

### ***No Medical Examination or Age Restriction***

No medical examination is required of any employee or dependent to secure this insurance, and all new employees who become eligible will be insured regardless of age.

### ***Family and Medical Leave Act (FMLA)***

Under this federal law, you may have a right to take up to 12 weeks of unpaid leave each year for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child. FMLA requires certain Employers to maintain health care coverage during the leave period. If you think that this law may apply to you, please contact your Employer or the Plan Administrator.

### ***Military Service***

If you go into active military service for up to 31 days, your medical and dental coverage will be continued during that leave period. If you go into active military service for more than 31 days, you may be able to continue your medical and dental coverage at your own expense for up to 18 months. Questions regarding your entitlement to this leave and to the continuation of medical and dental coverage should be referred to the Plan Administrator.

### ***Qualified Medical Child Support Orders (QMCSOs)***

A QMCSO is a court judgment, decree or order that creates or recognizes an alternative recipient-such as a child or stepchild-to be eligible for coverage under this Plan. The Plan must honor the terms of a QMCSO, provided it meets certain requirements. If the Plan receives an order which may be a QMCSO, the Plan Administrator will notify you (and all parties covered by the order), determine whether the order is QMCSO and, if it is, ensure that the alternative recipients are treated as beneficiaries under the Plan for ERISA reporting and disclosure. If you have any questions about QMCSOs, please contact the Plan Administrator.

## **COBRA CONTINUATION COVERAGE**

You and your Eligible Dependents have the right to continue your medical coverage (and dental, if applicable) under this Plan on a self-pay basis, if coverage would otherwise terminate due to a qualifying event. This provision does not apply to Life Insurance, Accidental Death and Dismemberment. ***Qualifying event*** means one of the following occurrences which would otherwise terminate your or your Eligible Dependent's coverage in the absence of this provision:

- your loss of eligibility;
- your retirement;
- your death;
- your entitlement to Medicare;
- your divorce or legal separation;
- with respect to your Dependent child, his/her ceasing to satisfy the Plan's definition of an Eligible Dependent.

It is your or your Eligible Dependent's responsibility to notify the Plan Administrator, in writing, of any of the following qualifying events: your death, your divorce or legal separation, or your Dependent child's ceasing to satisfy the Plan's definition of an Eligible Dependent. You and/or your Eligible Dependents must provide such notification within 60 days after the later of:

- the date of the qualifying event; or
- the date your Eligible Dependent would otherwise lose coverage due to the qualifying event.

If the Plan does not receive written notice of any such event within that 60-day period, your Eligible Dependent(s) will not be eligible for COBRA continuation coverage.

### ***Election Period***

You and/or your Eligible Dependents may elect to continue coverage within 60 days of the later of:

- the date you and/or your Eligible Dependents would otherwise lose coverage due to the qualifying event; or
- the date you and/or your Eligible Dependents are notified of your right to elect the continuation coverage.

Such election must be in writing, on a form provided by the Plan Administrator. Elected benefits will be continued provided:

- the election form is duly completed and returned to the Plan Administrator within the 60-day period noted above; and
- the initial required premium is paid to the Plan Administrator within 45 days of your and/or your Eligible Dependent's election and is subsequently remitted to the Plan Administrator on a timely basis for your and/or your Eligible Dependent's behalf.

### ***Continuation Period***

Coverage may continue on a self-pay basis as follows:

**A** Coverage for you and/or your Eligible Dependents may be continued for up to 18 months,\* if coverage terminated due to your:

- loss of eligibility; or
- retirement.

**B** Coverage for your Eligible Dependents may be continued for up to 36 months, if coverage terminated due to:

- your death;
- your entitlement to Medicare;
- divorce or legal separation; or
- with respect to your Dependent child, his ceasing to satisfy the Plan's definition of an Eligible Dependent.

**C** Coverage may be continued for up to 29 months if:

- you or any of your Dependents were totally disabled before your COBRA continuation coverage started or within the first 60 days of that coverage; and
- the disabled person is determined by the Social Security Administration to have been Totally Disabled within the 18-month COBRA continuation period; and
- the Plan Administrator is notified of that determination during the 18-month COBRA continuation period.

If your Dependent's coverage is continued for reasons listed under paragraph (A) of this section, and, during the initial Continuation Period, a Qualifying Event occurs which entitles the Dependent to continue coverage under paragraph (B) of this section, your Dependent may elect to continue coverage for up to a combined maximum of 36 months--in other words, the total period of coverage will never exceed 36 months from the date of the first qualifying event.

### ***COBRA Premium***

- The Trustees will set premium payments according to federal law, which allows the premium to cover the full cost to the Plan plus administrative expenses. If the cost changes, the Plan Administrator will revise the charge you are required to pay. In addition, if the benefits change for active Members, your coverage will change as well.
- You and/or your Eligible Dependent(s) who elect to continue coverage, will be solely responsible for the payment of the monthly premium for such continued coverage. If an election is made after the qualifying event, premium payment for continuation coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the premium may be paid in monthly installments within 30 days after the first of the month in which coverage is provided.

UNDER NO CIRCUMSTANCES WILL THE OPTION TO MAKE SELF-PAYMENT TO THE HEALTH & WELFARE FUND BE PERMITTED ON A RETROACTIVE BASIS. PAYMENTS MUST BE MADE CONTINUOUSLY AND WITHOUT INTERRUPTION, FAILURE TO MAKE THE MONTHLY PAYMENT WHEN DUE WILL RESULT IN THE TERMINATION OF YOUR HEALTH COVERAGE. THE FUND INTENDS TO PROVIDE YOU WITH NOTIFICATION OF YOUR LOSS OF ACTIVE COVERAGE BY FIRST CLASS MAIL TO YOUR LAST ADDRESS ON FILE AT THE PLAN ADMINISTRATOR. THE FUND ASSUMES NO RESPONSIBILITY OR LIABILITY IF YOU ALLOW YOUR COVERAGE TO TERMINATE. IF YOU HAVE ANY REASON TO BELIEVE THAT YOUR ELIGIBILITY WILL OR HAS TERMINATED, IT IS YOUR RESPONSIBILITY TO CONTACT THE PLAN ADMINISTRATOR TO VERIFY YOUR ELIGIBILITY STATUS. YOU HAVE THE RIGHT TO ELECT SELF-PAYMENT ONLY FOR THE HEALTH COVERAGE (PLAN OF BENEFITS) YOU WERE COVERED UNDER PRIOR TO THE TERMINATION OF ELIGIBILITY.

### ***Termination of COBRA Coverage***

Coverage under COBRA will cease on the first of the following dates:

- the date the Plan terminates;
- the date the required premium is due and unpaid after the applicable grace period;
- the date you and/or your Dependents become eligible for Medicare; or
- the date the applicable period of continuation is exhausted; or
- the date you and/or your Eligible Dependents become insured under another group plan. Please contact the Plan Administrator for additional information, when you and/or your Eligible Dependents become insured under another group plan.

Full details of COBRA continuation coverage will be furnished to you or your Eligible Dependents, when the Plan Administrator receives notice that one of the qualifying events shown above has occurred. Therefore, we urge you and your Eligible Dependents to contact the Plan Administrator as soon as possible after one of those events.

### **MEDICAL PLAN BENEFITS -Active and Retirees and Dependents**

IUOE Local 57 Health & Welfare medical coverage for Active and Retired employees is HealthMate Coast to Coast from Blue Cross Blue Shield of RI. A Benefit Summary and other medical coverage information can be found under Appendix A. A full description of coverage can be found in the Blue Cross Blue Shield Health Mate Coast to Coast Subscriber Agreement. A copy of the full agreement can be found at the Blue Cross of RI website BCBSRI.COM with other valuable information or by contacting the plan administrator. Medical Insurance includes the following:

- Blue Cross Blue Shield HealthMate Coast to Coast (\$250 individual deductible)
- Prescription Drug Coverage ( 20% co-insurance)
- Prescription Eyewear (\$100 max per member per year)

### **DENTAL PLAN BENEFITS -Active Employees and Dependents only**

IUOE Local 57 Dental coverage for Active employees is Delta Dental PPO Plus Premier. A Benefit Summary and other dental coverage information can be found under Appendix B. Delta Dental Insurance includes the following:

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|--------------------------------|-----------|
| ▪ Annual Maximum               | \$2000    |
| ▪ Orthodontic Lifetime Maximum | \$2000    |
| ▪ Implant Lifetime Maximum     | \$3500    |
| ▪ Maximum Lifetime Cap         | unlimited |