University of New England
Flexible Benefit Plan
Summary Plan Description
For The
Flexible Benefit Plan
Medical Flexible Spending Account
Dependent Care Flexible Spending Account

This Document is Effective: January 1, 2024

TABLE OF CONTENTS

GENERAL INFORMATION ABOUT THE PLAN **1**

FLEXIBLE BENEFIT PLAN COMPONENT SUMMARY **2**

Q-1. What is the purpose of the Flexible Benefit Plan? 2
Q-2. Who can participate in the Flexible Benefit Plan? 2
Q-3. When does my participation in the Flexible Benefit Plan end? 2
Q-4. How do I become a participant? 3
Q-5. What are tax advantages and disadvantages of participating in the Flexible Benefit Plan? 3
Q-6. What are the election periods for entering the Flexible Benefit Plan? 3
Q-7. How is my Benefit Option coverage paid for under this Plan? 4
Q-8. Under what circumstances can I change my election during the Plan Year? 5
Q-9. What happens to my participation under the Flexible Benefit Plan if I take a leave of absence? 5
[redacted] long will the Flexible Benefit Plan remain in effect? 7
[redacted]t happens if my request for a benefit under this Flexible Benefit Plan (e.g. an [redacted]tion change or other bl10(l10(l10(l10(l10(l10(l10(ll)-25( )-10(t)-25(h)-21(e)-22( )-21(F)-19(l)-14(e)-22(

.....

(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

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.

University of New England
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

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

x

Code Section 223 Health Savings Account unless the scope of expenses eligible for reimbursement under

costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan

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) upon the -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 children later of the Qualifying Event(s

A Qualified

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

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.

7R WKH H[WHQW WKH 0HGLFDO)6$ LV VXEMHFW WR UHGXFWLRQ 3$¶V SRU 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

University of New England
Flexible Benefit Plan

Dependent Care FSA Component Summary

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

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 ³Eligible 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.

- 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

Plan Year and unless noted otherwise in the Plan Information Summary, after your participation in the

University of New England
Flexible Benefit Plan

HEALTH SAVINGS ACCOUNT CONTRIBUTION SUMMARY

As

Q-4. Who is a Custodian or Trustee?

Any Pre-tax Contribution contributions that cannot be made to the HSA because it is determined that you

(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 one of the 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.

(c) **Change of Election Period**. If you experience a Change in Status Event or Loss of 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 ar1 0 0 1 205.37 507.31 Tm0 g0 G[(I)7(f)-3( )-151(y)11(ou)-140(ar)-4(r2(t)-4(hubs

Chang Q EMC 4 98 7T89pa011(t)-4(i)6(ons)-fec00000912 0 612 792 re W* n

The grace period will begin on the first day of the next Plan Year and will end two months and fifteen days later. For example, as the Plan Year ends December 31, the grace period begins January 1 and ends March 15.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- A Qualified Beneficiary who is receiving COBRA coverage under the Medical FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the Plan Year to which the grace period relates to the extent such expenses have not yet been submitted for reimbursement. Previous claims will not be reprocessed or re-characterized so as to change the order in which they were received.
- For example, assume that $200 remains in your Medical FSA account at the end of the 2020 Plan Year and further assume that you have elected to allocate $2400 to the Medical FSA for the 2021 Plan Year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred in the first month of the new plan year, $200 of your claim will be paid out of the unused amounts remaining in your Medical FSA from the 2020 Plan Year and the remaining $300 will be paid out of amounts allocated to your Medical FSA for 2021.
- Expenses incurred during a grace period must be submitted before the end of the Run-out Period described in this SPD. This is the same Run-out Period for expenses incurred during the Plan Year to which the grace period relates. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-out Period.
- You may not use Medical FSA amounts to reimburse Eligible Dependent Care Expenses (and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses).

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The Effective Date of this Appendix I is January 1, 2024. 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

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, 2024. 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).

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.

x *DLQ RI &RYHUDJH (OLJLELOLW\ 2WKHU &KDQJH LQ 6WDWXV ZKLFK D 3OD\HU¶

Participant or his or her Spouse or Dependent gain eligibility for coverage under another plan or benefit plan as a result of a change in marital status or a change

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

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.

(1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or under State ity 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.

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
of eligibility under their H P S O R \ H U ¶ V S F (P S O R \ H H ¶ V **in hours below 30 hours**	plan. In addition, other previously eligible dependents may also be - rule. Coverage option (e.g., HMO to PPO) change may be made; See HIPAA special enrollment rule below.		special enrollment rights likely do not apply).	cease Dependent Care loss of employment renders dependents ineligible.	

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				

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
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 Flexible Benefit plan must					

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life,

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
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

Event	Major Medical

Event	Major Medical	Dental and Vision	Medical FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
X. Judgment, Decree, or Order					
A. Order That Requires Coverage for the Child 8QGHU (PSOR\I	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.	[redacted]	Same as previous column.	No change permitted.	No change permitted.