ALLOWABLE CHANGES TO YOUR PRE-TAX BENEFIT ELECTIONS

The following benefits are paid for with pre-tax contributions. As a result of the pre-tax contributions, the law limits your ability to make changes to your election for the Plan Year (January 1 – December 31).

- Health Care Plan
- Dental Care Plan
- Vision Care Plan
- Medical Expense Reimbursement Plan
- Limited Use Medical Expense Reimbursement Plan
- Dependent Care Expense Reimbursement Plan

You cannot make changes to your tier (Employee Only, Employee +1, Family) of coverage (and related pre-tax contributions) under the above plans during the Plan Year unless any of the following occurs **and** your change is consistent with the event that allows for the change.

Your Change In Election Must Be Made Within 30 Days Of The Following Events:

You experience an event that is considered a "Change in Status."

- A change in the participant's legal marital status, including marriage, death of a spouse, divorce, legal separation, or annulment.
- A change in the participant's number of dependents, including birth, adoption, placement for adoption, or death of a dependent.
- A termination or commencement of employment by the participant, spouse, or dependent of the participant.
- An event that changes the employment status of the participant, spouse, or dependent of the participant, including a strike or lockout or commencement of, or return from, an unpaid leave of absence.
- A change in the employment status of the participant, spouse, or dependent of the participant that results in such individual becoming (or ceasing to be) eligible to participate in the plan.
- A participant's dependent satisfies, or ceases to satisfy, eligibility requirements for coverage due to attainment of age, or any similar circumstances as provided by the plan.
- A change in health plan access due to change in residency or work location of the employee, spouse, or dependent (this does not allow you to make any change to your payroll contribution to either Medical Expense Reimbursement Plan).

Your dependent child's coverage changes as a result of a court order, including a qualified medical child support order.

You take leave under the Family Medical Leave Act (FMLA).

There are cost changes:

- Health, Dental or Vision Care Plan – your cost significantly increases/decreases (this does not allow you to make any change to your payroll contribution to either Medical Expense Reimbursement Plan).
- Dependent Care Expense Reimbursement Plan – if the cost of dependent care provider services increases/ decreases, as long as the provider is not related to the participant. If the change in cost is due to a change in providers, then the new provider can be related to the participant.

Benefit options are added or eliminated under the plan (this does not allow you to make any change to your payroll contribution to either Medical Expense Reimbursement Plan).

There is a change to your spouse's or dependent's employer's plan (such as changes in cost or coverage) and your change corresponds to that change.

- Health, Dental, or Vision Care - change is allowed.
- Medical Expense/Limited Use Medical Expense - change is not allowed.
- Dependent Care Expense - change is allowed if your spouse has elected a corresponding change in coverage under the other employer plan.

– Change is also allowed for health, dental, vision and dependent care expense, if the plan year for these other employer plans are different than our Plan Year.
You, your spouse, or dependent becomes eligible for, or ceases to be eligible for Medicare, Medicaid or state CHIP coverage.
You, your spouse and dependents lose eligibility for coverage under a group health plan or other health insurance coverage, or when their employer terminates contributions toward that health coverage.
An individual becomes your new dependent through marriage, birth, adoption, or being placed for adoption.

Changes That Allow Change of Election within 60 Days (Health Care Plan Only):

An employee, spouse or dependent becomes eligible for or ceases to be eligible for Medicaid or state CHIP coverage or premium assistance for Medicaid or state CHIP

Changes due to Medicaid or state chip coverage or premium assistance for Medicaid or state chip must be made within 60 days of the government provided coverage beginning or ending or the determination of eligibility for the state premium assistance.