reimbursement Amount and Minimum Reimbursement Amount described in the Plan Information Summary. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Employer Contributions and/or Benefit Credits allocated to your Medical Care Account.

Any change in your Medical FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-8. How are Medical Care Reimbursement benefits paid for under this Plan?

When you complete the Flexible Benefit Enrollment Form, you specify the amount of Medical Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Non-elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment material will indicate if Non-elective Contributions or Benefit Credits are available for Medical FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Medical Care Account.

Q-9. What amounts will be available for Medical Care Reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full, annual amount of Medical Care Reimbursement you have elected, reduced by the amount of previous Medical Care Reimbursements received during the Year, will be available at any time during the Plan Year, without regard to how much you have contributed.

Q-10. How do I receive reimbursement under the Medical FSA?

You can complete and submit a written claim for reimbursement or use the Electronic Payment Card.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

- Name of person receiving service
- Name and address of service provider
- Nature of expense (e.g., what type of service or treatment was provided).
- If the expense is for an over-the-counter drug or medicine (other than insulin), a copy of the prescription must be provided or, alternatively, you may submit a receipt from the pharmacy with the RX number and identity of the person for whom the prescription was issued.
- Amount of the expense.
- Date of Service.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the Run Out Period. The Run Out Period is described in the Plan Information Summary.

Electronic Payment Card: The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

- *You must make an election to use the card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

- *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.

- *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your Medical FSA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your spouse, and your dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

- *Medical FSA reimbursement under the card is limited to health care providers (including pharmacies).* Except with respect to IIAS merchants described in this SPD, use of the card for Medical FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you will not be able to use the card at a regular retail store – e.g., a supermarket, grocery store, or discount store with a pharmacy.

- *You swipe the card at the health care provider like you do any other credit or debit card.* When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Medical FSA (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Medical FSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

- *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the same information noted above with regard to traditional claims.

- *You must retain this receipt for one year following the close of the Plan year in which the expense is incurred.* Even though payment is made under the card arrangement, a written third party statement is required to be submitted (except as otherwise provided in the Cardholder Agreement). Upon request, you must provide the third party statement to the Claims Administrator within 30 days of the swipe of the card. NOTE: If you purchase an over the counter drug or medicine with your Card from a merchant that does not utilize the IIAS system, you may be required to present to the Claims Administrator a copy of the prescription or, alternatively, a copy of the receipt that has the RX number and the identity of the individual for whom the prescription was issued. Use of the Card may be subject to additional restrictions established by the Claims Administrator.

- *There are situations where the third party statement may not be required to be provided to the Claims Administrator.* There may be situations in which you will not be required to provide the written statement to the claims administrator. More detail as to which situations apply under your Plan is specified in the Cardholder Agreement:

    - **Co-Pay Match:** As specified in the Cardholder Agreement, no written statement is necessary if the Electronic Payment Card payment matches a specific co-payment you have under the component medical plan for the particular service that was provided or a multiple of that copayment not to exceed five times the specific copayment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, you will not be required to provide the third party statement to the Claims Administrator.

    - **Previously Approved Claim Match:** As specified in the Cardholder Agreement, no written statement is required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the claims administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount.

- **Provider Match Program:** As specified in the Cardholder Agreement, no third party statement is required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefits manager) that identifies the nature of your expense and verifies the amount.

- **Inventory Information Approval System (available at participating merchants who do not have a health care related merchant category code or certain pharmacies who do not satisfy certain IRS criteria):** Under the Inventory Information Approval System, the merchant retains a list of Eligible Medical Expenses sold by the merchant. The merchant only allows the Card to purchase items identified on that list of Eligible Medical Expenses retained by the merchant. For example, if you place both a prescription drug and a non-medical item on the counter and submit your Card, the merchant will only allow the Card to be used for the prescription drug expense. You must pay for the expenses not on the merchant's Eligible Medical Expense list with another form of payment (cash, personal credit or debit card, etc). You will not be permitted to use the Card at any merchant who does not have a health care related merchant category code unless that merchant utilizes this Inventory Information Approval System.

- *Note: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator requires it.*

- *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as required by the Claims Administrator, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Medical FSA. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement). Lastly, the employer may treat the unreimbursed amount as a bad business debt, which could have income tax implications for you.

You can use either the payment card or the traditional paper claims approach. You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

Q-11. What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d);
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is

not limited to, both prescription and over-the-counter drugs (and over-the-counter products & devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a Medical Care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Over-the-counter drugs and medicines (other than insulin) that are "medical care" will not constitute an Eligible Medical Expense unless you or your eligible dependents have obtained a prescription from an authorized health care provider (e.g. physician or, where permitted by law, a physician's assistant) that complies with applicable state law. Insulin and over-the-counter devices and supplies (other than drugs or medicines) will still constitute an Eligible Medical Expense, even if not prescribed by a health care provider, to the extent they are otherwise for "medical care".

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Medical FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

Q-12. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while you are a participant in the Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the Medical FSA becomes effective, before your Flexible Benefit Enrollment Form or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year, or, after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Medical FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period", if adopted, will be described in the attached Plan Information Summary.

In lieu of adopting a grace period, the Employer may instead permit you to "carryover" unused amounts at the end of the Plan Year for expenses incurred in the next Plan Year. The terms of the "carryover," if adopted, will be described in the Plan Information Summary.

Q-13. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Medical Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a Medical Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the Run Out period described in the Plan Information Summary. Amounts so forfeited shall be used to offset administrative expenses and future

costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Medical FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. If the Employer adopted a carryover, the amount (detailed in the Plan Information Summary) remaining at the end of the Plan Year can be carried over to the next Plan Year and used to reimburse expenses incurred during the next Plan Year. Any amounts not used for expenses incurred during the Plan Year and during the grace period, or that are not permitted to be carried over, will be forfeited.

Q-14 What happens if a Claim for Benefits under the Medical FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Q-15. What happens to unclaimed Medical Care Reimbursements?

Any Medical Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) after the employer's plan reconciliation date (which occurs after the last day of each plan year's run out period) shall be forfeited.

Q-16. What is COBRA continuation coverage?

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of Medical Care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Medical FSA unless the Employer sponsoring the Medical FSA is not subject to these rules (e.g., the employer is a "small employer" or the Medical FSA is a church Plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee's Termination of employment or reduction in hours of employment	•	•	•
2. Divorce or Legal Separation		•	
3. Child ceasing to be an eligible dependent			•
4. Death of the covered employee		•	•

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Medical FSA upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Medical FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the COBRA Administrator identified in the Plan Information Summary in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) the date of the event (ii) the date on which coverage is lost because of the event. (If a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator). Your written notice should identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g., divorce decree).

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later and send it to the COBRA Administrator identified in the Plan Information Summary. Failure to return the election form to the COBRA Administrator identified in the Plan Information Summary within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the first day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);
- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if you become entitled to Medicare; or
- if the employer no longer provides group health coverage to any of its employees.

Q-17. What happens if I received erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Medical FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways during the Plan Year that receive an excess payment: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after your receipt of such notification; (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement; or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i)-(iii), or if for any reason the steps in (i)-(iii) are not applied during the Plan Year

that the excess reimbursement was made, the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences for you.

Q-18. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Medical FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

Q-19. How long will the Medical FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Q-20. How does this Medical FSA interact with a Health Reimbursement Arrangement (HRA) Sponsored by the Employer?

Typically, a Medical FSA is the payer of last resort. This means the Medical FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an HRA sponsored by the Employer that covers expenses covered by this Medical FSA, the employer may require the Medical FSA pay first, rather than the HRA. If the Medical FSA pays first, you must exhaust your Medical Care Account before using funds allocated to your HRA. The Plan Information Summary will indicate whether the Medical FSA or HRA must pay first.

Miscellaneous Rights Under the Medical FSA Plan

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. 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 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ERISA Rights (not applicable to non-ERISA Plans)

The Medical FSA Plan may be an ERISA welfare benefit plan if your employer is a private employer. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

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.

Continue Group Health Plan Coverage
You may continue Medical Care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents will have to pay for such coverage. You should review Q-16 of this Medical FSA Summary for more information concerning your COBRA continuation coverage rights.

(To the extent the Medical FSA is subject to HIPAA's portability rules) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining

documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Maine Media Workshops
Flexible Benefit Plan
DEPENDENT CARE FSA COMPONENT SUMMARY

Q-1. Who can participate in the Plan?

Each employee who satisfies the Dependent Care FSA Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Dependent Care FSA Eligibility Date. The Dependent Care FSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the Dependent Care FSA's Eligibility Requirements, you become a participant in the Dependent Care FSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in **Q-6** of the Flexible Benefit Plan Summary. Your participation in the Dependent Care FSA will be effective on the date that you make the election or your Dependent Care FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections.

You may also become a participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year (see **Q-8** of the Flexible Benefit Plan Summary for more details regarding mid-year election changes and the effective date of those changes).

Q-3. What is my "Dependent Care Account"?

If you elect to participate in the Dependent Care FSA, the Employer will establish a "Dependent Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4. When does my coverage under the Dependent Care FSA end?

Your coverage under the Dependent Care ends on the earlier of the following to occur:

- The date that you elect not to participate in accordance with the Flexible Benefit Plan Summary;
- The last day of the Plan Year unless you make an election during the Annual Election Period;
- The date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;
- The date that you terminate employment; or
- The date that the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

If you terminate employment or you cease to be eligible during the Plan Year, you may submit for reimbursement Eligible Dependent Care Expenses incurred after the date of separation up to the amount of your Dependent Care Account to the extent set forth in the Plan Information Summary.

Q-5. Can I ever change my Dependent Care FSA election?

You can change your election under the Dependent Care FSA in the following situations:

- *For any reason during the Annual Election Period*. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
- *Following a Change In Status Event or Cost or Coverage Change*. You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable Change in Status Event or there is a significant cost or coverage change. See Q8 of the Flexible Benefit Plan Summary for more information on election changes.

Q-6. What happens to my Dependent Care Account if I take an unpaid leave of absence?

Refer to the Flexible Benefit Plan Summary and the Election Change Appendix to determine what, if any, specific changes you can make during a leave of absence.

Q-7. What is the maximum annual Dependent Care Reimbursement that I may elect under the Dependent Care FSA?

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year if you –

- are married and file a joint return;
- are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or
- are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500.

In addition, the amount of reimbursement that you receive on a tax free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your spouse's earned income.

Except to the extent permitted by law, your Spouse will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is:

- physically or mentally incapable of caring for himself or herself, or
- a full-time student (as defined by Code Section 21).

Q-8. How Do I Pay for Dependent Care Reimbursements?

When you complete the Flexible Benefit Enrollment Form, you specify the amount of Dependent Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Employer Contributions (or Benefit Credits), to the extent available. Your enrollment material will indicate if Employer Contributions or Benefit Credits are available for Dependent Care FSA coverage. Thereafter, each paycheck will be reduced

by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Dependent Care Account.

Q-9. What is an "Eligible Dependent Care Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses ("Eligible Dependent Care Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Dependent Care Expense:

- The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

- Each individual for whom you incur the expense is a "Qualifying Individual." A Qualifying Individual is:

    - An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her own support; or
    - a Spouse or other tax Dependent (as defined generally in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this Dependent Care FSA only, a Dependent means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d); (ii) the individual is a dependent of a Participant who is a tax dependent of another taxpayer under Code Section 152 or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child on his or her tax return.

- The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

- If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

- If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

- The expense is not paid or payable to a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

- You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Dependent Care Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-10. How do I receive reimbursement under the Dependent Care FSA?

When you incur an Eligible Dependent Care Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, etc.) associated with each expense that indicates the following:

- The date the expense was incurred; and
- The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Dependent Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Dependent Care Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Dependent Care Expenses during the Plan Year in which they were incurred or during the Run Out Period. The Run Out Period is described in the Plan Information Summary.

If your claim was for an amount that was more than your current Dependent Care Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate.

You must incur the expense in order to receive payment. "Incurred" means the service has been provided without regard to whether you have paid for the service. Payments for advance services are not reimbursable because they have not yet been incurred. For example, Employee A pays the monthly day care fee on January 1 and then submits a copy of the receipt on January 3. The expense for the entire month is not reimbursable until the services for that month have been performed. In addition, you must certify with each claim that you have not been reimbursed for the expense(s) from any other source and you will not seek reimbursement from any other source.

Q-11. When must the expenses be incurred in order to receive reimbursement?

Eligible Dependent Care Expenses must be incurred ***during*** the Plan Year. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Flexible Benefit Enrollment Form or Election Form becomes effective, or for any expenses incurred after the close of the

Plan Year and unless noted otherwise in the Plan Information Summary, after your participation in the Dependent Care FSA ends.

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period", if adopted, will be described in the Plan Information Summary.

Q-12. What if the Eligible Dependent Care Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Dependent Care Expenses you have incurred, on the one hand, and the annual Dependent Care Reimbursement you have elected and paid for, on the other. Any amount credited to a Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by the end of the Run Out period following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or as otherwise permitted under applicable law.

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year and the grace period will be forfeited.

Q-13. Will I be taxed on the Dependent Care Reimbursement benefits I receive?

You will not normally be taxed on your Dependent Care Reimbursement so long as your family's aggregate Dependent Care Reimbursement (under this Dependent Care FSA and/or another employer's dependent care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-14. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Dependent Care Expenses may be eligible for the dependent care credit.

Q-15. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Dependent Care Expenses as a credit against your federal income tax liability under the U.S. Tax Code. Expenses reimbursed under this plan may not be used to calculate the applicable credit. See Publication 503 for a more detailed description of the dependent care tax credit.

Q-16. What happens to unclaimed Dependent Care Reimbursements?

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) after the employer's plan reconciliation date (which occurs after the last day of each plan year's run-out period) shall be forfeited.

Q-17. What happens if my claim for reimbursement under the Dependent Care FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Q-18. How long will the Dependent Care FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

Q-19. What happens if I received erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Dependent Care FSA that exceed the amount of Eligible Dependent Care Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g., reimbursement was made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways during the Plan Year that receive an excess payment: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after your receipt of such notification; (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Dependent Care Expenses submitted for reimbursement; or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i)-(iii), or if for any reason the steps in (i)-(iii) are not applied during the Plan Year that the excess reimbursement was made, the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debit. This could result in adverse income tax consequences for you.

PLAN INFORMATION SUMMARY

This Appendix provides information specific to the Maine Media Workshops Flexible Benefit Plan. The Effective Date of this Plan Information Summary is January 1, 2019. This Plan Information Summary replaces and supersedes any other Plan Information Summary with an earlier effective date.

I. EMPLOYER/PLAN SPONSOR/THIRD PARTY ADMINISTRATOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	Maine Media Workshops 70 Camden Street Rockport, ME 04856 (207)236-8581
2. Name, address, and telephone number of the Plan Administrator: (The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan.)	Maine Media Workshops 70 Camden Street Rockport, ME 04856 (207)236-8581
3. Employer's federal tax identification number:	20-5933625
4. Plan Number:	501
5. Effective Date of the Plan: (This is the date that the Plan was first established.)	January 1, 2009
6. Effective Date of this SPD (Note: This is the most recent date of the SPD other than the Plan Information Summary and the Appendices.)	January 1, 2019
7. Plan Year:	January 1 through December 31
8. Adopting Employers participating in the Plan:	None
9. Third Party Administrator:	Group Dynamic, Inc. 411 US Route One Falmouth, ME 04105 (207)781-8800

II. FLEXIBLE BENEFIT PLAN COMPONENT INFORMATION

(a) **Eligibility Requirements and Eligibility Date:** Each Employee who works 25 hours per week and who is eligible for coverage or participation under any of the Benefit Plan Options ("Flexible Benefit Plan Eligibility Requirements") will be eligible to participate in this Plan on the first day of the month following 30 days of employment ("Flexible Benefit Plan Eligibility Date").

The Employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Flexible Benefit Enrollment Form as summarized in this SPD. Eligibility for

coverage under any given Benefit Option shall be determined not by this Plan but by the terms of that Benefit Option.

(b) **Annual Election Rules**. With respect to Benefit Option elections (other than the Medical FSA and Dependent FSA elections), failure to make an election during the Annual Election Period will result in the one of following deemed election(s):

{X} The employee will be deemed to have elected not to participate during the subsequent plan year. Coverage under the Benefit Plan Options offered under the Plan will end the last day of the Plan Year made.

{ } The employee will be deemed to have elected to continue his or her Benefit Plan Option elections in effect as of the end of the Plan Year in which the Annual Election Period took place. This is called an "Evergreen election".

(c) **Change of Election Period**: If you experience a Change in Status Event or Cost or Coverage Change as described in the Flexible Benefit Plan Summary and in the Election Change Appendix, you may make the permitted election changes described in the Election Change Appendix if you complete and submit an election change form within **30 days** after the date of the event (or such longer period set forth in the Election Change Appendix). If you are participating in an insured arrangement that provides a longer election change period, the election change period described in the insurance policy will apply.

(d) **Benefit Options**: The Employer elects to offer to eligible Employees the following Benefit Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Options. These Benefit Option(s) are specifically incorporated herein by reference. The maximum Pre-tax Contributions a Participant can contribute via the Flexible Benefit Enrollment Form is the aggregate cost of the applicable Benefit Options selected reduced by any Nonelective Contributions made by the Employer. It is intended that such Pre-tax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

The following Benefit Options are made available under the Plan to all those eligible Employees who make an appropriate election: **Health and Dental Insurance, Medical and Dependent Care FSAs.**

III. MEDICAL FSA COMPONENT INFORMATION

(a) **Medical FSA Eligibility Requirements and Eligibility Date**. Each Employee who works 25 hours per week and who is eligible to participate in the Employer's major medical plan ("Medical FSA Eligibility Requirements") is eligible to participate in the Medical FSA on the first day of the month following 30 days of employment ("Medical FSA Eligibility Date").

(b) **Annual Medical Care Reimbursement Amounts**. The maximum annual Medical FSA reimbursement shall not exceed the Pre-tax Salary Reduction amount you may elect with respect to the Medical FSA, or if greater, the sum of the Pre-tax Salary Reduction amount you elect plus any additional non-elective Employer contributions that the Employer has agreed to make (as described in the enrollment materials). The maximum Pre-tax Salary Reduction amount you may elect for a plan year is **the statutory maximum prescribed by Code Section 125(i) (as adjusted by the IRS) unless a lower amount is identified below.** In no event may salary reductions made with respect to all Medical FSAs maintained by the Employer and any employer within the same controlled group (as defined by the Code) for a Plan Year exceed the statutory maximum prescribed by Code Section 125(i) (as adjusted by the IRS). The minimum reimbursement amount that may be elected under the Medical FSA is $500.

(c) **Qualified Reservist Distribution**. The Qualified Reservist Distribution is not offered under the plan.

(d) **Run Out Period.** The Run Out Period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

- The Run Out Period for active employees ends 90 days after the last day of the Plan Year.
- The Run Out Period for terminated employees ends 90 days after the date of termination.

(e) **COBRA Administrator.** The COBRA administrator for the Medical FSA is Group Dynamic, Inc.

(f) **Interaction with HRA.** See below regarding this Medical FSA's rules with respect to coordination with an HRA:

Does the Employer sponsor an HRA?	**Yes**
Does this Medical FSA or the HRA pay first with respect to any expenses that are covered by both the HRA and Medical FSA?	**HRA**

(g) **Method of Funding**: Medical FSA Benefits are paid from general assets.

IV. DEPENDENT CARE FSA COMPONENT INFORMATION

(a) **Dependent Care FSA Eligibility Requirements and Eligibility Date**. Each Employee who works 25 hours per week ("Dependent Care FSA Eligibility Requirements") is eligible to participate in the Dependent Care FSA on the first day of the month following 30 days of employment ("Dependent Care FSA Eligibility Date").

(b) **Run Out Period.** The Run Out Period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

- The Run Out Period for active employees ends 90 days after the last day of the Plan Year.
- The Run Out Period for terminated employees ends 90 days after the date of termination.

(c) **Expense incurred after termination of employment.** You may be reimbursed for Eligible Dependent Care Expenses incurred after you terminate employment up to the amount in your account balance, subject to the reimbursement rules set forth in the SPD.

(d) **Method of Funding**: Dependent Care FSA Benefits are paid from general assets.

V. CARRYOVER

Your employer has elected the Carryover Provision for the Medical FSA. You can waive the Carryover unless otherwise specified.

Up to $500 of the unused amount in a Medical FSA for a Plan Year ("Carryover Maximum") may be rolled over for use in the entire subsequent Plan Year. The minimum amount that may be rolled over is $10.

With a Carryover, Medical FSA balances that are unused for a Plan Year may be used for reimbursement of Eligible Medical Expenses incurred at any time in the subsequent Plan Year (in addition to the amount that is otherwise available for reimbursement in the subsequent Plan Year) subject to the following terms and conditions:

- The specific Carryover amount is generally determined at the end of the run out period following such Plan Year ("Carryover").

    - For example, if you have an unused Medical FSA balance at the end of the 2016 Plan Year equal to $1000, and you have no other expenses that were incurred in 2016, your 2016 Carryover amount that may be used in the 2017 Plan Year is $500. However, if you have 2016 Plan Year expenses equal to $600 that you timely submit during the run out period for the 2016 Plan Year, then your 2016 Carryover amount that may be used in the 2017 Plan Year will only be $400.

- The Carryover does not count against the maximum salary reduction election.

- If you are otherwise eligible for the Medical FSA for a Plan Year but you do not make an election to participate, you may still use any Carryover from the prior Plan Year for Current Year Expenses and Prior Year Expenses (in accordance with terms of the Plan and the ordering rules described above).

- Under IRS rules, if you have unused Medical FSA amounts on the last day of a Plan Year in a general purpose Medical FSA (i.e., anything other than a $0 balance), you (and your spouse, if you are married) cannot contribute to a health savings account ("HSA") under Code Section 223 during the following Plan Year. For this purpose, whether you have unused Medical FSA amounts is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not the claims have been submitted).

  However, if the Plan Administrator allows you to waive any Carryover eligibility before the last day of the Plan Year, then you will be eligible for the HSA in the following Plan Year.

- You must be a participant in the Medical FSA as of the last day of the Plan Year to benefit from the Carryover. Termination of employment and cessation of eligibility will generally result in a loss of Carryover eligibility unless a COBRA election is made.

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The Effective Date of this Appendix I is January 1, 2019. It should replace and supersede any other Appendix I with an earlier date.

The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan. The procedure set forth below does not apply to benefit claims filed under the Benefit Options other than the Medical FSA and Dependent Care FSA.

Step 1: *Notice is received from Third Party Administrator*. If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim,
- why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Third Party Administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim & any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from Third Party Administrator.* If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- (Medical FSA Only) Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

APPENDIX II

ELECTION CHANGE APPENDIX

The Effective Date of this Appendix II is January 1, 2019. It should replace and supersede any other Appendix II with an earlier date.

The following is a summary of the election changes that are permitted under this Plan. Also, election changes that are permitted under this Plan may not be permitted under the Benefit Option (e.g., the insurance carrier may not allow a change). If a change is not permitted under a Benefit Option, no election change is permitted under the Plan. Likewise, a Benefit Option may allow an election change that is not permitted by this Plan. In that case, your pre-tax reduction may not be changed even though a coverage change is permitted. For a description of the election change rules for Health Savings Accounts (if made available through the Plan), see the Health Savings Account Contribution Appendix).

First, we describe the general rules regarding election changes that are established by the IRS. Then, you should look to the following to determine under what circumstances you are permitted to make an election under this Plan and the scope of the changes you may make.

1. **Change in Status**. Election changes may be allowed if a Participant or a Participant's Spouse or Dependent experiences one of the following Change in Status Events: (i) change in legal marital status; (ii) change in the number of the participant's dependents (such as birth, death, adoption); (iii) change in the participant's or eligible dependent's employment status such as commencing employment, termination of employment, change in employment status (such as part-time to full-time) and commencement or return from a leave of absence. The election change must be on account of and correspond with the Change in Status Event as determined by the Plan Administrator (or its designated Third Party Administrator). With the exception of enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective (generally the first of the month following the date you make a new election with the Third Party Administrator but it may be earlier depending on the Employer's internal policies or procedures). As a general rule, a desired election change will only be found to be consistent with a Change in Status Event if the Change in Status affects eligibility for coverage. A Change in Status is also deemed to affect eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving a divorce, annulment or legal separation, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, an election to cancel accident or health benefits for any individual other than the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent. However, there are instances in which you may be able to <u>increase</u> your Pre-tax Contributions to pay for COBRA coverage of a Dependent. Contact the Third Party Administrator for more information.

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year Flexible Benefit plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon

subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which a Participant or his or her Spouse or Dependent gain eligibility for coverage under another employer's Flexible Benefit plan or benefit plan as a result of a change in marital status or a change in the Participant's, the Participant's Spouse's, or the Participant's Dependent's employment status, an election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care Reimbursement Plan Benefits* With respect to the Dependent Care FSA benefit, an election change is permitted only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care FSA expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its Flexible Benefit plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Options offered under the Plan).* For group term life insurance, disability income and accidental death and dismemberment benefits, an election to either increase or decrease coverage is permitted only if a Participant experiences any Change in Status (as described above).

  Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a Flexible Benefit plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If a Participant, Participant's Spouse and/or Dependent are entitled to special enrollment rights under a Benefit Option that is a group health plan, an election change to correspond with the special enrollment right is permitted. Thus, for example, if an otherwise eligible employee declined enrollment in medical coverage for the employee or the employee's eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period, or if your employer or your eligible dependent's employer stops contributing toward your or your dependents' other coverage), the employee may be able to elect medical coverage under the Plan for the

employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee gains a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may also be able to enroll the employee, the employee's Spouse, and the employee's newly acquired Dependent, provided that a request for enrollment is made within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan summary description for an explanation of special enrollment rights. If an unenrolled but otherwise eligible Employee or such Employee's dependent (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act due to a loss of eligibility for coverage under Medicaid or SCHIP; or (2) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the Employee is entitled to special enrollment rights under a benefit plan option that is a group health plan and an election change to correspond with the special enrollment right is permitted. However, you must request enrollment **within 60 days** after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for premium assistance subsidy, as applicable. Please refer to the group health plan summary description for an explanation of special enrollment rights. Note: This only applies to a Medical FSA to the extent that the Medical FSA is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires a Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, an election change to provide coverage for the Dependent child identified in the order is permissible. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If a Participant or the Participant's Dependents become entitled to Medicare or Medicaid, an election to cancel that person's accident or health coverage is permitted. Similarly, if a Participant or Participant's Dependents who had been entitled to Medicare or Medicaid loses eligibility for such, you may elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the cost of a Benefit Option significantly increases, a Participant may choose either to make an increase in contributions, revoke the election and receive coverage under another Benefit Option that provides similar coverage, or drop coverage altogether *if no similar coverage exists*. If the cost of a Benefit Option significantly decreases, a Participant who elected to participate in another Benefit Option may revoke the election and elect to receive coverage provided under the Benefit Option that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Plan may elect to participate in the Benefit Option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Option options, however, Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Medical FSA, to the extent offered under the Plan.)

> *Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.*

6. **Change in Coverage**. If coverage under a Benefit Option is significantly curtailed, a Participant elect to revoke his or her election and elect coverage under another Benefit Option that provides similar

coverage. If the significant curtailment amounts to a complete loss of coverage, a Participant may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, a Participant may revoke his or her election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, a Participant may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, a Participant may change his or her election to add coverage under this Plan for the Participant, the Participant's Spouse or Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Medical FSA, to the extent offered under the Plan.)

The following is a chart reflecting the election changes that may be made under the Plan with respect to each Benefit Option. In addition, election changes that are permitted under this Plan are subject to any limitations imposed by the Benefit Options. If an election change is permitted by this Plan but not by the Benefit Option, no election change under this Plan is permitted.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
I. Change in Status					
A. Change in Employee's Legal Marital Status					
1. Marriage	Employee may enroll or increase election for newly- eligible spouse and dependent children (Note: Under IRS "tag-along" interpretation, new and preexisting dependents may be enrolled); coverage option (e.g., HMO to PPO) change may be made; employee may revoke or decrease employee's or dependent's coverage only when such coverage becomes effective or is increased under the spouse's plan. Also, see HIPAA special enrollment rule below.	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase election for newly eligible spouse or dependents, or likely decrease election if employee or dependents become an eligible dependent under new spouse's health plan (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase to accommodate newly-eligible dependents or decrease or cease coverage if new spouse is not employed or makes a Dependent Care FSA coverage election under spouse's plan.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.
2. Lose spouse (divorce, legal separation, annulment, death of spouse) (See loss of dependent eligibility below for discussion of dependent eligibility loss following divorce, separation, etc.)	Employee may revoke election only for spouse; coverage option (e.g., HMO to PPO) change may be made; employee may elect coverage for self or dependents who lose eligibility under spouse's plan if such individual loses eligibility as a result of the divorce, legal separation, annulment, or death. (Note: Under IRS "tag-along" interpretation, any dependents may be enrolled so long as at least	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may decrease election for former spouse who loses eligibility (Note: HIPAA special enrollment rights likely do not apply). Employee may enroll or increase election where coverage lost under spouse's health plan.	Employee may enroll or increase to accommodate newly eligible dependents (e.g., due to death of spouse) or decrease or cease coverage if eligibility is lost (e.g., because dependent now resides with ex-spouse).	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
	one dependent has lost coverage under the spouse's plan.)				
B. Change in the Number of Employee's Dependents					
1. Gain Dependent (birth, adoption)	Employee may enroll or increase coverage for newly-eligible dependent (and any other dependents who were not previously covered under IRS "tag-along" rule); coverage option (e.g., HMO to PPO) change may be made; employee may revoke or decrease employee's or dependent's coverage if employee becomes eligible under spouse's plan. Also, see HIPAA special enrollment rule below.	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase to accommodate newly eligible dependents (and any other dependents who were not previously covered under IRS "tag-along" rule).	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.
2. Lose Dependent (death)	Employee may drop coverage only for the dependent who loses eligibility; coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Employee may decrease or cease election for dependent who loses eligibility.	Employee may decrease election for dependent who loses eligibility.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.
C. Change in Employment Status of Employee, Spouse, or Dependent That Affects Eligibility					
1. Commencement of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) That Triggers Eligibility					
a. Commencement of Employment by Employee or Other Change in Employment Status (e.g., PT to FT, hourly to salaried, etc.) Triggering Eligibility Under Component Plan	Provided eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependents and coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Same as previous column.	Same as previous column.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
b. Commencement of Employment by Spouse or Dependent or Other Employment Event Triggering Eligibility Under Their Employer's Plan	Employee may revoke or decrease election as to employee's, spouse's, or dependent's coverage if employee, spouse or dependent is added to spouse's or dependent's coverage; coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Employee may apparently decrease or cease FSA election if employee gains eligibility for health coverage under spouse's or dependent's plan.	Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work). Employee may revoke election as to dependent's coverage if dependent is added to spouse's plan.	Employee may enroll, increase, decrease or cease coverage even when spouse's or dependent's eligibility is not impacted.
2. Termination of Employment by Employee, Spouse, or Dependent (or Other Change in Employment-Status) That Causes Loss of Eligibility					
a. Termination of Employee's Employment or Other Change in Employment Status (e.g., unpaid leave, FT to PT, strike, salaried to hourly, etc.) Resulting in a Loss of Eligibility	Employee may revoke or decrease election for employee, spouse or dependents who lose eligibility under the plan. In addition, other previously eligible dependents may also be enrolled under "tag-along" rule. Coverage option (HMO to PPO) change may be made.	Same as previous column.	Same as previous column.	Employee may revoke or decrease election to reflect loss of eligibility.	Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.
i. Termination and Rehire Within 30 Days	Prior elections at termination are reinstated unless another event has occurred that allows a change (as an alternative, employer may prohibit participation until next plan year).	Same as previous column.	Same as previous column.	Same as previous column.	Same as previous column.
ii. Termination and Rehire After 30 Days	Employee may make new elections.	Same as previous column.	Same as previous column.	Same as previous column.	Same as previous column.
b. Termination of Spouse's or Dependent's Employment (or other change in employment	Employee may enroll or increase election for employee, spouse or dependents who lose	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase FSA election if spouse or dependent loses eligibility for health	Employee may enroll or increase if spouse or dependent loses eligibility for Dependent Care FSA.	Employee may enroll, increase, decrease or cease even when eligibility is not affected.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
status resulting in a loss of eligibility under their employer's plan)	eligibility under spouse's or dependent's employer's plan. In addition, other previously eligible dependents may also be enrolled under "tag-along" rule. Coverage option (e.g., HMO to PPO) change may be made; See HIPAA special enrollment rule below.		coverage (Note: HIPAA special enrollment rights likely do not apply).	Employee may decrease or cease Dependent Care FSA election if spouse's loss of employment renders dependents ineligible.	
c. Employee's reduction in hours below 30 hours of service per week due to change in employment status without loss of eligibility	Employee may revoke election as to employee's, spouse's, or dependent's coverage if: 1. Employee was in an employment status where he was reasonably expected to work at least 30 hours per week and there is a change in the employee's status so that employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the major medical plan; and 2. The revocation of the election of coverage under the major medical plan corresponds to intended	No change permitted.	No change permitted.	No change permitted.	No change permitted.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
	enrollment of the employee, spouse, and dependents (as applicable), in another plan that provides minimum essential coverage effective no later than the 1st day of the 2nd month after the month that include the date this coverage is revoked.				
D. Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements (Also see discussion of gain/loss of eligibility under dependent or spouse's employer's plan)					
1. Event by Which Dependent Satisfies Eligibility Requirements Under Employer's Plan (attaining a specified age, becoming single, becoming a student, etc.)	Employee may enroll or increase election for affected dependent. In addition, employee may apparently add previously eligible (but not enrolled) dependents under "tag-along" rule; coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Employee may increase election or enroll only if dependent gains eligibility under Medical FSA.	Employee may increase election or enroll to take into account expenses of affected dependent.	Employee may enroll, increase, decrease or cease even when eligibility is not affected.
2. Event by Which Dependent Ceases to Satisfy Eligibility Requirements Under Employer's Plan (attaining a specified age, getting married, ceasing to be a student, etc.)	Employee may decrease or revoke election only for affected dependent. Coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	Employee may decrease election to take into account ineligibility of expenses of affected dependent, but only if eligibility is lost.	Employee may decrease or drop election to take into account expenses of affected dependent.	Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
E. Change in Place of Residence of Employee, Spouse, or Dependent					
1. Move Triggers Eligibility	Employee may enroll or increase election for newly eligible employee, spouse, or dependent. Also, other previously eligible dependents may be re-enrolled under "tag-along" rule; coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	No change allowed, even if underlying health coverage change occurs.	N/A. Dependent care eligibility is not generally affected by place of residence (but see change in coverage below).	Employee may increase or decrease even if spouse's or dependent's eligibility is not affected.
2. Move Causes Loss of Eligibility (e.g., employee or dependent moves outside HMO service area)	Employee may revoke election or make new election if the change in residence affects the employee's, spouse's or dependent's eligibility for coverage option.	Same as previous column.	No change allowed, even if underlying health coverage change occurs.	N/A. Dependent care eligibility is not generally affected by place of residence (but see change in coverage below).	Employee may enroll, increase, decrease or cease even when eligibility is not affected.
II. Cost Changes With Automatic Increase/Decrease in Elective Contributions					
Cost Changes With Automatic Increase/Decrease in Elective Contributions (including employer motivated changes and changes in employee contribution rates)	Plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees' elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	Same as previous column.	No change permitted.	Application is unclear. Presumably, plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees' elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	Same as Major Medical column.
III. Significant Cost Changes					
Significant Cost Changes	**Significant Cost Increase:** Affected employee may increase election correspondingly OR revoke election and	Same as previous column.	No change permitted.	Same as Major Medical column for significant cost increase, except no change can be made when the cost change is imposed by a	Same as Major Medical column.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
	elect coverage under another benefit package option providing similar coverage. If no option providing similar coverage is available, employee may revoke election. **Significant Cost Decrease:** Employees may elect coverage (even if had not participated before) with decreased cost, and may drop election for similar coverage option. Though unclear, it appears that tag-along concepts may apply.			dependent care provider who is a relative of the employee.	
IV. Significant Coverage Curtailment (With or Without Loss of Coverage)					
Significant Coverage Curtailment (With or Without Loss of Coverage)	**Without Loss of Coverage:** Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option which provides similar coverage.	Same as previous column.	No change permitted.	Election change may apparently be made whenever there is a change in provider or a change in hours of dependent care.	Same as Major Medical column.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
	With Loss of Coverage: Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option which provides similar coverage OR drop coverage if no similar benefit package option is available.	Same as previous column.	No change permitted.	Election change may apparently be made whenever there is a change in provider or a change in hours of dependent care.	Same as Major Medical column.
V. Addition or Significant Improvement of Benefit Package Option					
Addition or Significant Improvement of Benefit Package Option	Eligible employees (whether currently participating or not) may revoke their existing election and elect the newly added (or newly improved) option. Though unclear, it appears that tag-along concepts may apply.	Same as previous column.	No change permitted.	Eligible employees (whether currently participating or not) may revoke their existing election and elect the newly added (or newly improved) option.	Same as previous column.
VI. Change in Coverage Under Other Employer's Flexible Benefit Plan or Qualified Benefits Plan					
Change in Coverage Under Other Employer's Flexible Benefit Plan or Qualified Benefits Plan (In order for election changes to be permitted under this exception, the election change must be on account of and correspond with the change in coverage under the other employer's Flexible Benefit plan or	Employee may decrease or revoke election for employee, spouse or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer plan.	Same as previous column.	No change permitted.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer plan.	Same as previous column.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
qualified benefits plan. In addition, either (1) the plan of the other employer must permit elections specified under the Regulations and an election must actually be made under such plan; or (2) the employee's Flexible Benefit plan must permit elections for a period of coverage different from that under the other employer plan ("Election Lock" rule).					
A. Other Employer's Plan Increases Coverage	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer's plan.	Same as previous column.	No change permitted.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer's plan	Same as previous column.
B. Other Employer's Plan Decreases or Ceases Coverage	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer's plan.	Same as previous column.	No change permitted.	Employee may increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer's plan.	Same as previous column.
C. Open Enrollment Under Plan of Other Employer	Corresponding changes can be made under employer's plan.	Corresponding changes can be made under employer's plan.	No change permitted.	Corresponding changes can be made under employer's plan.	Corresponding changes can be made under employer's plan.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
VII. FMLA Leave **(Employees can fund this coverage by (1) pre-paying their contribution obligations on a pre-tax basis (so long as the leave does not straddle two plan years); (2) making contributions on a month-by-month basis (pre-tax if they are receiving salary continuation payments); or (3) catching up on their contributions upon returning from the leave.)**					
A. Employee's Commencement of FMLA Leave	Employee can make same elections as employee on non-FMLA leave. An employer must allow an employee on unpaid FMLA leave either to revoke coverage or to continue coverage but allow employee to discontinue payment of his or her share of the contribution during the leave (the employer may recover the employee's share of contributions when the employee returns to work). FMLA also allows an employer to require that employees on paid FMLA leave continue coverage if employees on non-FMLA paid leave are required to continue coverage.	Same as previous column.	Same as previous column.	Employee may revoke election and make another election as provided under FMLA.	Same as previous column.
B. Employee's Return from FMLA Leave	Employee may make a new election if coverage terminated while on FMLA leave. In addition, an employer may require an employee to be reinstated in his or her election upon return from leave if employees who	Same as previous column.	Same as previous column. Note that, upon return, an employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) or at a level reduced prorate for the missed contributions.	Employee may make a new election if coverage terminated while on FMLA leave. In addition, an employer may require an employee to be reinstated in his or her election upon return from leave if employees who	Same as previous column.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
	return from a non-FMLA paid leave are required to be reinstated in their elections.			return from a non-FMLA leave are required to be reinstated in their elections.	
VIII. HIPAA Special Enrollment Rights (See related exception for addition of new dependents)					
A. Special Enrollment for Loss of Other Health Coverage	Employee may elect coverage for employee, spouse, or dependent who has lost other coverage (COBRA coverage exhausted or terminated, no longer eligible for non-COBRA coverage or employer contributions for non-COBRA coverage terminated, etc.) Though unclear, it appears that tag-along concepts may apply.	No change permitted, unless plan is subject to HIPAA.	No change permitted, unless Medical FSA is subject to HIPAA.	No change permitted.	No change permitted.
B. Special Enrollment for Acquisition of New Dependent by Birth, Marriage, Adoption, or Placement for Adoption (If newborn or newly adopted child is enrolled under HIPAA's special rules, child's coverage may be retroactive to date of birth, adoption, or placement for adoption; employee may change salary reduction election to pay for extra cost of child's coverage retroactive to date of birth, adoption, or placement for	Employee may elect coverage for employee, spouse, or dependent. Example provides that election of coverage may also extend to previously eligible (but not yet enrolled) dependents.	No change permitted, unless plan is subject to HIPAA.	No change permitted, unless Medical FSA is subject to HIPAA.	No change permitted.	No change permitted.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
adoption. For marriage, coverage is effective prospectively.					
C. Special Enrollment for Loss of Medicaid or SCHIP Coverage (applies beginning April 1, 2009). Note: There is a 60-day special enrollment period for this event.	Employee may elect coverage for employee or dependent who has lost Medicaid or SCHIP coverage.	Same as previous column if plan is subject to HIPAA portability rules	No change permitted, unless plan is subject to HIPAA.	No change permitted	No change permitted
D. Special Enrollment Due to Eligibility for State Premium Assistance Subsidy From Medicaid or SCHIP (applies beginning April 1, 2009). Note: There is a 60-day special enrollment period for this event.	Employee may elect coverage for employee or dependent who has become eligible for premium assistance subsidy from Medicaid or SCHIP	Same as previous column if plan is subject to HIPAA portability rules	Premium assistance subsidy does not apply	No change permitted	No change permitted
E. Special Enrollment Period or annual enrollment period in Qualified Health Plan on Marketplace (a.k.a., "Exchange")	Employee may revoke election as to employee's, spouse's, or dependent's coverage if: 1. Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace	No change permitted.	No change permitted.	No change permitted.	No change permitted.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
	during the Marketplace's annual open enrollment period; and 2. The revocation of the election under the group health plan corresponds to the intended enrollment of the employee, spouse, and dependents for whom coverage is revoked in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of group health plan coverage.				
IX. COBRA Events					
COBRA Events	Employee may increase pre-tax contributions under employer's plan for coverage if COBRA event (or similar state law continuation coverage event) occurs with respect to the employee, spouse, or dependents with respect to which the COBRA qualifying event occurred (such as a loss of eligibility for regular coverage due to loss of dependent status or a reduction in hours, etc.) and if applicable, the	Same as previous column.	No change permitted.	No change permitted.	No change permitted.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
	individual still qualifies as a tax dependent of employee.				
X. Judgment, Decree, or Order					
A. Order That Requires Coverage for the Child Under Employee's Plan	Employee may change election to provide coverage for the child. Though unclear, it appears that tag-along concepts may apply.	Same as previous column.	Same as previous column.	No change permitted.	No change permitted.
B. Order That Requires Spouse, Former Spouse, or Other Individual to Provide Coverage for the Child	Employee may change election to cancel coverage for the child.	Same as previous column.	Same as previous column.	No change permitted.	No change permitted.
XI. Medicare or Medicaid					
A. Employee, Spouse, or Dependent Enrolled in Employer's Accident or Health Plan Becomes Entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines)	Employee may elect to cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Unlikely that employee can elect to drop dental or vision coverage; presumably, employee must retain coverage.	Employee may apparently decrease or revoke election or increase election if Medical FSA is dropped due to Medicare (-aid) and prior employer coverage was more comprehensive.	No change permitted.	No change permitted.
B. Employee, Spouse, or Dependent Loses Eligibility for Medicare or Medicaid (other than coverage solely for pediatric vaccines)	Employee may elect to commence or increase coverage for employee, spouse, or dependent, as applicable. Though unclear, it appears that tag-along concepts may apply.	Unlikely that employee can elect to add dental or vision coverage; presumably, employee cannot.	Employee may apparently increase or decrease or revoke election where employer plan elected due to loss of eligibility for Medicare (-aid) is more comprehensive than Medicare (-aid).	No change permitted.	No change permitted.