Benefit Eligibility

Acadian Companies provides medical coverage to eligible employees and dependents. To become eligible you must meet the following criteria:

1. Employee. To be eligible to enroll as an Employee, an individual must be:
   a. A full-time Employee or Full-Time Equivalent, as designated by Employer.
2. Dependent. To be eligible to enroll as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Claims Administrator that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in the Benefit Plan.

   a. Spouse is defined as an employee's legal spouse, common law not recognized.
   b. Children: A child under age twenty-six (26) who is one of the following:
      (1) born of the Employee; or
      (2) legally placed for adoption with the Employee; or
      (3) legally adopted by the Employee; or
      (4) a child for whom the Employee or his Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Employee or his Spouse is a court appointed tutor/tutrix; or
      (5) a child supported by the Employee pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); Employees and beneficiaries of the Benefit Plan may obtain, without charge, a description of procedures for QMCSO determination from the Plan Administrator; or
      (6) a stepchild of the Employee; or
      (7) a grandchild residing with the Employee, provided the Employee has been granted legal custody or provisional custody by mandate of the grandchild; or
      (8) the Employee's child, or grandchild in the legal custody of and residing with the Employee, who is incapable of self-sustaining employment by reason of being mentally or physically disabled prior to attaining age twenty-six (26). The Employee must furnish Company with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's 26th birthday. The Plan may require subsequent proof once a year after the initial two-year period following the child's 26th birthday.

Enrollment Guidelines

Your benefit enrollment along with dependent documents must be received within 30 days from your date of hire or qualified change of family status/special enrollment right (as allowed under IRS Section 125 and the Plan). Any election made in the initial 30 days will continue for the remainder of the year (unless a qualifying event occurs). If the enrollment

and dependent documentation is not received within 30 days from the date of hire or qualified change of family status/special enrollment, coverage will not commence. This also means if dependent documents are not received, the requested coverage for the dependent (spouse and/or child(ren)) may not occur.

The next opportunity to make a change to a benefit election will occur during Open Enrollment and take effect January 1st of the following year.

If an employee and/ or eligible dependents decline the option for coverage and at a later time request coverage, the employee may be subject to enrollment limitations set forth by the Benefit Plan.

An initial COBRA notification will be mailed from the COBRA Administrator, explaining opportunities for temporary continuation of health care coverage (in the event an eligible employee and/ or a dependent have a qualifying circumstance).

Pre- Tax Enrollment Considerations

Employees are advised that some of the benefit plans offered are pre-tax benefits under our Cafeteria Section 125 plan whereby all employee paid contributions are deducted from pre-tax earnings. When premiums are deducted on pre-tax basis, the employee's take home pay is increased because the premiums are subtracted from the gross pay before taxes are applied. Pre-tax deductions also lower the taxable income for the year by the amount of the total payroll deduction for insurance premiums.

Individuals enrolled in a pre-tax Cafeteria Section 125 Plan benefit are only allowed to enroll or drop coverage during the annual open enrollment period unless there is a qualifying event. All elections made during this open enrollment period will remain in effect until end of the plan year.

Qualifying Event

One of the stipulations of a tax advantage plans is that coverage must remain in force until the beginning of the new plan year unless there is a qualifying event or change in family status.

A qualifying event or family status change may include:

- Birth or adoption of a child
- Marriage or divorce
- Death of a spouse or dependent
- Change in spouse's employment status

The qualifying event must be reported to the Human Resources / Benefits Department along with all required documentation within 30 days of the event to ensure coverage.

Continuation While Not Working

Acadian Ambulance Service's policies allow for insurance coverage to be maintained for a specified period (see below) in the event that you are not actively at work (as long as biweekly premiums are paid in full and on time).

- Group Health, Dental, Vision, Flexible Spending Account(s), Optional Life, Basic Life, Accidental Death and Dismemberment, and Aflac products can be maintained for a period of six (6) months as long as applicable premiums are paid by both employee and employer.
- Disability coverage will continue as outlined by the plans (if applicable); however, Short Term Disability premiums must be paid for the entire 6 months following last date worked (unless approved for Long Term Disability).

In the event an employee does not receive a paycheck due to not being actively at work (Worker's Compensation, qualified Family Medical Leave, Disability, or for any other approved reason), it is the employee's responsibility to remit premium payments directly to Human Resources. Payments are due by each scheduled Acadian "Pay date" (exact dates available on the Benefits tab of the Intranet). There will be a 30-day grace period following this due date. If a premium is not paid by the conclusion of the grace period, then coverage will be cancelled for non-payment.