Your Thryv Health & Welfare Benefits - Eligibility & Coverage

Active Employees

July 2019

Contents

Introduction

Overview

The **Company** offers eligible employees participation in the following benefit coverages:

- Medical and prescription drug, including Health Savings Account (HSA);
- Dental;
- Vision;
- Life insurance;
- Accidental Death and Dismemberment (AD&D) insurance;
- Disability Income;
- Employee Assistance Program (EAP);
- Health Care Flexible Spending Account;
- Dependent Care Flexible Spending Account; and
- Wellness Program.

Benefit coverages (except HSA coverage) are provided through The Thryv Plan for Employee Group Insurance (the "Plan"). HSA coverage is provided through the Thryv Cafeteria Plan ("Cafeteria Plan"). As long as you meet the Plan's eligibility requirements, you and your eligible dependents may participate in the benefit coverages options under the Plan and Cafeteria Plan. This is one part of a multi-part document that, when viewed together with the other parts, make up the Summary Plan Description (SPD) for the Plan.

In this part of the SPD you will find information about who is eligible for benefit coverage, when and how to enroll or change coverages, and when coverage ends. Other parts of the SPD provide details about the benefit coverages available under the Plan. Key terms are bolded throughout and defined in the Glossary part of the SPD. For general administration and contact information, claims and appeal procedures, continuation coverage under **COBRA**, and your rights under **ERISA**, see the General Administration part of the SPD.

Amendment and Termination

The information provided in the SPD describes the Plan generally as in effect on January 1, 2019. The **Company** and the **Plan Administrator** reserve the right to amend, modify, suspend, revoke, or terminate the Plan, in whole or in part at any time, including, but not limited to, **Company** and/or participant contributions, for any reason, at their discretion, and with or without advance notice, except to the extent limited by an applicable collective bargaining agreement. If a Plan or benefit coverage is terminated in whole or part, you will not have any further rights other than payment of expenses you had **incurred** before the Plan or benefit coverage was terminated. The SPD may be supplemented from time to time to reflect material amendments or modifications to the Plan.

Other Important Information

In summarizing the terms of the Plan in the SPD, every attempt has been made to make the SPD as detailed and accurate as possible. However, Plan documents and insurance/administrator policies/contracts/requirement documents (collectively "Plan Materials") govern the Plan. To the extent that there is a conflict between the SPD and the Plan Materials, the Plan Materials shall govern.

Your participation in the Plan and its benefit coverages does not ensure you of continued (or renewed) employment with the **Company**.

Eligibility

Employees

After you satisfy any applicable waiting periods, you are eligible to participate in the benefit coverages offered under the Plan if you are **actively at work** and paid directly by the **Company** as either an active regular:

- **Full-time employee**; or
- **Part-time employee** regularly working or scheduled to work 20 or more hours per week.

You are NOT eligible to participate in the benefit coverages offered under the Plan if you are:

- A **part-time employee** working or scheduled to work less than 20 hours per week;
- Under an individual employment contract (unless the contract or agreement specifies that you are eligible to participate in the Plan or specific benefit coverages);
- No longer employed by the **Company** (except as otherwise provided for under **COBRA** or an applicable severance plan);
- A leased employee;
- Under a collective bargaining agreement that does not provide for your participation in the benefits described here;
- Not paid directly by the **Company** (excluding long term disability income benefits); or
- An independent contractor, temporary, occasional, or seasonal employee (regardless of what a court or government agency may determine about your employment status).

You may be excluded from the Plan due to one of the circumstances previously listed. Your classification in the **Company's** payroll system is controlling for all eligibility purposes. If the **Company** does not classify you as an eligible employee, you are not eligible for coverage under the Plan. This is regardless of any subsequent reclassification of your status as an eligible employee by any court, governmental agency, or other enforcement authority, such as the Internal Revenue Service (IRS).

If You Become Ineligible

You may remain an employee of the **Company** but become ineligible for the Plan because you no longer meet the eligibility requirements. If this is the case, you become eligible to participate in the benefit coverages offered under the Plan on the day you once again become an eligible employee subject to any applicable coverage waiting periods that may still apply based on your most recent date of hire.

If You Are Rehired

Depending on the time that elapses between your termination date and the date on which you are rehired, you may or may not be eligible to make new coverage elections as follows:

- If the number of calendar days that elapse between your termination date and the date on which you are rehired is 30 days or less, the coverages in effect immediately before your termination will be reinstated to the extent still offered, and no coverage changes will be permitted.

- If the number of calendar days that elapse between your termination date and the date on which you are rehired is 31 days or more, you will be offered the same coverage options as a new hire and be subject to all applicable coverage waiting periods.

Dependents

Your dependents may be eligible for certain coverages under the Plan. All covered dependents must provide a valid Social Security number or, if the dependent is unable to obtain a valid Social Security number, he or she must provide an Individual Taxpayer Identification Number (ITIN). Failure to provide one of these numbers in a timely manner will result in ineligibility for coverage under the Plan. Your eligible dependents include your:

- Legal **spouse**.

- Child who has not yet attained age 26, including any of the following:
  - Your natural children;
  - Your stepchildren;
  - Your legally adopted children or children placed with you for adoption;
  - Children for whom you have legal guardianship; and
  - Any other children for whom you are required to provide coverage as a result of a court order or **Qualified Medical Child Support Order (QMCSO)**

- Child who is age 26 or older and is physically or mentally disabled prior to age 26 (see below).

If you enroll your eligible dependent(s), you must provide, and may be asked at any time in the future to provide, **proof** of your dependent's status (e.g., a marriage certificate, birth certificate, visa, or guardianship/adoption papers). Failure to provide **proof** that supports your dependent's status within the time provided may delay your eligible dependent's **coverage effective date(s)** or may result in your or your dependent's coverage being terminated. You are financially liable for claims **incurred** by any ineligible dependent and you may be required to reimburse the **Company** for any associated coverage costs.

*You must notify the Thryv Benefits Center within 60 days of the day you become legally divorced or separated. You must notify the Thryv Benefits Center within 30 days of the day your **spouse**, child, or any other covered dependent no longer meets the benefit coverage's definition of an eligible dependent.*

Eligibility Requirements for Disabled Children

If your dependent child is disabled and enrolled in a benefit coverage under the Plan on the day just prior to his or her 26th birthday, he or she may continue to be eligible for the benefit coverage as a dependent for ages 26 and older if he or she meets the criteria below. In addition, if you have a disabled child when you join the **Company** as a new hire or as the result of an acquisition, your child will be eligible for coverage as a dependent if he or she meets the criteria below.

Your child is considered disabled if all of the following criteria are met:

- Social Security determines your child is disabled (meaning your child is incapable of self-sustaining employment by reason of mental retardation or physical handicap).
- Your child:
  - Is not married;
  - Lives with you;

- Was disabled prior to the age of 26; and
- Depends on you for full financial support (i.e., the disability prevents your child from working, and therefore, he or she can't support himself or herself).

If you have a disabled dependent child, contact the Thryv Benefits Center before your child's 26th birthday or as soon as possible after you join the **Company**. Doing so will enable eligibility to be verified and continued. If your disabled child meets the eligibility requirements as stated above, your child may continue to be considered an eligible dependent for benefit coverages.

If you enroll your disabled child, you must provide, and may be asked at any time in the future to provide, satisfactory **proof** of your child's disabling condition. Failure to provide this **proof** within the time provided may delay your eligible dependent's **coverage effective date(s)** or may result in your or your dependent's coverage being terminated. You are financially liable for claims **incurred** by any ineligible dependent and you may be required to reimburse the **Company** for any associated coverage costs.

Your disabled child's eligibility ends on the day he or she no longer meets the definition of **disabled**, he or she fails to submit to a required exam, you fail to submit any required **proof** of your dependent child's disability, or you are no longer eligible for the Plan. Particular benefit coverages may end earlier, as described in the summary of those benefits.

Dual Eligibility

You, your **spouse**, and children may only be enrolled in one **Company** medical, dental, vision, supplemental life, and supplemental AD&D plan.

Eligibility Upon Retirement

If you retire, unless coverage is continued under this Plan through **COBRA** or an applicable severance plan, you are not eligible to participate in the benefit coverages summarized in this SPD. Please refer to the Retiree Benefits SPD for details about potential retiree coverage.

How to Enroll

Overview

When you are first eligible as an employee, and each year during the Annual Enrollment period, you have the opportunity to select the coverages you want for yourself and your eligible dependents under the Plan. Some benefit coverages can be enrolled in, or unenrolled from, at other times – see the "When You Can Change Coverages" section for additional details.

Newly Benefit Eligible or New Hire Enrollment

As a newly benefit eligible employee or new hire, information about enrolling in benefit coverages is sent to you via email. You enroll through an online enrollment system via the Thryv Benefits Center website. Enrollment and benefit materials about the benefit coverages described in this SPD are contained online. Your initial benefit enrollment is time sensitive – the deadline is included in your new hire enrollment guide found online on the Thryv Benefits Center website.

To assist in your enrollment, you should have the names, birth dates, and Social Security numbers of your eligible dependents (if you are enrolling them for coverages under the Plan) and your life insurance beneficiaries. Upon enrollment, you will be asked to provide documentation verifying each dependent's relationship to you so have this information readily available as well.

Completing the enrollment process ensures that you and your eligible dependents are enrolled under the Plan. It also authorizes the **Company** to deduct from your pay the required contributions for certain coverages - see the "Cost of Coverages" section for cost-related information.

Here are a few items to note regarding your enrollment:

- If you do not enroll when you are first eligible, you will receive "default coverages" under the Plan and authorize the **Company** to deduct applicable employee contributions.
- The coverages you receive as default coverage or elect when you are first eligible continue through the remainder of the **plan year** (through December 31), unless you:
    - Experience a Qualifying Life Event (QLE) and decide to change coverages as allowed.
    - Satisfy the requirements for enrolling due to another applicable change event, such as a:
        - HIPAA special enrollment;
        - **QMCSO**; or
        - Significant cost or coverage change.
    - Participate in a plan that does not require a QLE or one of the other items above.
    - Cease to be eligible for the Plan or fail to make the required contributions.

If You Do Not Enroll When First Eligible (Default Coverages)

When first eligible, if you do not actively enroll for coverages within the deadline posted on your enrollment materials, you receive default coverages under the Plan. *Important*: these benefit coverages have waiting periods before coverage begins. Default coverages are shown in the chart below.

Coverage	Defaults To
Medical and Prescription Drugs	High Deductible Health Plan without HSA (Tobacco user, employee only coverage)
Dental	No Coverage
Vision	No Coverage
Savings/Spending Accounts	
▪ Health Care FSA	No Participation
▪ Dependent Care FSA	No Participation
▪ Health Savings Account (HSA)	No Participation[1]
Wellness Program	You may participate
Basic Life	Coverage
Supplemental Life—Employee	No Coverage[2]
Supplemental Life—Spouse	No Coverage[2]
Supplemental Life—Child	No Coverage[2]
Basic AD&D	Coverage
Supplemental AD&D	No Coverage
Business Travel Accident	Coverage
Disability	
▪ Short Term Disability (STD)	Coverage
▪ Long Term Disability (LTD)	Coverage
Employee Assistance Program (EAP)	Coverage

[1] To participate in the HSA, your consent is automatically given when you elect the HDHP with HSA medical plan option. **Company** contributions will not be provided to your HSA unless your coverage in the HDHP with HSA is in effect and the HSA account is in an active status.

[2] Supplemental life—employee, and supplemental life—spouse, coverage may require satisfactory **Evidence of Insurability (EOI)** when first eligible. In addition, **EOI** is required should you wish to enroll yourself and/or your **spouse** for such coverage or increase your and/or your **spouse's** coverage tier, at a later date.

When Coverage Begins

Overview

As long as you meet the Plan's eligibility, enrollment, and contribution requirements, most coverages first begin on your 31st day of employment from your most recent date of hire, provided you are **actively at work** on that day. However:

- Short-Term Disability (STD) and Long-Term Disability (LTD) coverages begin at the start of the 27th week after your date of hire provided you are **actively at work** on that day.
- HSA participation automatically begins the same day your participation in the High Deductible Health Plan begins provided you have enrolled in the High Deductible Health Plan with HSA.
- Any coverage subject to **EOI** is not effective until the **claims administrator** approves the **EOI** for you or your family member as applicable.

Here are a few additional items to note regarding when coverages begin:

- If you transfer into the **Company** as a result of an acquisition or merger, coverages begin in accordance with the terms of the acquisition or merger agreement.
- If you are a new hire and have not yet reported for work when coverages are scheduled to begin, coverages begin on the first date you are **actively at work** after your effective date of coverage.
- If you meet the Plan's eligibility requirements but do not enroll when first eligible, default coverages will apply.
- Coverages for your eligible dependents begin on the same day as your coverages begin, or on the day your dependent first becomes eligible (whichever is later), but only if you have provided satisfactory documentation as to your dependents' status as your dependent, and they are properly enrolled in a timely manner. For details regarding adding eligible dependents under the benefit coverages, see the "When You Can Change Coverages" section. If you are an existing employee, see the "When You Can Change Coverages" section for additional details.

Cost of Coverage

Paying for Coverage As An Active Employee

The **Company** pays the full cost of some coverages, you pay the full cost of others, and you and the **Company** share in the cost of the other coverages. Your cost consists of payroll contributions and when services are received, for example, when you have a medical procedure. When paying your share of the cost through payroll, you do so on either a before-or after-tax basis, as shown in the chart below.

Coverage	Who Pays for this Coverage	Your Payroll Contributions
Health Care		
Medical (includes prescription drug coverage)	Shared	Before Tax
Dental	Shared	Before Tax
Vision	You	Before Tax
Savings/Spending Accounts		
Health Care FSA	You	Before Tax
Dependent Care FSA	You	Before Tax
Health Savings Account	**Company**, Your contributions are optional	Before Tax
Life and AD&D		
Basic Life	**Company**	N/A
Supplemental Life—Employee	You	After Tax
Supplemental Life—Spouse	You	After Tax
Supplemental Life—Child	You	After Tax
Basic AD&D	**Company**	N/A
Supplemental AD&D	You	After Tax
Business Travel Accident	**Company**	N/A
Disability		
Short Term Disability (STD)	**Company**	N/A
Long Term Disability (LTD)	**Company**	N/A
Employee Assistance Program (EAP)	**Company**	N/A
Wellness Program	**Company**	N/A

Your contributions are deducted in equal amounts from your pay check each pay period (unless catch-up deductions are required). Deductions are withheld as soon as administratively possible after you enroll retroactive to your **coverage effective date**.

The **Company** determines coverage costs each year. Costs can change at any time under certain circumstances. Cost information is available on the Thryv Benefits Center website.

Using **before-tax-dollars** can reduce your taxable income for federal, Social Security, and (in most cases) state income taxes, but does not affect how your benefit levels for coverages are determined under other **Company** plans. *Please Note:* Using **before-tax dollars** can affect Social Security benefits you may eventually receive. This is because you do not pay Social Security (FICA) taxes on **before-tax dollars**. For most people, the Social Security benefit reduction is just a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any concerns, or if you need additional information, contact your local Social Security Administration office or tax advisor.

How Your Payroll Cost Is Determined

How much you pay for each coverage under the Plan is determined by the rates set by the **Company** for the self-insured options and the premium rates charged by the insurance company for fully-insured options. Contributions are not prorated under the Plan - if you are covered for one day of a pay period, your contributions are due and payable for the entire pay period.

When enrolled, the primary factors used to determine your cost are as follows:

- Medical:
  - The coverage option you elect;
  - Which eligible dependents you cover;
  - Your **spouse's** eligibility for medical coverage through his/her employer (if applicable); and
  - Your family's use of tobacco products
- Dental:
  - The coverage option you elect;
  - Which eligible dependents you cover;
- Vision:
  - Which eligible dependents you cover;
- Short Term Disability: New York and New Jersey State Benefits only:
  - An amount up to the maximum amount allowed by the applicable state
- Supplemental Life - Employee:
  - The coverage option you elect;
  - Your use of tobacco products;
  - Your eligible pay; and
  - Your age as of December 31 of the coverage year.
- Supplemental Life - Spouse:
  - The coverage option you elect; and
  - Your **spouse's** age as of December 31 of the coverage year.
- Supplemental Life - Child:
  - The coverage option you elect.

- Supplemental AD&D:
  - The coverage option you elect;
  - Your eligible pay; and
  - Whether you elect coverage for yourself only or for you and your eligible dependents.

Medical Coverage: Tobacco-User Surcharge

You may be subject to a tobacco-user surcharge when enrolled in a medical plan and a covered member of your family is a tobacco user. The tobacco-user surcharge applies if you or any of your enrolled family members have used tobacco in the twelve months prior to you enrolling in the Plan. Your family's tobacco status is first determined at your initial enrollment, and thereafter at annual enrollment. The default is that you are subject to the tobacco-user surcharge.

You can only update your family's tobacco-user status during an annual enrollment. However, you may be able to have this surcharge discontinued, for example, by successfully completing the tobacco cessation program through Virgin Pulse – contact the Thryv Benefits Center or Virgin Pulse for details.

The tobacco-user surcharge amount is described in your enrollment materials and is included in your medical contribution on your payroll check each pay period. This surcharge increases your cost for medical coverage.

Medical Coverage: Spousal Surcharge

You may be subject to a spousal surcharge if your **spouse** is enrolled in medical coverage as your dependent. This surcharge applies while your **spouse** is enrolled in the **Company** medical plan as your dependent and medical coverage is offered to your **spouse** through his/her employer (regardless of cost or your **spouse's** enrollment through his/her employer). The default is that you are subject to the spousal surcharge if you enroll your **spouse** as your dependent for medical coverage, but you have the opportunity to confirm otherwise when enrolling.

You can only update your status during an annual enrollment or if you have a Qualifying Life Event (QLE) – contact the Thryv Benefits Center or log onto the Thryv Benefits Center website for details.

The spousal surcharge amount is described in your enrollment materials and appears as a separate item on your payroll check each pay period. This surcharge increases your cost for medical coverage.

Paying for Coverage When Your Payroll Check Has Insufficient Funds

If your benefit coverages continue, for example while on short-term disability or an approved leave of absence, and your payroll check is insufficient to cover your required contributions, the Thryv Payroll Department will hold past due contributions in arrears, and will collect them as wages become available. In certain circumstances, you may receive an invoice for your contributions.

Paying for Your Coverage While on Long Term Disability

If you are receiving a long term disability income benefit under the Plan, the following provisions apply:

Coverage	While you are employed with the Company	When you are no longer employed by the Company
Health Care		
Medical (includes prescription drug coverage), Dental, Vision, HC Flexible Spending Account, EAP*	You can continue coverage in plans then available to active employees by paying the active employee premium contribution rates.	You can continue coverage through **COBRA** in plans then available to active employees. You pay the maximum amount allowed through **COBRA**.
Wellness Program	You can continue coverage in the program then available to active employees.	Program is not available.
Life and AD&D		
Basic Life	Coverage in effect on the date of your disability continues at the **Company's** expense.	You can convert your coverage to an individual policy or you can port your coverage.
Basic AD&D	Coverage in effect on the date of your disability continues at the **Company's** expense.	No coverage is available.
Supplemental Life (Employee, **Spouse**, and Child)*	You can continue the coverages in effect on the date of your disability by paying the active employee premium rates via direct bill.	You can convert your coverage to an individual policy or you can port your coverage.
Supplemental AD&D*	You can continue the coverage in effect on the date of your disability by paying the active employee premium rates via direct bill.	No coverage is available.
All other benefits under the Plan	No coverage is available if you are not **actively at work**.	No coverage is available.
* Thryv Benefits Center (or its vendor) invoices you for your coverage as a courtesy.		

When You Can Change Coverages

When Mid-Year Changes Are Allowed

Because your contributions are made with **before-tax-dollars** for health care coverages (medical, dental, vision), the Health Care FSA, the Dependent Care FSA, and the HSA, tax advantages are associated with these benefit coverages. As a result, the Internal Revenue Service (IRS) limits your ability to change most of these coverages during the **plan year**. The IRS and the Plan also has rules that govern the types of changes that you may make, which are highlighted in this section.

- You can make mid-year changes to your health care coverages, as well as your FSA contribution elections, due to either of the following:
  - A Qualifying Life Event (QLE) that occurs during the **plan year**; or
  - Another applicable change event that occurs during the **plan year.**
- You can initiate a contribution change to your Health Savings Account at any time if enrolled in the High Deductible Health Plan with HSA.
- You can initiate a change to your supplemental life (employee, **spouse**, or child) and/or supplemental AD&D if you have a QLE – check with the Thryv Benefits Center. **Evidence of Insurability (EOI)** requirements generally apply to increasing coverage under the supplemental life options. Any increase in coverage is subject to the **actively at work** provision.

Coverage/contribution changes must be requested within 30 days of the event (60 days for requested changes due to gain/loss of Medicaid or CHIP coverage) including the day the event actually occurs, and must be consistent with the QLE or other applicable change event and follows Plan rules.

Annual Enrollment

Each year during the Annual Enrollment period, you can change your benefit elections under the Plan for the following year using the online enrollment system. When you make a coverage and/or contribution change, the changes take effect the following January 1 and generally remain in effect through the following December 31.

Completing the enrollment process ensures that you and your eligible dependents are enrolled under the Plan, subject to **EOI** provisions for certain coverages and documentation of newly enrolled dependents. It also authorizes the **Company** to deduct from your pay the required contributions for certain coverages. To help you make informed benefit-related decisions, benefit enrollment information is made available by the start of the Annual Enrollment period.

If you do not make any changes during an Annual Enrollment period, your participation in most of the benefit coverage options will continue for the next year to the extent you remain eligible for the coverage option. However, your FSA contributions and your employee contribution to the HSA, if any, will be reset to zero dollars (even if you re-enroll in the HDHP with HSA coverage option). Other than the FSAs and HSA, coverages default to the same coverage category or level in effect, but at the coverage option's applicable price for the following year. *Please Note:* Your current coverage or default coverage option must be offered for the following **plan year** to carryover, otherwise your coverage will be mapped as described in enrollment materials. There may be times when the **Company** requires you to make active elections into the benefit plans for the upcoming year. This will be addressed in your Annual Enrollment materials.

Remember: The Health Care FSA and Dependent Care FSA do not carryover and require an annual election. In addition, if you want to participate in the HSA, you must enroll (or re-enroll) in the High Deductible Health Plan w/HSA medical option.

Qualifying Life Events (QLEs)

In general, your elections remain in effect for the entire **plan year**.

If, however, you experience a QLE that affects eligibility, you may be eligible to change your coverage elections. A change may be made as long as it is due to and consistent with the QLE (the change also must follow the benefit coverage's rules). Not all changes are considered "consistent" with a QLE under the applicable tax laws and regulations. Contact the Thryv Benefits Center to ensure your desired change in coverage will be consistent with your QLE. You must request such a change within the time frame stated in the "When Mid-year Changes Are Allowed" section (generally within either 30 or 60 days). A QLE is any of the following circumstances:

- You get married.
- You get divorced or have your marriage legally annulled.
- Your **spouse** dies.
- Your dependent child dies.
- You have a baby, adopt, or have a child placed with you for adoption.
- You or your dependent experiences a change in employment status that affects your coverage options and/or payroll cost, including any of the following (to the extent coverage is affected):
  - The start or end of employment;
  - A strike, lockout, or layoff;
  - The start of or return from an unpaid or significantly reduced paid leave of absence;
  - A change in work site; and
  - Any other change in employment status that affects your or your dependent's health care coverages or your participation in the FSAs.
- Your dependent child becomes eligible or ineligible for the coverage (e.g., he or she reaches the benefit coverage's eligibility age limit or other similar circumstance).
- Your **spouse's** or your dependent's home address changes (which affects health care coverages).
- You, your **spouse** or your dependent experiences any other event that is recognized under applicable law and regulations as a reason to change health care coverage or FSA contribution elections.

Supporting documentation (**proof**) which supports the QLE may be requested by the Thryv Benefits Center. Failure to provide such **proof** may delay or nullify your requested QLE.

If you want to make a change due to a QLE and learn when the new coverage/election change takes effect, see the "How to Make a Midyear Change" section, below.

Other Applicable Change Events

You can make certain changes to your health care coverages and/or FSA contribution elections due to any of the following:

- Special enrollment opportunity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- **QMCSO**;
- Significant cost or coverage change; and
- Gain or loss of **Medicaid, CHIP,** or **Medicare** coverage.

You must request the change within the time frame stated in the "When Mid-year Changes Are Allowed" section.

HIPAA Special Enrollment

A federal law known as "HIPAA" provides you with special enrollment in certain circumstances described below.

Birth, Marriage, Adoption, Placement for Adoption

If you decline participation and acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you qualify for a special enrollment opportunity under HIPAA. As a result, you can enroll yourself and/or your eligible dependents mid-year for health care coverages and/or make a change to your Health Care FSA contribution election.

Loss of Other Group Health Coverage

You also qualify for the special enrollment if you or your eligible dependents lose coverage under another group health plan or another health care FSA for any of the following reasons:

- You or your dependents exhaust **COBRA** coverage under another employer's group health plan (other than due to failure to pay contributions, or for cause). You must have been covered under **COBRA** for the maximum time period available to you.
- The employer's contributions toward the other group health plan coverage that is not **COBRA** coverage terminates (not applicable for the Health Care FSA).
- You or your dependents are no longer eligible for coverage under the other group health plan or other health care FSA (that is not **COBRA** coverage). "Loss of eligibility" includes a loss of coverage or participation due to any of the following:
  - Legal separation or divorce**;**
  - Your or your dependent's death;
  - A dependent who no longer satisfies a plan's definition of an eligible dependent;
  - Termination of employment or reduction in the number of hours of employment;

- A loss of HMO or DHMO coverage because you or your dependent no longer resides or works within the HMO/DHMO service area and no other coverage option is available; and
- A plan that no longer offers benefits to you or your dependent.

Loss of eligibility does not include the loss of coverage because you fail to pay required contributions on time or you lose coverage for cause (e.g., fraud or intentional misrepresentation).

Change in Eligibility for Medicaid or CHIP Coverage

If you or your dependent is eligible but not enrolled for coverage under the Plan's health coverages, you are eligible to enroll for coverage if you meet either of the following conditions:

- You or your dependent loses eligibility for **Medicaid** or Children's Health Insurance Program (CHIP) coverage; or
- You or your dependent becomes eligible for premium assistance with respect to coverage under the Plan due to coverage with **Medicaid** or CHIP.

If you want to change your health care coverages or your Health Care FSA contribution election due to a special enrollment event that qualifies under HIPAA and learn when the new coverage/contribution election takes effect, see "How to Make a Midyear Change", below. *You must request the change within the time frame stated in the "When Mid-year Changes Are Allowed" section.* HIPAA special enrollment rights do not allow you to make changes to benefits other than your health care coverages or your Health Care FSA unless the special enrollment right is also a QLE.

To request special enrollment or for more information, you should contact the Thryv Benefits Center at 1-866-847-1300, option 3, then option 1.

Qualified Medical Child Support Order (QMCSO)

The Plan also provides health care coverages and participation in the Health Care FSA for your child pursuant to the terms of a **QMCSO**. If you become subject to a **QMCSO,** this may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions that might otherwise exist for dependent coverages.

Federal law requires that a **QMCSO** must meet certain form and content requirements to be valid. The **Company** follows certain procedures to determine if a medical child support notice is "qualified." You will receive a copy of the **QMCSO** administrative procedures, free of charge, from the Thryv Benefits Center. If you become subject to an order, you and the affected child(ren) will automatically be notified, that the order is received, about further procedures, and will receive a copy of the **QMCSO**.

If the **Company** receives a valid **QMCSO**, you may change your medical, vision and/or dental coverage and/or your Health Care FSA contribution election under the Plan accordingly. The change you elect takes effect as of the date the Thryv Benefits Center processes the **QMCSO**. If you do not enroll the affected child, the **Company** may enroll him or her and withhold from your wages any contributions required for such coverages (unless payment is made by a state agency). If you enroll a child who's eligible for health care coverages pursuant to a **QMCSO**, you may not enroll that child's dependents for coverages under the Plan. A QMCSO does not allow you to make changes to benefits other than your health care coverages or your Health Care FSA.

At your request, the Thryv Benefits Center will furnish you with **QMCSO** procedures at no charge that describe the process that is followed when entering a **QMCSO**.

Significant Cost or Coverage Change

You also may be able to change your health care coverage elections and FSA contribution elections under the Plan mid-year under certain circumstances – check with the Thryv Benefits Center for events such as:

- The **Company** determines the current cost of health care coverages for you, your **spouse**, or your dependent significantly increases or significantly decreases. This applies for health care coverages and the Health Care FSA.

- The current cost of your dependent day care significantly increases or decreases. You can make a Dependent Care FSA contribution election change only due to a significant change in cost or coverage.

- An event occurs that significantly curtails your, your **spouse's**, or your dependent's health care coverages, or causes you to lose health care coverages under your current coverage options.

- A new health care coverage option is added or is significantly improved under the Plan or under your **spouse's** plan, and you are eligible for such health care coverage option.

- You, your **spouse**, or your eligible dependent gains/loses health care coverages under any group health plan coverage, including coverage sponsored by a governmental or educational institution.

- The change corresponds with a change made by you, your **spouse**, or your dependent under another employer's plan due to any of the following:
    - You elected no health coverage under this Plan because you had coverage elsewhere and that coverage ends because of a loss of eligibility caused by events such as divorce or termination of employment;
    - The Annual Enrollment period under the other employer's plan is different from this Plan's Annual Enrollment period;
    - The other employer's plan has a different **plan year** than this Plan; and
    - The other employer's plan allows you, your **spouse**, or dependent to change health care coverage elections due to the reasons described in this section (e.g., QLEs, special enrollment due to HIPAA, **QMCSO**, significant cost or coverage changes, or **Medicare** or **Medicaid** entitlement).

See "How to Make a Midyear Change" for more details.

Medicaid, CHIP, or Medicare Entitlement

You or your **spouse** may gain or lose **Medicaid,** or **Medicare** coverage. If this is the case, you may change your health care coverages, as well as your Health Care FSA contribution election, under the Plan accordingly. If there is a loss of coverage under a state children’s health insurance program (CHIP) you may change your health care coverages. You must request such a change within the time frame stated in the “When Mid-year Changes Are Allowed” section.

How to Make a Mid-year Change

If you experience a QLE or other applicable change event during the **plan year** and want to change your coverage elections, you must request such a change within the time frame stated in the "When Mid-year Changes Are Allowed" section.

Initiate your request online via the Thryv Benefits Center website or by calling the Thryv Benefits Center. Regardless of which method you choose, you must make your change request within the time frame stated in the "When Mid-year Changes Are Allowed" section. Your coverage or contribution election change is approved only if it is consistent with the QLE or other applicable change event and follows the Plan's rules.

As long as you request the change within the timeframe stated in the "When Mid-year Changes Are Allowed" section, the requested change is consistent with the event, and you provide acceptable supporting documentation as requested by the Thryv Benefits Center, the coverage/contribution election changes take effect as shown in the chart below.

Type of Change	Coverages/Contribution Election Changes Take Effect On ...
Qualifying Life Events (QLEs)	The actual date of the QLE in most circumstances.
Other Applicable Change Events	
▪ HIPAA Special Enrollments	The actual date of the event in most circumstances.
▪ **QMCSO**	The date the Thryv Benefits Center processes the **QMCSO**.
▪ Significant Cost or Coverage Change	The actual date of the event.
▪ **Medicaid** Entitlement	The actual date of the event.

If you experience a QLE or other applicable change event and you do not request a coverage and/or FSA contribution change within the time frame stated in the "When Mid-year Changes Are Allowed" section, you must wait until the next Annual Enrollment period (unless you experience another QLE or other applicable change event).

When Coverages End

When Your Coverages End

As long as you and your enrolled dependents continue to meet the benefit coverage's eligibility requirements and make the required employee contributions, coverages generally continue while you are employed by the **Company**. Your coverages under the Plan, however, end on any of the following:

- The last day of the month in which your employment with the **Company** ends, unless coverage is continued through **COBRA** or an applicable severance plan. Notwithstanding, all Life, AD&D, Disability coverages, and Wellness Program contributions end on the date your termination of employment occurs.

- The last day for which you pay the required contribution for your coverage options that require contributions, including contributions for **COBRA**.

- The day you misrepresent your or your covered dependent's eligibility status retroactive to the date benefits became effective.

- The day you no longer meet the Plan or benefit coverage's eligibility requirements.

- The day you die.

- The day the Plan terminates.

- The Plan Materials are amended to eliminate coverage under the Plan for participants, or is amended to eliminate coverage under the Plan for a specific group of participants in which you are a member.

Here are some additional things to keep in mind when certain coverages under the Plan end:

- When health care coverages end or your participation in the Health Care FSA ends, you may be eligible to continue such coverages under **COBRA**.

- When your participation in the Health Care FSA ends, you can submit claims until the claims filing deadline as long as the claims are for eligible expenses **incurred** before your participation ends.

- When your participation in the Dependent Care FSA ends, you can submit claims until the claims filing deadline against any contributions that remain, provided the claims are for eligible expenses **incurred** before your participation ends.

- When certain life insurance coverages end, you may be eligible to port your coverages or convert such coverages to an individual policy. See the Life & AD&D part of the SPD for details.

- If you are retirement eligible, please refer to the Retiree Benefits SPD for details.

When Dependent Coverages End

Your dependent coverages under the Plan end on the day:

- Your coverages under the Plan end.
- Your dependent no longer meets the Plan or a benefit coverage's eligibility requirements. A child who loses eligibility due to attainment of age 26 has his/her health coverage continued through the last day of the month in which the child attains age 26.
- You or your dependent misrepresents his or her eligibility status for any benefit.
- You refuse or fail to submit documentation required to substantiate dependent eligibility.
- Your dependent begins active military duty (be sure to contact the Thryv Benefits Center before your dependent's military duty begins).
- Your dependent becomes eligible for the Plan as an employee.
- The Plan terminates.
- The Plan Materials are amended to eliminate dependent coverage under the Plan for participants, or is amended to eliminate dependent coverage under the Plan for a specific group of participants or dependents in which you or dependent(s) are a member.
- Your dependent dies.

Here are some additional things to keep in mind when certain dependent coverages under the Plan end:

- When health care coverages for your dependent end, your dependent may be eligible to continue such coverages under **COBRA**. See the General Administration part of the SPD for details.
- Call the Thryv Benefits Center within 30 days of the date your dependent loses eligibility. If you do not:
  - you may not be able to update your coverage until the next Annual Enrollment period.
  - your dependent may lose his or her right to continue health care coverages under **COBRA.**
  - your contributions for dependent coverage will continue.
  - you will not be reimbursed for ineligible dependent coverage during this period.
  - your dependent will not be covered and you are financially liable for all claims that are paid for an ineligible dependent.

Other Important Facts About Coverages

IRS Tax Definition of Dependent and Imputed Income

An IRS tax dependent is a U.S. citizen or national, or a resident of the United States or a country contiguous to the United States, who is considered either a:

- **Qualifying child**; or
- **Qualifying relative**.

These terms are further defined in the Glossary part of the SPD.

The Internal Revenue Code (IRC) allows you to exclude from income the amount the **Company** spends to provide you with health care coverages. This exclusion extends to health care coverages the **Company** provides to your tax-eligible dependents under IRC Section 152. You also can exclude from income the amount the **Company** spends to provide you with health care coverage for your covered dependent children younger than age 26.

The **Company** is required to impute income to employees for the coverage for those dependents who are not IRC Section 152 tax-eligible dependents (with the exception of your covered dependent children younger than age 26).

Therefore, if you elect health coverage for a dependent who does not qualify as your tax dependent under IRC Section 152, the **Company** must include in your reportable income the cost of any health care coverage the **Company** provides to such dependents. And, you must pay for these coverages on an after-tax basis. The current-year cost of health care coverages that the **Company** provides can be found on the Thryv Benefits Center website. Also, if you participate in the Health Care FSA or HSA, you may use that account to pay eligible expenses of a dependent only if he or she qualifies as your tax dependent. If you participate in the Dependent Care FSA, you may use that account to pay eligible expenses of a dependent only if he or she qualifies as your tax dependent.

Please Note: Before you enroll your dependent for health care coverages under the Plan, check with your tax advisor to determine how these additional benefits affect your personal income tax situation. (Different rules may apply for state income tax purposes.)

Special Rules for Separation Agreements & Separation Programs

If your employment is terminated pursuant to a **Company** separation agreement/program that provides full or partial **Company**-paid coverage under the Plan after your termination that is concurrent with **COBRA**, your **COBRA** effective date is not affected or delayed by the separation agreement.

If your employment is terminated pursuant to a **Company** separation agreement/program that provides full or partial **Company**-paid coverage under the Plan after your termination that is not concurrent with **COBRA**, your **COBRA** effective date is affected or delayed by the separation agreement.

In either case, you are responsible to make the required contribution which is not paid for by the **Company** for any continued coverage after you have been separated. If you do not pay or you stop paying your required contributions, applicable coverage will end on the last day for which you've paid for coverage. Be sure to refer to your separation agreement/program for details.

State Eligibility Laws and the Employee Retirement Income Security Act of 1974, as amended (ERISA)

States and local governments sometimes pass laws that require a benefit plan to provide benefits and/or coverage to an individual who otherwise would not be eligible. For example, a state might require an employer to provide coverage to an ex-**spouse** or a child who exceeds the plan's age requirements or who would otherwise not be eligible for coverage under the **Company's** medical plan.

The federal law, known as **ERISA**, supersedes state and local government law. As a result, the **Company** only covers individuals as described in the SPD. However, if you elect a fully-insured coverage option under the Plan, such as an HMO, the HMO or insurance company may be required to comply with particular state or local laws.

The Thryv Benefits Center Website & the Thryv Benefits Center

Resources for Benefit Information

The **Company** offers you the following two ways to access benefit information:

- The Thryv Benefits Center Website at: https://MyThryvBenefits.com; and
- The Thryv Benefits Center at 1-866-847-1300, option 3, then option 1.

The Thryv Benefits Center Website

This online resource is your primary point of access to view personalized benefit information, initially enroll in coverages, enroll during Annual Enrollment periods, retrieve detailed benefit information, link to various online tools, make a mid-year change to your coverages, and keep your beneficiary information current.

You can reach the Thryv Benefits Center Website directly at: https://MyThryvBenefits.com or from the HR section of the **Company**'s intranet. You can access the Thryv Benefits Center Website remotely, 24 hours a day, seven days a week.

The Thryv Benefits Center

The Thryv Benefits Center is available to help you enroll, make changes, or ask questions. Customer Service representatives (CSRs) staff the center, are trained in and knowledgeable about the Plan's eligibility requirements and your enrollment status, and can help answer your questions

CSRs are available between 8:00 a.m. and 5:00 p.m. Central time Monday through Friday (except **Company**-wide holidays). You will be asked to validate your identity when you call.

Please Note: **COBRA** is administered through a separate division of the Thryv Benefits Center.