SECTION TWO: Eligibility for Coverage

I. Introduction

As a participant in the Teamsters Local 251 Health Services and Insurance Plan, you and your eligible dependents have access to a generous package of health and welfare benefits. This section describes the eligibility requirements you must meet in order to participate in the Plan, how you may maintain your coverage, and when your coverage ends.

Fast Facts:

- You must work at least 300 hours for a contributing employer during a qualifying period to participate in the Plan and receive Level 1 or Level 1 EBL benefits.
- You must continue to work at least 300 hours per qualifying period in order to maintain eligibility for Level 1 or Level 1 EBL benefits.
- If you do not work the required 300 hours, you may maintain your healthcare coverage if you've worked at least 250 hours by:
    - applying the hours you've accumulated in your banked hours ;
    - "dropping down" to a Level 2 coverage;
    - using your overtime hours;
    - buying the additional hours you need to maintain your coverage; or
    - combining hours in your bank, overtime hours or buy-in hours
- Certain part-time employees, or employees who drop down to Level 2 coverage must work at least 200 contributory hours in a qualifying period to be eligible for Level 2 benefits for themselves and their dependents.

  "**Contributory Hours**" are defined as hours of work performed by a participant for which a participating employer is required to make a contribution to the Fund. This does not include any overtime hours worked. Overtime hours are any hours worked in excess of 40 hours in a one week payroll period.

Teamsters Local 251 Health Services and Insurance Plan offers two benefit Plans for active employees: Level 1 and Level 2. The chart below shows some of the differences in coverage and eligibility requirements.

	Level 1	Level 2
Participants	All employees with at least 300 contributory hours in a qualifying period	• Certain part-time employees with at least 200 contributory hours in a qualifying period; or • Level 1 employees who have "dropped down" to Level 2 because they have worked at least 200 (but not 300) hours in a qualifying period

Benefits	• Medical • Prescription Drugs • Dental • Legal Insurance • Employee Assistance Program • Gym Reimbursement • Weight Watchers Reimbursement • Income tax preparation • Vision • Hearing • Weekly Accident and Sickness • Life Insurance • Accidental Death and Dismemberment Insurance	• Medical • Prescription Drugs • Dental • Legal Insurance • Employee Assistance Program • Gym Reimbursement • Weight Watchers Reimbursement • Income tax preparation

A. Level 1 Coverage

1. Eligibility Rules

Unless the Trustees determine otherwise, you are required to work at least 300 contributory hours in covered employment during a calendar quarter — called a **qualifying period** — to be eligible for Level 1 or Level 1 EBL coverage during the next calendar quarter — called an **eligibility period**. Some exceptions are discussed below. The chart below shows the qualifying periods and eligibility periods for this Plan.

Qualifying Periods	Eligibility Periods
If you work at least 300 hours in…	*You'll be eligible for coverage during…*
January, February, March	June, July August
April, May, June	September, October, November
July, August, September	December, January, February
October, November, December	March, April, May

a. Beginning of Coverage

Your coverage begins on the first day of your eligibility period; therefore, any expenses you may incur before your eligibility period will not be reimbursable.

b. Covered Employment

"Covered Employment" is a category of work under which your employer is required to make contributions to the Fund on your behalf under a collective bargaining agreement.

2. Maintaining Your Coverage Without Working 300 Contributory Hours

There are several ways for you to **keep** your Level 1 or Level 1 EBL healthcare coverage, even if you do not work the required 300 contributory hours in a qualifying period. You may:

- Use hours from your **banked hours** (hours over 520);
- Use **overtime hours** (over 40 hours);
- Pay for the hours you need **(buy-in)**; or
- Combine any of the above three options.
  (See below for details.)

If your coverage for benefits terminates, you may also be eligible for a monthly Level 1 or Level 1 EBL **reinstatement**.

a. Banked Hours

If your company contributes in excess of 520 hours during a qualifying period and in the *following* qualifying period you do not work the required 300 hours, you may use the extra hours you earned to avoid a break in coverage. The excess hours that you accrued during the prior qualifying period may be used, if necessary, to continue your Level 1 or Level 1 EBL coverage for **one** eligibility period. Contact the Fund Office if you would like to use your banked hours to maintain your coverage.

b. Overtime Hours

Your overtime hours from one qualifying period can count toward your hours for eligibility for the corresponding eligibility period (refer to chart above) if you have at least 250 (but less than 300) contributory hours during a qualifying period **and**:

- you've been eligible for Level 1 or Level 1 EBL benefits at least one of the last four eligibility periods; **and**
- you've earned enough overtime hours so that, when applied, you'd meet the 300 contributory hour requirement;

"Overtime hours" are all hours **exceeding 40 hours** in a week. You may also use your overtime hours to reduce the amount you pay to "buy in" to Level 1 or Level 1 EBL coverage, as discussed below.

You must show proof of your overtime hours to the Fund Office. Pay stubs indicating your overtime hours will be accepted as proof.

c. Buy-In Rule

If you do not work the required minimum of 300 contributory hours in covered employment during a qualifying period, you may continue your coverage by buying the hours you need to maintain your Level 1 or Level 1 EBL coverage. You must work at least 250 contributory hours to be eligible to buy-in and have been eligible for Level 1 or Level 1 EBL benefits during the past year at least one of the four most recent eligibility periods. You may also apply your overtime hours (see above) to reduce your cost. Contact the Fund Office at (401) 467-3323 for the current hourly cost.

d. 150 Hours in a Month Reinstatement Rule

If your eligibility for Level 1 or Level 1 EBL coverage terminates, you may be able to regain eligibility without meeting the 300 hours requirement. If you work at least 150 hours in a calendar month within 12 months of losing your eligibility, you will be reinstated for coverage for one month, starting on the third month following the month in which you worked 150 hours. You will remain eligible for one month for each month in which you work at least 150 hours for up to five consecutive months, or until you become eligible under the regular eligibility rules.

For example, if you lost your eligibility on May 31 and worked at least 150 hours in the month of June, your eligibility would be reinstated for the month of September.

The following restrictions apply to the Reinstatement Rule:

- You may use this rule to earn eligibility for benefits for a maximum of **five** consecutive months;
- The Reinstatement Rule does not apply unless you have already lost your eligibility. You cannot begin to accrue hours under this rule until after your benefits terminate.

B. Level 2 Coverage

1. Drop Down Rule

The Plan will allow you to "drop down" to Level 2 or Level 2 EBL coverage for the corresponding eligibility period if you do not work the required 300 hours, but you do work at least 200 hours in a qualifying period. Level 2 or Level 2 EBL coverage consists of medical, prescriptions, dental, EAP, Legal Insurance, gym reimbursement, weight watchers reimbursement and Income Tax Preparation.

2. 80 Hours in a Month Reinstatement Rule

If your eligibility for Level 2 or Level 2 EBL coverage terminates, you may be able to regain eligibility without meeting the 200 hours requirement. If you work at least 80 hours in a calendar month within 12 months of losing your eligibility, you will be reinstated for coverage for one month, starting on the third month following the month in which you worked 80 hours. You will remain eligible for one month for each month in which you work at least 80 hours for up to five consecutive months, or until you become eligible under the regular eligibility rules.

For example, if you lost your eligibility on May 31 and worked at least 80 hours in the month of June, your eligibility would be reinstated for the month of September.

The following restrictions apply to the Reinstatement Rule:

- You may use this rule to earn eligibility for benefits for a maximum of **five** consecutive months;
- The Reinstatement Rule does not apply unless you have already lost your eligibility. You cannot begin to accrue hours under this rule until after your benefits terminate.

C. Enhanced Benefit Level Coverage (EBL)

- Enhanced Benefit Level Coverage is available under Level 1, Level 2, Retiree and Cobra Coverage. Both you and your eligible dependents, if qualified, are eligible for EBL Coverage. EBL Coverage reduces out-of-pocket expenses, including medical co-payments and deductibles as well as pharmacy coinsurance. Participation in predetermined wellness activities are required in order to apply for EBL.
- The Fund Office sends out an annual letter describing the requirements for EBL. Please review this letter and comply with all applicable requirements and deadlines. If you fail to comply with the EBL application requirements, you will not be eligible for EBL coverage. If you have any questions about applying for EBL coverage please contact the Fund Office.

RHODE ISLAND HOSPITAL (RIH) EMPLOYEE MEMBERS BENEFITS AND ELIGIBILITY

I. ELIGIBILITY FOR MEMBERS EMPLOYED BY RHODE ISLAND HOSPITAL

If you are employed by Rhode Island Hospital (RIH) as a full time employee, your eligibility for benefits is different and it is important that you are aware of this fact. Eligible RIH employees may only elect dual or family Level 1 coverage. Except as described below, all benefits and copays are the same for RIH members as they are for all other members who have Level 1 or Level 1 EBL coverage. They are not able to elect EBL they must meet the requirements.

Pursuant to the collective bargaining agreement (CBA) between RIH and Teamsters Local Union 251, this Plan provides eligible RIH employees with medical, prescription, dental, EAP, vision, weekly accident and sickness, hearing, life insurance and accidental death benefits and dismemberment insurance, legal insurance, income tax preparation, gym reimbursement, weight watchers reimbursement. RIH employees are not eligible for retiree coverage through the Fund Office.

If you are a RIH employee, the following eligibility rules and restrictions apply.

1. You Must be an RIH Employee Who Performs Work Within the Scope of the RIH Collective Bargaining Agreement with Teamsters Union Local 251.

2. You Must be a Full Time Employee With Regularly Scheduled Hours of Thirty-Five (35) Hours or More Per Week.

3. You Must Elect Dual or Family Coverage Through the Teamsters Local 251 Heath Services and Insurance Plan.

Pursuant to the CBA, RIH only makes contributions to the Fund for full time employees, who work regularly scheduled hours of 35 hours or more per week, that elect dual or family health coverage. Thus, the Fund only provides coverage to eligible RIH employees that elect dual or family coverage. All eligible members of the bargaining unit employed by RIH who seek individual coverage will not receive individual coverage from the Plan. RIH employees seeking individual coverage should contact a representative in Human Resources at RIH.

4. You Are Eligible For Benefits As of the First of the Month Following the Date of Hire.

5. Your Benefits Terminate on the Last Day of the Month Following the Termination of Your Employment with RIH.

6. You are Not Eligible for Retiree Coverage. You need to contact Human Resources at RIH

Full time members that change to part time employment on or after January 1st will remain on the Fund's benefits through December 31st. Part time members that change to full time employment on or after January 1st will remain on

Lifespans benefits through December 31st. Any mid-year employment changes will not affect benefits until the 1st of the following year.

Members that become Full time on or after January 1st you will need to log into Lifespans website during that years open enrollment to elect benefits for the following year.

Full time individuals may become eligible for the Fund's benefits during the calendar year if they have a family status change. i.e. Marriage, birth, adoption of a child (ren).

Full time dual and family may return to Lifespan's benefits during the calendar year if they have a family status change. i.e. divorce, death of a dependent or a dependent is no longer an eligible dependent.

II. RIH Special Transfer Rule

If you are eligible for benefits through Teamsters Local 251 Health Services and Insurance Plan as a RIH employee for at least the immediately preceding six (6) months, and you begin to work for a different contributing employer (where benefit eligibility is based on quarterly hours) this special rule will apply.

1. You will be eligible for Fund Coverage on the first day of the month following a month in which the employer is required to contribute for 100 hours or more, and your eligibility will continue so long as you satisfy the quarterly eligibility rule. You may need to provide proof of hours worked if the Health Services Office has not received a remittance report from the contributing employer.

2. After twelve months of employment, you will remain covered through the last day of the current eligibility period (the last day of August, November, February or May, as applicable.) For example, if you come to work during the month of April, May or June and work at least 100 hours, you will remain eligible through November 30th. If you leave employment before twelve months, your benefits will terminate at the end of the month you leave employment.

3. In order to remain eligible for benefits, you must meet the on-going requirements for quarterly eligibility.

4. Your RIH employment time does not count towards retiree health benefits eligibility. All hours with other contributing employers and eligibility for benefits during periods of employment with other contributing employers will count toward retiree health benefit eligibility.

D. Life Events Effecting Coverage

Your coverage under the Health Services Plan may be affected when certain life events occur. Your failure to notify the Plan when these events occur may result in the termination of coverage for you or your dependents. **The Fund Office must be contacted if:**

- You get married
- Your spouse or dependent gets coverage under another health plan
- You have a baby, adopt a child or a foster child
- You become a legal guardian of a child
- You take Family Medical Leave
- Your child's eligibility for benefits changes
- You become divorced or legally separated
- You become disabled
- You stop working
- You are on Workers Compensation
- You enter active military service
- You retire
- You or your spouse become eligible for Medicare or Medicaid
- You or your eligible dependent dies

A. The Fund Office Must be Contacted if the Following Events Occur

1. Special Enrollment Event - If You Get Married

If you marry, and would like to cover your new spouse and/or stepchildren, you must apply for Family Membership within 60 days of your marriage. Your spouse and stepchildren will be covered on the first day of the month following the date of your marriage for all of your benefits that are available to eligible dependents. To apply, contact the Fund Office. You will need to supply the Fund Office with a copy of your marriage certificate, your spouse's social security card, date of birth and complete a stepchild form, stepchild's birth certificate and social security card.

If you fail to apply within 60 days, your spouse will not become eligible for benefits until the month after the marriage certificate is provided.

The following year you will be obligated to provide a copy of your Federal Income taxes for the previous calendar year in order for your spouse to remain on coverage. The Trustees require that you file as married filing jointly or married filing separately. The Fund Office requires a copy of the first page signed by both member and spouse of your Federal Income Taxes. If you file married filing separately, we will need a copy of both Income Tax forms back. Benefits for the spouse will be suspended if your Federal Income Taxes are not filed as the Trustees require.

2. Special Enrollment Event - If You Have a Baby, Adopt a Child, become a Step Parent or become a Legal Guardian

If you have a baby, you may enroll your new child in the Plan. However, you must provide the Fund Office with a copy of your child's birth record, birth certificate and the social security card within 60 days of delivery in order for your child to be covered for all of your benefits that are available to eligible dependents. If you fail to apply within 60 days, your child will not become eligible for benefits until the month after the birth certificate and social security card is provided.

Your newly born baby will be eligible for coverage under this Plan from birth. However, if you have Level 1 or Level 1 EBL coverage, eligibility for dependent Life Insurance will not begin until your child is 14 days old.

If you become a parent by adoption (or placement for adoption), you may also enroll your new child in the Plan, but you must notify the Fund Office within 60 days of the date the child is placed with you. You are required to submit the court document, adoption papers, a copy of the birth certificate and the child's social security card to the Fund Office to verify your child's eligibility for coverage. If you fail to apply within 60 days, your child will not become eligible for benefits until the month after the birth certificate and social security card is provided.

If you become a step parent by marriage, you must notify the Fund within 60 days of the date of your marriage. You are required to submit the marriage certificate, a copy of your stepchild/ren's birth certificate, a copy of your spouse and stepchild's social security card and a completed stepchild form to the Fund Office to verify your stepchild/ren's eligibility for coverage. If you fail to apply within 60 days, your stepchild/ren will not become eligible for benefits until the month after the birth certificate, social security card and stepchild form is provided.

If you become a foster parent or legal guardian over a child who has not attained age 18, referred to as "wards", you may add wards to your coverage if you satisfy all of the requirements. A court of competent jurisdiction has issued an order or judgment declaring you to the legal guardian of the ward and the member provides the Fund with a copy of the order or judgment, the ward is under the age of 18, provide a copy of the wards birth certificate, social security card and complete a legal guardian reimbursement agreement. You must re-certify the status of legal guardian in a court of competent jurisdiction within 90 days of the ward's 18th birthday to continue benefits up to age 26. If you fail to do so the ward will be terminated from benefits, you agree to provide notice within 30 days of any change in guardianship status and signs a reimbursement agreement provided by the Fund.

If you do not elect to add your adult child as of the date that you become eligible for benefits, your adult child will not be eligible for benefits without a qualifying event. For your child under the age 19 years old they will be eligible for benefits the month after the Fund office receives the birth certification and social security card if it not within 60 days.

3. Special Enrollment Event – Loss of Other Coverage

If:

- You did not enroll yourself, your spouse and/or any dependent child(ren) for coverage when you or they first became eligible for coverage because you or they had health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid, or other public program; **and**

- You, your spouse and/or any dependent child(ren) cease to be covered by that other health insurance policy or plan;

Then:

You may enroll yourself and/or your spouse and/or dependent child (ren) within 60 days after the termination of their coverage under another other health insurance policy or plan if the other coverage terminated because:

- Of the loss of eligibility for the other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; or
- Of the termination of employer contributions toward the other coverage; or
- A covered individual reaches the lifetime limit for all benefits under the other health plan; or
- If the other coverage was COBRA Continuation Coverage, the coverage was "Exhausted." COBRA Continuation Coverage is "Exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim). For example, COBRA coverage is considered "exhausted" when the 18- or 36-month maximum coverage period expires; or
- When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual.

  Also, an individual may be eligible for Special Enrollment even if they did not have other health coverage when they initially refused to enroll in the Plan. This may occur if, after subsequently obtaining other health coverage, they later lose the other health coverage.
- Finally, if you or your dependent lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP), or become eligible to participate in a premium assistance program under Medicaid or CHIP, you may enroll yourself or your eligible dependent in the Fund's health coverage if you request enrollment within 60 days of the loss of Medicaid or CHIP coverage, or the date you or your dependent are determined to be eligible for a Medicaid or CHIP premium assistance program.

If you have any questions about Special Enrollment Events, contact the Fund Office.

4. If Your Dependent Gets Coverage Under Another Health Plan

You must contact the Fund Office if your spouse or dependent children are eligible for coverage under another health plan. Refer to the section entitled "Coordination of Benefits", located in Section Fifteen, to learn how claims are paid for your spouse and/or your dependent children when more than one family member has health care coverage.

5. If You Take FMLA Leave or TCI Leave

a. FMLA Leave (Federal Program)

The Family and Medical Leave Act of 1993 ("FMLA") requires participating employers with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for his/her own sickness or to care for a seriously ill child, spouse, or parent.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a military service member. The military service member must:

- Be your spouse, son, daughter, parent or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary disability retired list of the armed services.

Some employers require members to exhaust available vacation or sick time before they are eligible for FMLA benefits. Some employers require you to pay your employee portion of the contributions. Please check your collective bargaining agreement to see if this applies to you.

In compliance with the provisions of the FMLA, your participating employer is required to contribute to your coverage by continuing contributions under the Plan during your period of leave under the FMLA just as if you were actively employed. Your coverage under the FMLA will cease once the Fund office is notified or otherwise determines that you have terminated employment, exhausted your 12 week FMLA leave entitlement, or do not intend to return from leave.

Your coverage may cease if your participating employer fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect to continue your coverage under the COBRA continuation rules, as described in Section Fourteen. The qualifying event entitling you to COBRA continuation coverage is the last day of your FMLA leave.

If you fail to return to covered employment following your leave, the Fund may recover the cost of benefits it paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the FMLA. If you fail to return from FMLA for impermissible reasons, the Fund may offset payment

of outstanding medical claims incurred prior to the period of FMLA leave against the cost of benefits paid on your behalf during the period of FMLA leave.

b. TCI Leave (RI Program)

The Temporary Caregiver Insurance program (TCI), operated by the State of Rhode Island, provides up to four (4) weeks of wage replacement benefits to eligible workers who need to be out of work in order to care for a seriously ill child, spouse, domestic partner, parent, parent-in-law or grandparent or to bond with a newborn child, adopted child, or foster child. Eligibility details and an application may be found at www.dlt.ri.gov/tdi.

Your participating employer is required to contribute to your coverage by continuing contributions under the Plan during your period of TCI leave just as if you were actively employed. However, you must continue to pay any employee share of the cost of health benefits as required prior to the commencement of TCI benefits. Your employer's obligation to remit contributions will cease once the Fund office is notified or otherwise determines that you have terminated employment, exhausted your 4 week TCI leave entitlement, or do not intend to return from leave.

Your coverage may cease if your participating employer fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of TCI leave, you may elect to continue your coverage under the COBRA continuation rules, as described in Section Fourteen. The qualifying event entitling you to COBRA continuation coverage is the last day of your TCI leave or if you do not meet the Fund's eligibility rules. If you fail to return to covered employment following your leave, the Fund may recover the cost of benefits it paid to maintain your health coverage during the period of TCI leave.

6. If Your Child's Eligibility For Benefits Changes

Generally, your child is covered under this Plan until your coverage ends or the end of the month in which your child turns 26. If your child becomes ineligible for coverage under this Plan, you are required to notify the Fund Office as soon as possible. Your child may be eligible for coverage under the UnitedHealthcare Direct Payment program or through COBRA Continuation Coverage for up to 36 months. See Section Fourteen, Continuation of Coverage for more information about COBRA.

a. Qualified Medical Child Support Orders

The Fund will provide dependent coverage to a child if it is required to do so under the terms of a Qualified Medical Child Support Order (QMCSO) even if the participant does not have legal custody of the child, the child is not dependent upon the participant for support, and regardless of enrollment restrictions which otherwise may exist for dependent coverage. A QMCSO is a court order, judgment or decree that recognizes that an alternate recipient may be entitled to benefits under this Plan in the event of divorce or other family law action. Orders must be submitted to

the Fund Office to determine whether the order is a QMCSO as required under federal law. As required under the Employee Retirement Income Security Act (ERISA), this Plan will recognize a QMCSO that:

- provides for child support of child(ren) under this Plan;
- provides for health coverage to the child(ren) under state domestic relations laws (including a community property law); and
- relates to benefits under this Plan.

7. If You Divorce or Legally Separate

If you divorce or legally separate from your spouse, your benefits and those of your spouse may be affected. Notify the Fund Office at (401) 467-3323 as soon as possible.

Your former spouse will terminate from all benefits beginning the first day of the month after your divorce becomes final.

Upon your divorce, your former spouse's children will no longer be considered your "stepchildren" under the Plan. Therefore, his or her children's coverage will also terminate.

8. If You Become Disabled

If you become disabled due to a non-work-related disability, notify your employer and the Fund Office. If you have Level 1 or Level 1 EBL coverage, you may be eligible for certain benefits under this Plan, as provided below, depending on the type and/or cause of your disability.

a. Weekly Accident and Sickness Benefits

If you are on Level 1 or Level 1 EBL coverage and become temporarily disabled and cannot work due to a non-work related disability, you may be eligible to receive a Weekly Accident and Sickness Benefit from this Plan for up to 26 weeks. See Section Twelve, Weekly Accident and Sickness Benefits for more information.

b. Accidental Death and Dismemberment Insurance

If you are on Level 1 or Level 1 EBL and become disabled due to an injury that is covered by the Accidental Death and Dismemberment Insurance Benefit, you may be eligible for a lump sum payment from the Insurance Company. See Section Eleven, Life Insurance for details.

c. Extended Life Insurance During Total Disability

If you are on Level 1 or Level 1 EBL and become totally disabled while you are covered by this Plan, and you are under age 60 when your disability starts, your life insurance may be extended while you are totally disabled. See Section Eleven, Life Insurance for details.

d. Workers' Compensation Benefits

If you are out of work due to a work-related disability, you may be eligible for Workers' Compensation from your employer. Notify the Fund Office, your employer's personnel office and your local or state Workers' Compensation Office to apply for Workers' Compensation benefits. Please remember that medical benefits available under workers' compensation law are not available to you under your health insurance. Fraudulent presentation of medical claims to your health insurance carrier would be improper. Any medical bills or prescriptions that are incurred as a result of your injury should be submitted to your employer's insurance carrier or adjusting company, not UnitedHealthcare or Caremark.

9 If You Stop Working

If your eligibility for coverage ends because you are laid off, your hours are reduced, or you've terminated employment, you may elect to continue coverage under COBRA for yourself and your family for up to 18 months. See Section Fourteen, Continuing Your Coverage for more information.

10. If You Enter Active Military Service

a. Continuation of Coverage Under USERRA

As required by the Uniformed Services Employment and Re-Employment Rights Act of 1994 ("USERRA"), the Fund provides you with the right to elect continuous health coverage for you and your eligible dependent(s) for up to 24 months, beginning on the date your absence begins from employment due to military service, including Reserve and National Guard Duty, as described below.

Coverage under USERRA for you and your eligible dependent will terminate on the earlier of:

1) The end of the 24-month period beginning on the date on which your absence begins; **or**

2) The day after the date on which you are required but fail to apply, under USERRA, for a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge); **or**

3) Return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

After 31 days or the termination of your eligibility for coverage, you must pay the cost of the coverage unless your participating employer elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in

accordance with the provisions of the USERRA by the same method that the Fund uses to determine the cost of COBRA continuation coverage. *See Section Fourteen*.

You must notify your employer and the Fund Office prior to your absence from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must contact the Fund Office and elect continuation coverage for yourself or your eligible dependent(s) under the provisions of USERRA within 60 days after your military service begins. Payment of the USERRA premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of election of your USERRA coverage.

Ongoing payments must be made by the last day of the month for which coverage is to be provided. **You will not be billed; it is your responsibility to remit payments to the *Fund office.* Late payments can result in termination of coverage.** You are responsible for the payment of the required premiums.

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under USERRA.

Contact the Fund office for more information if this may apply to you.

11. If You Retire

If you are ready to retire, you should apply for Retiree coverage under the Retiree Plan by calling the Fund Office at (401) 467-3323.

The Retirees coverage includes Medical, Prescription Drug, Hearing, Vision, EAP and Legal insurance, Income Tax, gym reimbursement and weight watchers benefits for you and your eligible dependents. **The Retiree benefits do not include wa&s, dental or dependent life coverage.** Delta Dental offers Teamster Retirees a dental plan. You may also be eligible for a $5,000 Life Insurance Benefit.

You must make monthly payments and meet certain eligibility requirements to qualify for coverage under the Retiree Plan. Payments are due on the first of the month in order to have coverage for the following month. For more information, see *Section Thirteen, Retiree Benefits*.

Rhode Island Hospital employees are not entitled to Retirees benefits through the Health Services office. RIH members should contact Human Resource for possible benefits through the hospital.

12. If You Become Eligible for Medicare

When you reach age 65 you are entitled to enroll in Medicare — the federally-sponsored health care program consisting of hospital insurance (Part A) and supplementary medical insurance (Part B). At that time, you will no longer be eligible for most of this Plan's regular benefits

unless you are still working and covered as an active employee. You may wish to seek out coverage through a Medicare Supplemental health plan.

If you are eligible for Medicare and you are still an active employee, the Plan will continue to cover your eligible medical expenses. You may submit claims to Medicare for any unpaid balances. However, if you become entitled to Medicare because of a disability, you will no longer be considered an active employee, and Medicare will pay first. See "Coordination of Benefits" in Section Fifteen for more information.

The Fund pays claims first for members and dependents that are eligible for Medicare

13. If You or Your Eligible Dependent Dies

a. If You Die

If you die from any cause while you have Level 1 or Level 1 EBL coverage under this Plan, your beneficiary may be eligible to receive a benefit from your Life Insurance, and/or your Accidental Death and Dismemberment Insurance Benefit, depending on your cause of death. Your designated beneficiary must provide a certified death certificate and complete an application for the Life Insurance benefit within one ***year*** of the date of your death in order to receive a benefit.

Your dependents may purchase COBRA to continue their health coverage for up to 36 months. See Section Fourteen, Continuation of Coverage for more information.

If you die from any cause while a Retiree, your beneficiary may be entitled to a $5,000 life insurance benefit and any balance remaining in your account if you were eligible for the Vested Benefit at the time of your death. See Section Thirteen, "Vested Benefit*"* for more information.

b. If Your Spouse or Child Dies

If your eligible spouse or eligible child dies, notify the Fund Office as soon as possible. If your eligible spouse dies, you may be eligible for a Life Insurance benefit of $20,000 if you have Level 1 or Level 1 EBL coverage. You must provide the Fund Office with a copy of your marriage certificate and your spouse's certified death certificate.

If your eligible child is at least 14 days old and he or she dies, you will be eligible for a $20,000 Life Insurance if you have Level 1 or Level 1 EBL coverage. You will need to provide the Fund Office with a copy of the child's death certificate.

III. Coverage for Your Dependents

While you are covered under the Plan, your dependents are also covered as provided below.

A. Verifying Eligible Dependents

When you become eligible for health coverage, the Plan requires documentation for your dependents as detailed in the chart below. In addition, you are responsible for notifying the Fund Office when you move, acquire new dependents, marry or divorce. There are deadlines in connection with some of these notices and there may be consequences for missing these deadlines. For details contact the Fund Office or view the Eligibility For Coverage in "Life Events" section located within this Section of this SPD.

Dependents	**Life Event**	**Documentation Required**
Spouse	Marriage	Marriage Certificate, social security card and the following years Federal Income Tax return
Married Same-Sex Partner	Marriage	Marriage Certificate, social security card and the following years Federal Income Tax return
Natural children	Birth	Birth Certificate and social security card
Stepchildren	Marriage	Birth Certificate and social security card and affidavit for stepchild
Adopted Children	Adoption	Order of Adoption or Order Placing Child (if adoption is pending). Birth certificate and social security card
Foster child/ren	Placement of child/ren	Birth certificate, social security card and court documents
Disabled Children Ages 26 and over	Before turning age 19	Statement from physician, psychologist or psychiatrist documenting the child's total and permanent disability (see page 17 & 18) and evidence that the disability occurred while your child was covered under this Plan: and evidence that the child is chiefly dependent upon you for support
Ward Under age 26	Guardianship	Birth Certificate, social security card, court order or judgment declaring the Member to be the legal Guardian of the ward, signed Reimbursement agreement

B. Updating Dependent Information

You are required to notify the Fund immediately of any changes in family status due to marriage, divorce, death, birth, placement for adoption, new Dependent child status due to Total and Permanent Disability, cessation of Dependent child status, a change in your spouse's eligibility for coverage through his or her employer.

You are required to respond to the Fund's periodic requests for continued verification of dependent status. If the Fund, requests a copy of your most recent Federal Income Tax return, you must provide a copy of your most recent tax return within thirty days of the date of the Fund's request. You may remove any financial information from your tax return prior to submitting it to the Fund. If you fail to respond to the Fund's request for information, including your most recent signed tax return, the Fund may terminate your dependent's benefits.

You are required to re-certify your status as legal guardian in a court of competent jurisdiction within ninety days of your ward's eighteenth birthday and if you fail to do so, the coverage for your ward may be terminated.

1. Upon receipt of timely notification (as defined below) and the required documentation, coverage will be provided as follows:

- Marriage: retroactive to the first of the month following the date of your marriage;
- Birth, placement for adoption, or adoption: retroactive of the date of the event;
- Stepchild: retroactive to the first of the month following the date of your marriage to the child's natural parent;
- Adult child: on the first day of the month following approval of an adult child's application for coverage with a qualifying event;
- Ward: retroactive of the date of the event;

2. Timely Notification:

You must notify the Fund of a change in family status within 60 days following the date of the event. Failure to comply with this 60 day requirement will, for new Dependents, eliminate retroactivity; coverage will be prospective only from the date of the Fund's receipt of notification.

3. Participant Liability for Failure to Provide Notice

Your failure to notify the Plan of the loss of a Dependent status at the earliest possible date will result in the Plan's pursuit of recovery from you for Dependent claims paid after the loss of the Dependent status, and may result in the unavailability of COBRA continuation coverage. *See Section Fourteen COBRA Coverage*.

Furthermore, in the event that you fail to timely notify the Plan of updated dependent information, the Trustees have the discretion to terminate your coverage, offset future benefits for you or your dependents, and/or pursue legal action to recover any erroneously paid claims.

C. Dependent Coverage

1. Your Spouse

Your legal spouse is a person to whom you are legally married in the state of your permanent residence.

2. Children

a. Your Dependent Child is:

- Your natural child/ren or stepchild/ren, or foster child/ren or child/ren who has been placed with you for adoption, or whom you have adopted, through the end of the month of his/her 26th birthday;
- Your natural child or stepchild, or foster child or child who has been placed with you for adoption, or whom you have adopted prior to turning the age of 26 who is chiefly dependent on you for support and care and who has been determined by a Physician, psychologist or psychiatrist to be disabled prior to age 19;
- If your disabled child is age 26 or greater and the Disability began before you were covered under this Plan, the disabled child will not be entitled to benefits under this Plan;
- If you are on Level 1 or Level 1 EBL Coverage, your eligible Dependent Child is eligible for medical, prescription drug, dental, vision, hearing, life insurance, accidental death and dismemberment insurance, legal insurance, EAP, gym, weight watchers. If you are Level 2 or Level 2 EBL Coverage, your eligible Dependent Child is eligible for medical, prescription drug, dental, EAP, gym, weight watchers and legal insurance benefits. If you are on Retirees or Retirees EBL Coverage, your eligible Dependent Child is eligible for medical, prescription drug, vision, hearing, gym, weight watchers and legal benefits.
- Your child by birth is eligible from the date of birth for health care coverage, and from 14 days after birth for dependent life insurance coverage.
- Your Dependent Child is eligible for medical, prescription drug, dental, vision, hearing, life insurance, gym, weight watchers and accidental death and dismemberment insurance benefits.
- Your stepchild is your spouse's biological or adopted child from a different partner.

D. Loss of Eligibility for Dependent Coverage

1. Generally

Generally, coverage for you and your dependents will end on the last day of the eligibility period that corresponds with the qualifying period during which you did not meet the requirements for coverage. However:

a. Coverage for your dependents will end immediately when they no longer meet the Plan's definition of an eligible dependent (except that if the dependent loses eligibility due to age, coverage will continue to the end

of the month the dependent reaches age 26).

b. If you die, your dependents' coverage will continue until the last day of the eligibility period.

c. If your employer is no longer required to make contributions to the Fund on your behalf, your eligibility for coverage will cease at the end of the month in which the employer is last required to make contributions, as determined by the Trustees.

d. The Plan expressly reserves the right to terminate a participant's and beneficiary's eligibility and coverage for cause, as determined by the Trustees. For cause termination includes, but is not limited to, filing fraudulent claims and covering ineligible dependents (e.g. divorced spouses or over age dependent children).

In certain circumstances when your coverage ends, you and/or your dependents may purchase healthcare coverage through COBRA. Please see COBRA continuation coverage in Section Fourteen for more information.