Enrollment

You may enroll for coverage during the following times:

- Initial Enrollment (see below);
- Annual Open Enrollment Period (prior to January 1 of each year in which your benefits will be effective); or
- Within 31 calendars days after a Qualifying Family Status Change.

Initial enrollment

You may enroll in the Medical, Dental, Life, Personal Accident, FSA and 401(k) Plan within the initial enrollment period, which is the first 30 calendar days following your date of hire. You will receive notification of your enrollment period. Your enrollment is completed on-line.

Failure to enroll

If you do not enroll during your initial enrollment period, you and all of your dependents will not be eligible for benefits until January 1 of the following year except where noted below.

Automatic enrollment

All eligible employees are automatically enrolled in the following company-paid benefits:

- Life and Accidental Death & Dismemberment;
- Short-term and Long-term Disability;
- Business Travel Accident Insurance;
- Employee Assistance Plan;
- Nurse Line Program.

Annual open enrollment period

Prior to January 1 of each year, you will be allowed to enroll in and/or change your coverage effective January 1 for the following benefits, if you are eligible for these benefits:

- Medical;
- Dental;
- Supplemental Life Insurance (including spouse and dependent Life Insurance);
- Personal Accident;
- Flexible Spending Accounts;
- Employee Stock Purchase Plan;
- 401(k); and
- Nonqualified Savings Plan (enrollment is required prior to July 1).

Note: You may enroll in the Employee Stock Purchase Plan up to July 31; and in the 401(k) Plan at any time.

Annual open enrollment period facts

- You may change your level of coverage, enroll or waive coverage for yourself and/or any of your eligible dependents during the Annual Open Enrollment Period.
- If you do not enroll by the end of the Annual Open Enrollment Period, you and your dependents will be automatically covered for the same level of benefits that you elected in the preceding year, with the exception of the Employee Stock Purchase Plan, NQSP and the Flexible Spending Accounts. You must re-enroll for those plans if you wish for them to continue.
- Your benefit elections during the Annual Open Enrollment Period will be effective on the following January 1.

Changing your coverage mid-year

Changes to your Medical, Dental, Supplemental Life and FSA coverage can be made mid-year:

- With a valid Qualifying Family Status Change; or
- During a special enrollment period as described under the section below entitled Loss of Coverage for Other Criteria.

Qualifying family status changes

For Medical, Dental, Supplemental Life and FSA, federal tax laws generally require that the benefit choices you make remain in effect for the entire calendar year for which the choices are made. The only exceptions are the circumstances listed under Status Events. If you do have a status change:

- You must contact the Benefits department and provide the appropriate documentation of the event (i.e., marriage license, birth certificate, etc.) within 31 calendar days after the date of the event.
- You may add or delete dependents affected by the Qualifying Family Status Change.
- The change in coverage must be consistent with the Qualifying Family Status Change.
- The change in coverage will be effective as of the date of the Qualifying Family Status Change.
- There is no limit to the number of Qualifying Family Status Changes that can occur during a calendar year.
- The pre-existing condition exclusion provision of the plan will apply (there are no pre-existing condition exclusions for newborns, adopted child(ren) or child(ren) placed for adoption if application is made within 31 calendar days after the event).

Status events

You may change coverage for the balance of the calendar year if one of the following events occurs and your benefit change is consistent with the event (the determination of the occurrence and consistency of the event will be made by the plan administrator):

- Employee/dependent loses coverage elsewhere
- Employee/dependent gains coverage elsewhere
- Significant change in plan
- Marriage
- Divorce, legal separation or annulment
- Birth or adoption of a child
- Addition of a stepchild or legal ward to your family
- Adding an eligible grandchild
- Child or grandchild's loss of eligibility for coverage (age, marriage, moves out, becomes eligible for insurance through own employment)
- Death of an employee/dependent
- Employee/dependent gains Medicare/Medicaid eligibility
- Employee/dependent loses Medicare/Medicaid eligibility

You may also modify coverage for the rest of the calendar year if either of the following requires you to provide coverage for your child under this plan or requires your former spouse to provide coverage:

- A judgment, decree or order resulting from a divorce, legal separation, annulment; or
- A change in legal custody.

If you, your spouse or dependents are enrolled for Medical coverage, you may modify your Medical coverage choices for the rest of the year by dropping or adding coverage (as appropriate) to the extent that you, your spouse or dependents become entitled to Medicare or Medicaid benefits.

When is coverage effective?

If your enrollment is received during your initial enrollment period:

- You and any eligible dependents' coverage will begin on the first day of the month following the first date you begin service for Manpower (provided you are continuously employed with Manpower through this period).

If your enrollment is received during the annual open enrollment period:

- For most benefits, your and any eligible dependents' coverage will begin on January 1 following the Annual Open Enrollment Period.
- For Supplemental Life Insurance, if you are required to provide Evidence of Insurability, your coverage will begin on the date that the insurance company approves your application for coverage.

If a change in coverage is made because of a valid qualifying family status change:

- The change will be effective on the date of the Qualifying Family Status Change.
- If the change occurs for one of the following reasons, the change in coverage will be effective to terminate benefits as of the last day of the month following the date of the Qualifying Family Status Change:
  - Employee/dependent gains coverage elsewhere.
  - Significant change in plan.
  - Divorce, legal separation or annulment.
  - Child or grandchild's loss of eligibility for coverage.
  - Employee/dependent gains Medicare/Medicaid eligibility.

Family and medical leave

If you are granted a leave of absence (Leave) by Manpower as required by the Federal Family and Medical Leave Act, you may continue to be covered under most benefit plans for the duration of the Leave under the same conditions as other employees who are in active status and covered by the plans. If you choose to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date you return to active status immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if you had been continuously covered.

Loss of coverage for other criteria

If you declined Medical and/or Dental coverage because you and/or your dependents had Medical and/or Dental coverage elsewhere and have since lost the other coverage, you will have a special enrollment period if:

- You confirm in writing that you declined coverage because you and/or your dependents had coverage elsewhere;
- When you declined coverage you and/or your dependents had:
  - COBRA coverage (see Important Notice on Your Rights to Continuation of Group Health Coverage in this summary) which has since been exhausted;
  - Coverage other than COBRA which has since terminated because of loss of eligibility; or
  - Coverage for which employer contributions have terminated.

Notes:

- Loss of eligibility for coverage includes a loss due to legal separation, divorce, annulment, death, termination of employment, reduction in hours worked and any loss of eligibility after a period that is measured by reference to any of the above.
- Loss of eligibility does not, however, include a loss due to failure to pay for the cost of benefits on a timely basis or termination of coverage for cause, such as making a fraudulent claim or intentional misrepresentation.
- You must enroll no later than 31 days after the date the other coverage ended.

When coverage ends

Most benefits end for you and/or your dependents on the earliest of:

- The last day of the month in which a termination of your employment occurs or you cease to be an active employee;
- The last day of the month in which your dependent ceases to be eligible;
- The last day of the month in which you voluntarily cancel coverage even though you are eligible;
- On the date of death; or
- The date the plan is terminated or otherwise amended to exclude yours or a dependent's coverage.

Coordination of benefits (COB)

Coordination of benefits is a feature used to determine how much the Manpower Medical or Dental Plan pays when you or one of your dependents is covered by more than one group plan. This feature is designed to prevent overpayment of benefits.

Under the coordination of benefits rules, one plan pays benefits first (the "primary payer") and one plan pays second (the "secondary payer"). The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan.

The sum of the benefits paid from each plan will not exceed the actual expense incurred. If the Manpower plan is the secondary payer, the combined benefit from both plans won't be more than the Manpower plan's limit for the covered charges.

Different coordination of benefits rules apply under different circumstances. The following sections address different circumstances.

If you or a dependent is covered by more than one plan

The other plan (not a Manpower plan) will be the primary payer if any of the following conditions applies to the other plan:

- It doesn't have a coordination of benefits rule;
- It covers the individual as an eligible employee or retiree (while your Manpower plan covers the individual as a dependent);
- It covers the individual as an employee (while your Manpower plan covers the individual as an eligible retiree); or
- It has covered the individual longer than your Manpower plan (if the other points in this section don't apply).

If your Manpower plan is the secondary payer, the combined benefit from both plans won't be more than your Manpower plan's limit for the covered charges.

Coordinating your children's coverage with your spouse's plan

If you're covered by a Manpower plan and your spouse is covered by another group plan, special rules apply to dependent children covered under both plans:

- The medical plan of the parent whose birthday falls earlier in the calendar year is the primary payer;
- If both parents have the same birthday, the plan that covered a parent the longest is the primary plan;
- If the other plan does not have a birthday rule, the plan of the male is the primary plan; or
- If the other plan does not have a birthday rule but instead has a rule based on the gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

Your children's coverage if you're divorced or separated

When parents are separated or divorced and children are covered under more than one health care plan and there is no court order to the contrary, the following rules apply:

- The plan of the parent with custody of the child (or court-ordered financial responsibility) is the primary payer;
- The plan of the spouse of the parent with custody of the child is the secondary payer; and
- The plan of the parent without custody (or court-ordered financial responsibility) pays last.