STATE OF MARYLAND FLEXIBLE BENEFITS PLAN

PLAN SUMMARY

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The State of Maryland maintains the State of Maryland Flexible Benefits Plan for the benefit of its eligible employees. The terms of the Plan are contained in a lengthy, legally worded document. This Plan Summary is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive; and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or to add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.

IDENTIFYING INFORMATION

1. Plan Name:

   State of Maryland Flexible Benefits Plan

2. Employer/Plan Administrator Name and Address:
   State of Maryland
   301 West Preston Street, Room 510
   Baltimore, MD 21201
   410-767-4775

3. Claims Administrator:

   The Plan Administrator has retained P&A Administrative Services, Inc. to assist in Plan administration.

   You may submit your claims online at P&A's website, www.md.padmin.com, by logging into your P&A Account or by using your smartphone.

   Or you may mail your claims to P&A Administrative Services, Inc., 17 Court Street, Suite 500, Buffalo, NY 14202 or fax them to 844 638-1901.

4. Plan Year-End:

   December 31

THE FLEXIBLE BENEFITS PLAN
OVERVIEW

The Plan gives you the opportunity to avoid taxes on the part of your pay that you spend on certain expenses: your share of the cost of insurance coverage you receive through your Employer; health care expenses that are not covered by insurance; and expenses for the care of your children or other dependents so that you are able to work. So that you and other eligible employees can enjoy the tax savings the Plan is intended to provide, the Plan is operated according to certain rules contained in the federal tax laws and regulations.

If you want to take advantage of the tax savings potential that the Plan offers, you will need to figure out the types and amounts of covered expenses that you will have each year. Then, you will need to complete an election form based on your determination. When you complete an election form, you will indicate the benefits that you want, and you will instruct your Employer to withhold from your pay any money needed to cover the cost of those benefits.

The following is a list of some of the more commonly asked questions regarding your Plan.

PLAN YEAR

WHAT IS THE EFFECTIVE DATE OF THE PLAN?

The Plan started on January 1, 2017.

WHAT IS THE PLAN YEAR?

"Plan Year" refers to the accounting period that is used for purposes of maintaining the Plan's records, which is the 12-month period beginning on January 1 and ending on the following December 31.

ELIGIBILITY AND PARTICIPATION

WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?

You qualify to elect benefits under the Plan by becoming a Plan "Participant" as soon as you start working for the Employer.

HOW DO I PARTICIPATE?

When you become a Participant, you will receive a form that you can use to elect the benefits that you desire.

PLAN CONTRIBUTIONS

HOW ARE BENEFITS PAID FOR?

You pay for your own benefits under the Plan with money that is withheld from your pay based on your election form. These pay reductions do not count as income for income tax or Social Security tax purposes (exceptions: *If you are a New Jersey taxpayer, the New Jersey state income tax will apply to any salary reductions that you elect and, if you are a Pennsylvania taxpayer, the Pennsylvania state income tax will apply to any salary reductions that you elect to pay for benefits under the Dependent Care Assistance Account Option*). This means that the Plan allows you to use tax-free dollars to pay for expenses that would otherwise have to be paid with money that has been included in your taxable income.

WHEN ARE CONTRIBUTIONS MADE TO THE PLAN?

Unless your Employer tells you otherwise, the cost of your benefits will be withheld each pay period on a pro rata basis over the course of the Plan Year.

WILL MY SOCIAL SECURITY BENEFITS BE AFFECTED BY MY CONTRIBUTIONS TO THE PLAN?

Your Social Security benefits may be slightly reduced because, when your pay is reduced to cover your benefits under the Plan, the amount of contributions that are made to the federal Social Security system to provide you Social Security benefits also are reduced.

PLAN BENEFITS

WHAT BENEFITS MAY I CHOOSE UNDER THIS PLAN?

The benefits that may be elected in lieu of cash compensation consist of expenses that may be paid with money that is not subject to tax. If you want to pay for your share of the cost of insurance coverage you receive from your Employer through the Plan, elect the Insurance Premium Pre-tax Payment Option described below; if you want to pay for your uninsured health care expenses through the Plan, elect the Medical Expense Reimbursement Account Option described below; and, if you want to pay for day care costs through the Plan, elect the Dependent Care Assistance Account Option described below.

If you elect benefits under the Medical Expense Reimbursement Account Option or the Dependent Care Assistance Account Option (referred to together as the "Flexible Spending Account Options"), your contributions to pay for your expenses covered by that option will be credited to an account in your name. This "Account" is for record-keeping purposes only and does not involve any actual segregation of funds.

WHAT BENEFITS ARE AVAILABLE UNDER THE INSURANCE PREMIUM PRE-TAX PAYMENT OPTION?

The Insurance Premium Pre-tax Payment Option gives you the opportunity to elect to pay your share of the premiums for coverage under the Employer's group medical, dental and prescription plans with funds that are not subject to tax.

Unless you file an election with the Plan Administrator before the beginning of a Plan Year on a form that is provided to you, you automatically will be enrolled in the Insurance Premium Pre-tax Payment Option portion of the Plan. This means that the amounts that are taken from your pay during that Plan Year to cover your share of the cost of your insurance coverage will not be subject to taxes.

WHAT BENEFITS ARE AVAILABLE UNDER THE MEDICAL EXPENSE REIMBURSEMENT ACCOUNT OPTION?

If you elect the Medical Expense Reimbursement Account Option, you will be reimbursed for the cost of medical care for yourself, your Spouse, and Dependents that is not covered under any other plan or policy. "Medical care" involves the diagnosis, cure, treatment or prevention of disease. Expenses for medical care include expenses for routine and extraordinary medical and dental examinations, vision exams and eye-wear, surgery, psychiatric care, hospitalization, insulin, drugs and medicines purchased with a prescription, therapeutic, orthopedic and prosthetic aids and devices, and transportation primarily for essential medical care.

The largest amount of benefits that you may elect under this Medical Expense Reimbursement Account Option is the highest dollar amount that the law allows at the time of your benefits election. This amount was $2,600 as of January 1, 2017, but will increase over time based on IRS-determined annual cost-of-living increases.

The smallest amount of benefits that you may elect is $120.

WHAT BENEFITS ARE AVAILABLE UNDER THE DEPENDENT CARE ASSISTANCE ACCOUNT OPTION?

If you select the Dependent Care Assistance Account Option, you will be reimbursed for your qualified dependent care expenses. Only expenses that meet all the following conditions qualify for reimbursement:

1. The expenses were incurred for services rendered after the date you became a Participant.

2. Each individual for whom you incur the expense:

   (a) Is either (i) a Dependent under age 13 whom you are entitled to claim as a Dependent on your federal income tax return or (ii) a Spouse or other Dependent for tax purposes who is physically or mentally incapable of caring for himself or herself, and

   (b) Lived with you for most of the calendar year.

3. The expenses are incurred for the care of a Dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.

4. If the expenses are 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.

5. The expenses are not for services provided by a child of yours who is under age 19 at the end of the year in which the expenses are incurred.

6. The expenses are not for services provided by an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

Eligible expenses include the cost of babysitters, daycare centers, nursery schools, after-school programs, eldercare and day camps. The cost of overnight camp is not an eligible expense.

WHAT EFFECT WILL PARTICIPATION IN THE DEPENDENT CARE ASSISTANCE ACCOUNT OPTION HAVE ON MY RIGHT TO THE DEPENDENT CARE CREDIT ON MY TAX RETURN?

The amount of your expenses that are eligible for the federal dependent care credit must be reduced, dollar for dollar, by the amount of expenses that you pay through the Dependent Care Assistance Account Option under this Plan. Before choosing that benefit option, you should determine if you would save more money by choosing instead to use the full, unreduced tax credit amount.

ARE THERE ANY LIMITS ON THE AMOUNT THAT MAY BE EXCLUDED FROM MY PAY FOR DEPENDENT CARE ASSISTANCE?

Yes. In general, the amount of expenses that you may pay through the Dependent Care Assistance Option is limited to $5,000 per *calendar* year ($2,500 if you are married but you and your Spouse file separate tax returns). However, the amount of expenses can never exceed your earnings for the year or the earnings of your Spouse, whichever is lower. Special rules apply in determining the earnings of a Spouse who is a student or incapable of caring for himself or herself.

WHO IS CONSIDERED A SPOUSE? A DEPENDENT?

Only insurance coverage for a Participant, a Participant's Spouse or a Participant's Dependent may be paid with funds that are not subject to tax, and only the medical expenses of a Participant, a Participant's Spouse or a Participant's Dependent may be reimbursed with funds that are not subject to tax.

Spouses

A person will be considered the Spouse of a Participant if the Spouse and Participant are married for purposes of federal tax law. Under federal tax law, a couple will be treated as married if they were married in a state where their marriage was legal under the law of that state at the time it occurred, irrespective of whether they continue to reside in that state.

Relatives as Dependents

A Participant's relative will be considered to be his or her Dependent if the Participant provided over half of the relative's financial support for the calendar year. If the relative is a child, grandchild, brother, sister, niece or nephew of the Participant who is under age 19 (age 24 in the case of a full-time student), it is not necessary for the Participant to have provided over half of the relative's support if the relative lived with the Participant for more than half of the calendar year and the relative did not provide more than one-half of his or her own support.

A special rule applies to the reimbursement under the Medical Expense Reimbursement Account Option of the health expenses of children of divorced parents. The child of divorced parents or legally separated parents is considered to be a Dependent of both parents if both parents together provide more than 50% of the child's support and have custody of the child for more than half the year.

For purposes of insurance coverage that may be elected under the Insurance Premium Pre-tax Payment

Option and the benefits that may be elected under the Medical Expense Reimbursement Account Option, "Dependent" also includes any child of a Participant whose 27th birthday will not have occurred by the last day of the current calendar year, irrespective of whether the child satisfies any of the financial support or residency requirements referred to above in this section of the Summary.

Non-Relatives as Dependents

To qualify as a Dependent, a person who is not related to a Participant must:

1. receive over 50% of his or her financial support from the Participant for the calendar year;

2. have the same principal residence as the Participant for the entire calendar year; and

3. be a member of the Participant's household (which is not possible if their living together violates the law of the state where they live).

FLEXIBLE SPENDING ACCOUNT CLAIMS

HOW DO I RECEIVE FLEXIBLE SPENDING ACCOUNT BENEFITS?

Submit Your Claims to the Claims Administrator

If you have elected benefits under the Medical Expense Reimbursement Account Option or the Dependent Care Assistance Account Option, you may obtain reimbursement for your eligible expenses by submitting claim forms and supporting documentation from the provider of the services you received (e.g., a receipted bill, an unpaid bill, or a signed affidavit) stating the nature, date and amount of the expense. A claim for dependent care benefits must include the name, address and taxpayer identification number of the dependent care service provided. In the case of a babysitter, the taxpayer identification number is the babysitter's Social Security number. It is your responsibility to maintain adequate records to verify these expenses. The Claims Administrator will determine the extent to which the expenses are covered and will pay any benefits due you under the Plan.

To insure timely reimbursement, please submit your claims directly to the Claims Administrator.

Electronic Payment Method-for Medical Expense Reimbursement Account Option Only

If you have elected benefits under the Medical Expense Reimbursement Account Option, the Administrator will issue a debit card for you to use. Then, as you have eligible medical expenses, you can present your debit card to the provider of the goods or services (e.g., a doctor's office or a pharmacy). If the provider accepts the card, the provider will swipe the card in a manner similar to the way a credit card or bank debit card is swiped to pay for goods or services. Using your card in this manner will reduce your available account balance under the Plan by the amount of your purchase and will generate information regarding the transaction that automatically will be forwarded to the Plan's Claims Administrator.

These rules apply to your use of the debit card:

1. When you use the card to obtain benefits, you will be certifying to the Plan that you are using it only for payment of eligible expenses.

2. You are not excused from the legal requirement that every benefit payment by the Plan must be supported by information that shows who provided you with the eligible product or service, the date you received the product or service and the amount you paid for the product or service. If the information that the Claims Administrator receives electronically about an expense when you swipe the card to pay for that expense is not sufficient, then you will be required to provide the missing information.

3. You will not be required to provide any follow-up information for certain expenses that you have paid for using the card. These are: (a) expenses that match exactly a co-payment amount under your health insurance; (b) repeating expenses that have already been approved by the Plan such as prescription drug refills; and (c) expenses where the information that the Claims Administrator receives electronically when you swipe the card is detailed enough to adequately justify the payment without any further information from you.

4. If you are required to provide additional support for an expense and fail to do so or if the Claims Administrator determines that an expense was ineligible for payment, you will be required to immediately repay the Plan. If you do not repay the Plan, your Employer will withhold the amount involved from your paycheck and, if necessary, the Plan will reduce your right to the payment of future claims. Also, you will lose the right to use the card.

5. You will lose the right to use the card immediately if you lose eligibility for the Plan.

WHAT IS THE MAXIMUM AMOUNT AVAILABLE TO PAY MY SUBMITTED CLAIM?

Medical Expense Reimbursement Claims

If, for any Plan Year, you make an election under the Medical Expense Reimbursement Account Option, the amount that you elect will be immediately credited to a Medical Expense Reimbursement Account in your name. Starting on the first day of that Plan Year, you will be entitled to be reimbursed for claims up to the entire elected amount (reduced by the amount of reimbursement that you've already received from your Account during that Plan Year) at any time during the Plan Year, even if the total salary reduction contributions that you have made to your Medical Expense Reimbursement Account are less that the total amount of claims that you have submitted.

Dependent Care Claims

The largest amount available to pay a claim that you submit under the Dependent Care Assistance Account option will be the amount credited to your Dependent Care Assistance Account at the time your claim is received.

Claims Submission Grace Period for *Medical Expense Reimbursement Account Option*

If you have a Medical Expense Reimbursement Account on the last day of a Plan Year and still have money credited to the Account after all of your claims for expenses during the Plan Year have been paid, the left over money may be used to reimburse you for any eligible medical expenses that you have on or before March 15th of the following Plan Year.

WHAT IS THE DEADLINE FOR SUBMITTING CLAIMS?

The deadline for submitting Flexible Spending Account claims (*including claims for reimbursement of medical expenses that you have during the applicable Grace Period*) normally will be April 15th of the following Plan Year. See, however, the special rule that applies if you lose Plan eligibility after the Plan Year has begun.

WHAT HAPPENS IF MY CLAIM FOR BENEFITS IS DENIED?

When a Claim is Denied

You will be notified in writing by the Claims Administrator if a claim that you submitted has been denied. As a general rule, you will receive notification of a claim denial within 30 days of the date you submitted your claim. However, the 30-day period may be extended for an additional 15 days due to circumstances beyond the Claims Administrator's control. This would be the case if, for example, you did not include enough information about a particular claim for the Claims Administrator to either allow or deny the claim.

The Claims Administrator will provide you with written notice if it becomes necessary to extend the 30-day period with regard to any claim that you file. The written notice will tell you the reason for the extension and when the Claims Administrator expects to make its decision. If the reason for the extension is that your claim was incomplete, you will also be notified of what additional information the Claims Administrator needs to allow or deny your claim, and you will be given 45 days after you receive the notice to provide the information during which time the claims submission deadline will be suspended.

Any notification that you receive from the Claims Administrator denying a claim that you have submitted will include:

1. The reason or reasons that your claim was denied;

2. The specific Plan provision on which the denial was based;

3. A description of any additional material or information that you would need to have your claim approved and an explanation of why that additional material or information is needed; and

4. Information on the steps that you must take to appeal the Claims Administrator's decision, including your right to submit written comments and have them considered, your right to review, upon request and at no charge, relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appealing a Claim Denial

If the Claims Administrator denies your claim or any part of your claim, you or an authorized representative of yours may apply to the Claims Administrator's Operations Manager for the Plan to review the denial. Your appeal must be made in writing within 180 days after you received notification from the Claims Administrator that your claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to sue in court. Your written appeal should state the reasons that you feel your claim should

not have been denied. It should include any additional facts or documents that you believe to support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review, upon request and for no charge, documents and other information relevant to your appeal.

Decision on Review

The Claims Administrator's Operations Manager will review and decide your appeal in a reasonable time not later than 60 days after he or she receives your request for review. The Claims Administrator's Operations Manager may, in his or her discretion, hold a hearing of the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. You will be informed of the identity of any medical expert consulted in connection with your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review that will include:

1. The specific reasons for the decision on review;

2. The specific Plan provision or provisions on which the decision is based;

3. A statement of your right to review, upon request and at no charge, relevant documents and other information;

4. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request; and

5. A statement of your right to bring suit under ERISA Section 502(a) (where applicable).

WHAT HAPPENS TO MONEY LEFT IN MY FLEXIBLE SPENDING ACCOUNT?

Any amount credited to a Flexible Spending Account at the end of the permissible reimbursement period for a Plan Year will be forfeited and used to offset the Plan's administrative expenses and future costs. Because your salary reduction contributions not used to reimburse you for expenses incurred in the Plan Year will be forfeited, it is important that you carefully determine the proper amount of your compensation to allocate to each account.

WHAT IS A QUALIFIED RESERVIST DISTRIBUTION?

The Plan includes a special rule that allows reservists called up to military duty to avoid the forfeiture of certain left over Flexible Spending Account balances.

To be eligible for this special rule:

1. you must be a member of the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, the Coast Guard Reserve or the Reserve Corps of the Public Health Service;

2. while working for the Employer, you must be ordered or called to active military duty either for a fixed period of 180 or more days or for an indefinite period;

3. you must have a Medical Expense Reimbursement Account at the time you are called to duty; and

4. the total amount that you've contributed to that Medical Expense Reimbursement Account is more than the total benefits that you've received from the Account. The difference is the amount that is available to be distributed to you under this special rule.

You must request a qualified reservist distribution on or after the date of your order or call to active duty and before the last day of the claims "grace period" for the Plan Year during which the order or call to active duty occurred. Submit your request to the Employer's Employee Benefits Division together with a copy of your order or call to active duty.

MID-YEAR CHANGES

WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE?

If you take a leave of absence from your employment with your Employer, your election for benefits under the Plan will remain in effect if your compensation from your Employer will continue to be paid during that leave. If, on the other hand, your leave is unpaid, you will have the opportunity, before the leave starts, to revoke your election and, if desired, make a new election in accordance with the rules discussed below at the Section entitled, "May I Change My Benefit Election?"

If you take a leave of absence to which the Family Medical Leave Act of 1993 ("FMLA") applies, during the period of such leave you will have the option of continuing your coverage under your Employer's medical insurance plan and Medical Expense Reimbursement Account Option on the same terms and conditions as though you were still an active Employee (i.e., your Employer will continue to pay its share of the premium to the extent you elect to continue your coverage). You may do so by either paying your share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave), or by prepaying all or a portion of your share of the premium for the anticipated duration of the leave on a pre-tax salary reduction out of your pre-leave compensation by making a special election to that effect prior to the date such compensation normally would be made available to you (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreeable to the Administrator. Upon return from FMLA leave, you will be permitted to reenter the Plan on the same basis on which you were participating prior to taking leave.

MAY I CHANGE MY BENEFIT ELECTION?

While you may change your election before the beginning of a new Plan Year, as a rule, you may not change an election of benefits during the Plan Year. However, if you experience any of the following events, you may revoke your election after the Plan Year has commenced and make a new election for the balance of the Plan Year:

1. *Change in Status.*

   (a) A change in your legal status (e.g., marriage, death of your Spouse, divorce, legal

separation or annulment).

(b) A change in the number of your dependents due to events such as birth, adoption, placement for adoption or death.

(c) A termination or commencement of employment by your Spouse or Dependent.

(d) A reduction or increase in the hours that you, your Spouse or your dependents work, including a switch between part-time and full-time status and commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan or of any other employee benefit plan that you, your Spouse or your Dependent depend on the employment status of the individual and a change in that individual's employment status causes that individual either to become eligible or cease to be eligible under the plan, that change constitutes a Change in Status.

(e) An event that causes your Dependent to satisfy or cease to satisfy the eligibility requirements for a certain benefit (e.g., due to attainment of a certain age).

(f) A change in the place where you, your Spouse or your Dependent work or reside.

If you wish to change your election based on a Change in Status, the change must be consistent with that Change in Status, under the following rules:

Your change of election will be considered to be consistent with a Change in Status only if the Change in Status results in you, your Spouse or your Dependent gaining or losing eligibility for a benefit (or particular benefit option) under a plan of your Employer or under a plan of your Spouse's or Dependent's employer, and the change of election corresponds with that gain or loss of coverage, or, if the Change in Status affects dependent care expenses.

If the Change of Status is your divorce, annulment or legal separation, the death of your Spouse or Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, you may not make an election under the Plan to cancel accident or health coverage for any individual other than your Spouse involved in the divorce, annulment or legal separation, your deceased Spouse or Dependent or the Dependent that ceased to satisfy the eligibility requirements for coverage, as the case may be, since such an election would not correspond with that Change in Status. In addition, if you or your Spouse or Dependent gains eligibility for coverage under this Plan, another cafeteria plan or any other plan providing benefits that are nontaxable benefits under Code Section 125 as a result of a change in marital status or a change in employment status described above, an election under this Plan to cease or decrease coverage for that individual corresponds with that Change in Status only if coverage for that individual becomes available or is increased under the plan from which eligibility for coverage has been gained.

2. *Special Enrollment Rights*. If you become eligible to exercise any HIPAA special enrollment rights regarding group health plan coverage, you may change your election for the balance of the Plan Year and file a new election that corresponds with your exercise of those rights.

3. *Certain Judgments and Orders*. If a judgment, decree or order from a divorce, legal separation, annulment or custody change requires that your child, or a foster child who is your Dependent, be

covered under your Employer's health plan or the health plan of your former Spouse's employer, you may change your election to provide coverage for the child under your Employer's plan if the order requires it or change your election to cancel coverage for the child under your Employer's plan if the order requires your Spouse or former Spouse, or any other individual, to provide the coverage.

4. *Entitlement to Medicare or Medicaid*. If you, your Spouse, or your Dependent becomes entitled to coverage under Medicare or Medicaid, you may cancel that person's coverage under your Employer's health plan. In addition, if you, your Spouse, or your Dependent loses eligibility for Medicare or Medicaid coverage, you may make an election to commence or to increase that person's coverage under your Employer's health plan.

5. *Change in Cost or Coverage.* A change of cost or change of coverage with respect to non-cash benefits that may be elected under this Plan may be the basis for a change of election based on the following rules:

(a) These rules do not apply to benefits under the Medical Expense Reimbursement Account Option.

(b) If the cost of any of your benefits increases or decreases during a period of coverage and, as a result, you are required to increase or decrease your payments for those benefits, your salary reductions contributions under this Plan will be adjusted accordingly, unless you make a change to your election under (c) below.

(c) If the cost of any of your benefits significantly increases during a period of coverage, you may elect either to increase your contributions to pay for the increased cost or to revoke your election and to receive instead coverage under another benefit option of the plan providing the benefits. If the cost of any benefit or benefit option significantly decreases during a period of coverage for which you have not elected that benefit or benefit option, you may make a new election of that type of benefit or benefit option. If you have an election in effect at that time for that type of benefit (e.g., medical insurance coverage) but under a benefit option other than the one the cost of which has significantly decreased, you may revoke that existing election and elect the benefit option that has significantly decreased in cost.

(d) You may only change your election due to an increase in the cost of dependent care assistance benefits if your Dependent care provider is not your relative.

(e) If your coverage under any benefit plan is significantly reduced or stops, you may make a new election going forward of any other coverage option available under that plan. Coverage under an accident or health plan is considered to be reduced only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage to Participants generally.

(f) You may make an election change that is on account of and corresponds with a change made under a benefit plan of your Spouse or Dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules or if that plan permits participants to make an election for a period of coverage under the cafeteria plan or other plan that is different than that under this Plan.

6. *Changes in Coverage Attributable to Spouse's Employment*. You may revoke a prior election and make a new election where there has been a significant change in benefit plan coverage for you, your Spouse, or your Dependent related to your employment or the employment of your Spouse or Dependent, if that change of election is determined by the Administrator to be consistent with the change in benefit plan coverage.

7. *Revoking Insurance Premium Pre-tax Payment Option Election to Pay for Employer Group Major Medical Coverage Premiums.*

(a) If you were reasonably expected to average thirty hours of service or more per week and experience an employment status change such that you are reasonably expected to average less than thirty hours of service per week, you may prospectively revoke your election related to coverage under the group major medical plan of the Employer, provided that you certify that you and any related individuals whose coverage under the group major medical plan of the Employer is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage (as that term is used for purposes of the Affordable Care Act) that is effective no later than the first day of the second month following the month that includes the date as of which coverage under the group major medical plan of the Employer is revoked.

(b) If you are eligible to enroll for coverage in a government-sponsored health insurance Exchange during an Exchange special or annual open enrollment period, you may prospectively revoke your election related to coverage under the group major medical plan of the Employer, provided that you certify that you and any related individuals whose coverage under the group major medical plan of the Employer is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of coverage under the group major medical plan of the Employer.

The Administrator must be notified within 30 days of any such event or circumstance to make an election change, except if you become eligible for HIPAA special enrollment rights that may be exercised within 60 days after you become eligible, in which case the Plan Administrator must be notified of your election change within 60 days after you become eligible.

Even if you are permitted to change your election under these rules, you may not change your election for Flexible Spending Account benefits below the amount of such benefits already reimbursed for the Plan Year.

If you fail to submit a new election form for any new Plan Year, your election under the Insurance Premium Payment Option will remain the same as for the prior Plan Year, but you will be considered not to have elected any Flexible Spending Account benefits for the new Plan Year.

MAY MY ELECTION BE CHANGED WITHOUT MY CONSENT?

If the Plan Administrator determines before or during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirements imposed by the Internal Revenue Code, the Administrator may take action to assure compliance with any requirements or limitations. This action may include a modification of any elections with or without the consent of the Employee.

WHAT HAPPENS IF I STOP WORKING FOR THE EMPLOYER OR I BECOME INELIGIBLE FOR THE PLAN FOR ANOTHER REASON?

You will lose eligibility for the Plan if you stop working for your Employer. When you lose eligibility for the Plan:

1. Your contributions for benefits will cease.

2. If you still had money credited to a Medical Expense Reimbursement Account or Dependent Care Assistance Account on the date that you lost eligibility, the remaining balance may be used to reimburse you for eligible expenses that you had in the current Plan Year before you lost eligibility.

3. Your remaining claims must be submitted within 90 days after you lost eligibility.

MISCELLANEOUS

CAN MY EMPLOYER TERMINATE OR CHANGE THE PLAN?

Although the Employer presently anticipates the Plan continuing indefinitely, it has the right to amend or terminate the Plan at any time.

WHO PAYS THE COSTS OF THE PLAN?

The Employer pays the cost of Plan administration.

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.