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Benefit FAQs

General Benefit Questions

1. When am I eligible for benefits?
2. Where do I go to enroll?
3. What is a "cafeteria-style" plan?
4. Can I change my benefit elections mid-year?
5. Is a common-law marriage the same as a domestic partnership?
6. What can I access at anthem.com or through the Sydney Health mobile app?
7. What is Health Advocate?
8. What can Health Advocate assist with?
9. Is there a cost to use Health Advocate?
10. How do I contact Health Advocate?

Medical

11. How does medical insurance work?
12. How are the plans different?
13. Why can't I have a Health Savings Account (HSA) with the HDHP plan?
14. How do I know which plan to select?
15. Can I continue to contribute to or use my Health Savings Account if I switch to the PPO or HDHP plan?
16. How does a Flexible Spending Account (FSA) work with the medical plans?
17. What is considered preventative care?
18. What is Hinge Health?
19. What does the program include?
20. Is there a cost?
21. How do I get support?
22. When should I consider using Hinge Health?
23. What is Transcarent?
24. What procedures does Transcarent offer?
25. What is the cost?
26. How do I get started?
27. Is Transcarent part of my medical plan through Anthem?

Dental

28. What is the difference between the Base and Buy-Up plan?
29. Is orthodontia covered?
30. What is the difference between the deductible and the annual maximum on a dental plan?
31. What is the cost of preventive dental care?
32. What is preventive dental care?
33. What are the benefits of preventive dental care?
34. How do I access my dental card?

Vision

35. What is the difference between the Base and Buy-Up plan?
36. Can I file a claim for out-of-network eyeglasses?
37. What does it mean by "frequency period"?
38. What is the cost of preventive vision care?
39. What is vision preventive care?
40. What are the benefits of preventive vision care?
41. Can I use the plan at Eye Pieces?
42. How do I access my vision insurance card?

Flexible Spending Accounts

43. What is a Flexible Spending Account (FSA)?
44. How much can I contribute to an FSA?
45. When am I eligible for an FSA?
46. If I am currently enrolled in the HSA medical plan, can I have an FSA?
47. Can I change my FSA or Dependent Care FSA (DCFSA) amount mid-year?
48. How do I access my account?
49. What happens if I don't use all of my funds by the end of the year?

Health Savings Accounts

50. What is a Health Savings Account (HSA)?
51. How does a HSA work?
52. Does East West Family of Companies contribute to my HSA?
53. What happens to the money if I am no longer working for East West Family of Companies?
54. How much can I contribute?
55. How do I access my account?

Supplemental Coverages: Voluntary Accident, Critical Illness, and Hospital Indemnity

56. What is Supplemental coverage?
57. How does Voluntary Accident coverage work?
58. How does Critical Illness coverage work?
59. How does Hospital Indemnity coverage work
60. How do I file a claim?

Voluntary Elections

61. Do I need Voluntary Life coverage if I get basic coverage?
62. Is Accidental Death & Dismemberment (AD&D) different from Life Insurance?
63. How does Pet Insurance work?
64. What is the difference between Legal Insurance and the ID Theft coverage?

401(k)

65. When will I be eligible for 401(k)?
66. How do I change my 401(k) election?
67. Why and How to designate a beneficiary?

Qualifying Life Event (QLE)

68. What is a QLE?
69. How do I request a QLE?
70. What do I need to complete a QLE?

General Benefit Questions

1. When am I eligible for benefits?
You are eligible for benefits on the 1st of the month following a full month of employment in the Full-time Year Round status.

2. Where do I go to enroll?
Enrolling is done at the same site where you complete on-boarding as well as access your time sheets and pay statements at **app.rippling.com/sign-in/id**.

3. What is a "cafeteria-style" plan?
"Cafeteria-style" means that you are able to pick and choose from most of the offerings including the voluntary elections. The options can be selected a-la-carte, so you decide which plans you want as well as which dependents you want on each plan.

4. Can I change my benefit elections mid-year?
You can only make changes outside of the Open Enrollment period if you experience a Qualifying Life Even (QLE) such as, marriage, divorce, birth or adoption of a child, among other things. For a more detailed explanation on QLE including how to request one and what information you will need to complete the process please see page 9.

5. Is a common-law marriage the same as a domestic partnership?
No. The state of Colorado recognizes common-law marriage the same as a ceremonial marriage, a domestic partnership does not meet the requirements for a partner to be considered a dependent. Please visit the Colorado department of revenue for more information **tax.colorado.gov/common-law-marriage**.

6. What can I access at anthem.com or the Sydney Health mobile app?
By registering online with Anthem you will have access to finding in-network care; track claims and out of pocket payments towards your deductible and max-out- of-pocket; view, print, or email Insurance Cards; access virtual health; many behavioral health options; and much more.

7. What is Health Advocate?
Health Advocate is a free, confidential service that helps employees and their families navigate healthcare and insurance-related issues. Services include enrollment assistance and plan questions, finding providers, resolving billing issues, understanding diagnoses, and more.

8. What can Health Advocate assist with?
- Assistance in understanding and choosing the plan that is best for you
- Finding in-network doctors and specialists
- Scheduling appointments
- Clarifying medical bills and insurance claims
- Explaining diagnoses and treatment options
- Coordinating second opinions
- Supporting eldercare and special needs services.

9. Is there a cost to use Health Advocate?
The service is provided at no cost to eligible employees and their families.

10. How do I contact Health Advocate?
You can reach Health Advocate 24/7 by phone at 866-989-2972 or online at **HealthAdvocate.com/eastwest** or by downloading the Health Advocate mobile app. Registration code eastwest.

Medical

11. How does medical insurance work?
The key terms to know:

Deductible — This is the amount you pay out of pocket before the plan starts paying. This can happen with one high medical expense or as an accumulation of smaller expenses until the deductible is reached.

Coinsurance — After the deductible is reached, the remaining balance of a large expense and future expenses are subject to this cost-share where the plan will cover 80% of the cost to your 20%.

Copay — This is a flat fee you pay for specific health care services, such as doctor or specialist visits as well as prescription drugs.

Out-of-pocket maximum — This is the total amount you are responsible for all medical expenses in the plan year. It is the accumulation of the deductible + your portion of coinsurance. Additional medical expenses would be covered entirely by the plan.

12. How are the plans different?
Below is a simple comparison chart highlighting the main differences in the plans.

Coverage amounts are for In-network providers	PPO	HSA	HDHP
Per-check Cost	Highest	Middle	Lowest
Preventative Care	Covered 100%	Covered 100%	Covered 100%
Deductible (individual/family)	$1,000/ $3,000	$2,500/ $5,000**	$6,650/ $13,300
Out-of-pocket maximum (individual/family)	$4,000/ $12,000	$5,000/ $10,000	$6,650/ $13,300
Coinsurance (Plan%/Your%)	80%/20%	80%/20%	100%*/0%
Prescription Drugs	Copay	Deductible	Copay
Flexible Spending Account	Full Medical, Dental, and Vision	Limited Dental and Vision	Full Medical, Dental, and Vision
Office Visits	Copay	Deductible	Deductible

*After deductible
**Per IRS guidelines, individual deductible is $3,500 when enrolled with dependents.

13. Why can't I have a Health Savings Account (HSA) with the HDHP plan?
While the HDHP plan is a High Deductible Health Plan, it does not meet all of the requirements put forth by the IRS to be able to pair a Health Savings Account with that plan. Due to the tax- advantaged nature of a Health Savings Account, IRS requirements are very strict regarding not receiving other cost assistance such as copays.

14. How do I know which plan to select?
It is important to use the tools available online with Anthem and Health Advocate as well as the plan information to answer questions, like:

- Am I expecting any high cost medical expenses this year such as a planned surgery or having a baby?
- Where do I currently stand with my deductible and max-out-of-pocket? Am I using the benefits I am paying for?
- Could I benefit from investing outside of the premiums, like a Health Savings Account? In the event of an unexpected expense, you could pay more up front, but a moderate to low expense means you could still be putting extra money aside.

15. Can I continue to contribute to or use my Health Savings Account if I switch to the PPO or HDHP plan?
No and Yes, a Health Savings Account has very specific rules regarding eligibility. In order to contribute to a Health Savings Account, you must be enrolled in an HSA qualified health plan and the HSA Medical Plan is the only plan we offer that is qualified to pair with a Health Savings Account. While you can no longer contribute to an HSA on a non-qualified health plan, you can continue to use the funds for any qualified expenses.

16. How does a Flexible Spending Account (FSA) work with the medical plans?
An FSA is a great option for individuals anticipating certain medical, dental, or vision expenses. Once eligible, the FSA is pre-funded with the elected amount and those funds can then be used on any qualified expenses. It is also helpful in covering high initial costs if you are on a higher deductible plan like the HDHP.

Please note if you enroll in the HSA plan, your Flexible Spending Account expenses are limited to just dental and vision expenses.

17. What is considered preventative care?
Preventative care is a specific group of services recommended when you don't have any symptoms and haven't been diagnosed with a related health issue. It includes your periodic wellness exam and specific tests, certain health screenings and most immunizations.

For a full listing, login to your **anthem.com** account, under "Coverage" select "Medical" and scroll down to Preventative Care.

18. What is Hinge Health?
Hinge Health is a digital musculoskeletal (MSK) clinic that supports a wide range of MSK conditions including pain in the back, neck, shoulders, hips, knees, ankles, and even pelvic health.

19. What does the program include?
- Personalized exercise therapy plans
- 1-on-1 health coaching
- Virtual physical therapist support
- Educational resources
- Optional wearable technology for motion tracking.

20. Is there a cost?
For eligible participants, the program is free.

21. How do I get support?
You can visit Hinge Health online at hingehealth.com, download the Hinge Health app or contact them via phone at 855-902-2777.

22. When should I consider using Hinge Health?
If you are experiencing joint, muscle or back pain, whether you're trying to avoid surgery, recovering from one, or just looking for a convenient, at-home way to manage pain.

23. What is Transcarent?
Transcarent provides Anthem health plan members access to top-rated surgeons for non-emergency, covered surgical procedures — often at little to no cost to you. Please note that Transcarent operates independently from your Anthem insurance plan, and these surgeries are not billed through Anthem.

24. What procedures does Transcarent offer?
- Cardiac
- General
- Orthopedic
- Women's Health
- Neurological
- Spine
- Vascular

25. What is the cost?
Qualified surgeries are provided at no cost to you when enrolled in the HDHP or PPO medical plans. IRS minimum guidelines apply for the HSA medical plan, requiring that the member meet a minimum deductible of $1,750 in 2027, but there is no additional cost once that is met.

26. How do I get started?
Visit Transcarent online at **member.transcarent.com**, download the Transcarent app or call them via phone at 888-781-2417.

27. Is Transcarent part of my medical plan through Anthem?
While you're eligible for Transcarent because you're enrolled in Anthem, it is a separate benefit offered outside of your health plan. Your provider may not be aware of it, so it's a good idea to mention it during your visit.

Dental

28. What is the difference between the Base and Buy-Up plan?
Both the Base and Buy-Up dental plans include preventative care and two cleanings per year.

The key differences are, the Buy-Up plan offers more coverage, with a higher annual maximum of $2,500 compared to $1,500 for the Base plan. It also covers a greater percentage of basic and major restorative procedures, including implants. Additionally, the Buy-Up plan includes orthodontia coverage, which the Base plan does not.

	Anthem Base Plan		Anthem Buy-up Plan	
$5,000 in-network expense	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual/Family	$100/$300		$50/$150	
Annual Maximum Per Person	$1,500		$2,500	
Diagnostic and Preventive	100%, no deductible			
Basic Service	80% after deductible		90% after deductible	
Major Services	50% after deductible		60% after deductible	
Orthodontia	Not covered		50% — $2,000 lifetime max	

29. Is orthodontia covered?
The Base plan does not cover orthodontia. The Buy-Up plan will pay 50-50 on approved orthodontics, up to a lifetime max of $2,000 per covered individual. The lifetime max carries year to year and does not reset at the turn of the calendar year, once it has been reached there is no more coverage for orthodontia.

30. What is the difference between the deductible and the annual maximum on a dental plan?
The deductible is how much you pay out-of-pocket before the plan starts paying. The annual maximum is how much the plan will pay after the deductible is reached for the calendar year (January 1 through December 31). Note that some diagnostic and preventative care visits are covered 100% and do not count towards the deductible or the annual maximum.

31. What is the cost of preventive dental care?
Preventive care is covered at 100% under both Base and Buy-up plans.

32. What is preventive dental care?
Preventive helps maintain good oral health through a combination of dental check-ups along with developing good habits like brushing and flossing.

Preventive dentistry services may include:

- Regular oral exams, usually every 6 months
- Teeth cleaning
- Routine X-Rays
- Fluoride treatments. Only for children under the age of 19

33. What are the benefits of preventive dental care?

- Lower your risk for developing tooth decay, gum disease, and more serious dental problems.
- Early identification of dental problems may help minimize treatment and cost.
- Enables your dentist to do a full exam of your mouth, jaw, neck, etc. to identify any related problems, including some cancers.
- Can help reduce your risk of medical conditions such as heart disease and diabetes.

34. How do I access my dental card?
Anthem doesn't provide a separate dental card. Your dental care provider can pull your information by using your medical card. You can still access a dental card by logging in to **anthem.com** or downloading the Sydney Health mobile app.

Vision

35. What is the difference between the Base and Buy-Up plan?
While the Base and Buy-Up plan share the same exam coverage, you will see differences in coverage for the elective contact lens allowance as well as the frame allowance. The other main difference is the frequency period for frames is 12 months with the Buy-Up plan and 24 months with the Base plan, meaning the plan covers new frames every year with the Buy-Up plan and every other year with the Base plan.

	Anthem Base Plan		Anthem Buy-up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam Copay	$10	Up to $45	$10	Up to $45
Material Copay	$20	N/A	$10	N/A
Frequency Period Exam Lenses or contacts Frames	12 months 12 months 24 months		12 months 12 months 12 months	
Basic Service	Up to $130 after copay	Up to $71	Up to $250 after copay	Up to $71

36. Can I file a claim for out-of-network eyeglasses?
Yes, you can fill out a claim form for out-of-network vision expenses at **anthem.com**. The completed form must be submitted along with an itemized receipt to receive the reimbursement.

37. What does it mean by "frequency period"?
Both vision plans go by a frequency period that begins January 1 and goes through December 31. The frequency period resets at the next calendar year (January 1). As an example, purchasing contact lenses in June does not mean you have to wait until June of the next year to purchase again. The frequency period resets on January 1.

38. What is the cost of preventive vision care?
Your annual exam is covered 100% after your $10 copay under both plans when seeing an in-network provider.

39. What is vision preventive care?
Preventive vision care can give you and your eye care provider the opportunity to detect and treat potential disease early.

Preventative vision care may include:

- Vision testing
- Glaucoma testing
- Wellness examinations

40. What are the benefits of preventive vision care?
A yearly eye exam allows your eye care provider to monitor your vision and eye health over the long-term, can help detect signs of medical conditions such as:

- High blood pressure
- Heart disease
- Diabetes
- and many more

41. Can I use the plan at Eye Pieces?
Yes. Simply let an Eye Pieces associate know that you are an East West employee, and they will apply a 30% discount after they process your vision claim through your East West vision insurance. You can contact Eye Pieces at 970-476-1947.

42. How do I access my vision insurance card?
Anthem doesn't provide a separate vision card. Your vision care provider can pull your information by using your medical card. You can still access your vision coverage information by login in to **anthem.com** or downloading the Sydney Health mobile app.

Flexible Spending Accounts

43. What is a Flexible Spending Account (FSA)?
A Flexible Spending Account is a special account you put money into that you use to pay for certain out-of-pocket health care cost. You don't pay taxes on this money. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. One thing to note, these are use it or lose it accounts.

There are 3 types of FSAs:

- Healthcare FSA — can be used for all eligible medical, dental and vision expenses.
- Limited Purpose FSA — can only be used with dental and vision expenses. This account is available when enrolled in the HSA medical plan.
- Dependent Care FSA — can be used to pay for childcare expenses, such as daycare.

44. How much can I contribute to an FSA?
The IRS sets annual contribution maximums to these accounts, due to their tax-advantaged benefit.

- FSA (both Limited and Healthcare) — $3,400
- DCFSA — $5,000

It is important to note that these are use it or lose it accounts and unused funds could be forfeit.

45. When am I eligible for an FSA?
Because the FSA is a pre-funded account, new employees are eligible to enroll the first of the month following 6 months of being a full-time year-round employee.

The Dependent Care FSA is eligible the same date as you are eligible for benefits. The contributions are not available to be used until they are posted into your account.

46. If I am currently enrolled in the HSA medical plan, can I have an FSA?
If enrolled in the HSA Medical Plan you can also elect a Limited Purpose FSA to help cover dental and vision expenses. There is no reimbursement for medical or prescription drug expenses with a limited purpose FSA.

47. Can I change my FSA or Dependent Care FSA (DCFSA) amount mid-year?
You can make changes to the elected amounts if you experience a qualifying life event.

Please contact the Benefits department at **benefits@eastwest.com** or 970-790-3102 if you feel that you have experienced a QLE and would like to change your election.

48. How do I access my account?
Simply login to **401k.com** to manage your accounts, file claims, and/or request new cards.

49. What happens if I don't use all of my funds by the end of the year?
These are use-it-or-lose-it accounts, meaning any unused funds after the plan year would be forfeit. There is a run-out period that goes until mid-March of the next year to allow you to file for reimbursements, this helps for expenses for care or dependent care in the month of December.

The IRS does allow for $680 of Healthcare and Limited Purpose FSA to roll over to the next plan year, but the Dependent Care FSA does not have any rollover amount.

Health Savings Accounts

50. What is a Health Savings Account (HSA)?
A Health Savings Accounts (HSA) is a type of savings account that lets you set aside money on a pre-tax basis that can be used to pay for qualified medical, dental or vision expenses. This account is yours and rolls over whether you use the funds during the year or not. HSAs offer a triple tax advantage: contributions are tax-deductible, interest growth is tax-free, and withdrawals for qualified medical expenses are tax-free.

51. How does a HSA work?
A Health Savings Account works like an FSA in functional use but has a few key differences.

- Health Savings Accounts are not pre-funded
- Contributions are available as the funds are deducted from your paycheck and/or quarterly from the employer contribution.
- Contribution amounts can be changed at any time throughout the year.
- Available funds rollover year-to-year and can be taken with you if you leave the company or change to a non-qualified medical plan.

52. Does East West Family of Companies contribute to my HSA?
East West Family of Companies will contribute to employee HSAs as follows; $250 for employee only, $500 for employee + spouse, and $750 for employee + child(ren) or family coverage.

53. What happens to the money if I am no longer working for East West Family of Companies?
The account stays with you. Much like a 401(k), the funds you contribute into your account are yours whether still employed with us or not.

54. How much can I contribute?
While there is no minimum you can contribute, the IRS sets annual maximums of $4,500 under an individual medical plan and $9,000 under an individual plus family member(s) plan. If you are aged 55 or older during the tax year, you may also be eligible to make an additional $1,000 catch-up contribution annually.

55. How do I access my account?
You can visit 401k.com or call Fidelity at 800-544-3716. They will be able to assist in ordering a new card, investing your savings, and managing your payments.

Supplemental Coverage: Voluntary Accident, Critical Illness, and Hospital Indemnity

56. What is Supplemental coverage?
Supplemental coverage provides a payment directly to you. This means in the event of an incident covered by a supplemental policy, you would file a claim and decide how best to spend the money.

57. How does Voluntary Accident coverage work?
There are fixed cash payments dependent on the treatment and injuries in the case of an accident. ER visit, fractures/dislocations, follow-up visits, physical therapy and more. Treatment you receive as a result of an accident still goes through your medical plan (if applicable), you would file a separate claim to receive a payment where you decide how to spend it. This can help with out-of-pocket expenses like your deductible, personal expenses if you have to miss work, you can even hang on to it for extra expenses down the road. The check is sent to you, and you decide how it will best help you.

This benefit is included with enrollment in the HSA Medical plan as well as the HDHP Medical plan. You have the option to enroll in this benefit if you are enrolled in the PPO Medical plan.

58. How does Critical Illness coverage work?
You elect the amount of coverage you want; $5k, $10k, or $20k; and in the event of being diagnosed with a critical illness that amount would be paid as a lump sum to you. As a supplemental coverage, the payment is for you to decide how best to use it whether it be medical expenses, personal expenses if time away from work is needed, or held onto for extra financial security while recovering.

Some covered critical illnesses are cancer, heart attack, stroke, organ transplant and more.

59. How does Hospital Indemnity coverage work?
Hospital Indemnity Insurance coverage provides a benefit payable upon a stay in a covered medical facility or other covered loss. Use your paid benefit for any purpose, such as paying out-of-pocket medical expenses, copays, deductibles, groceries, gas, utilities and more, it's up to you.

60. How do I file a claim?
Easily submit your claims online:

- Step 1: Visit **https://presents.voya.com/EBRC/EastWestPartners**
- Step 2: Complete the questionnaire
- Step 3: Download your claim form package, if applicable
- Step 4: Complete the form package and gather supporting documents, if applicable
- Step 5: Submit your claim
- Step 6: Monitor your claim's status
- You can also call 877-236-7564 to file your claim

Voluntary Elections

61. Do I need Voluntary Life coverage if I get basic coverage?
Life Insurance is an important part of your financial security, especially if others depend on you for support. Life insurance offers your family financial resources and support at the time of your death.

Basic Life includes up to 1.5X your annual basic earnings (some exclusions apply), up to a max benefit of $200,000. This coverage is 100% tied to your employment. If you leave your position at East West, your coverage will end.

Additional Voluntary Life Insurance can increase your financial security in addition to any basic life coverage. Coverage can be elected in increments of $10,000 for the employee up to the lesser of 5X your salary or $500,000. Voluntary Life and AD&D is a 100% portable plan, if you leave employment with East West you can take this plan with you.

62. Is Accidental Death & Dismemberment (AD&D) different from Life Insurance?
Accidental Death and Dismemberment insurance is designed to provide additional benefits in the event of accidental death or loss of a limb or vision (dismemberment) but does not cover death from a natural cause. Life Insurance covers for death both accidental and natural.

63. How does Pet Insurance work?
As part of East West Family of Companies you can receive preferred pricing through Nationwide Pet Insurance. This is administered by Nationwide and can be added or canceled at anytime throughout the year and payments are made directly to Nationwide. Go to **benefits.petinsurance.com/ewpartners** or call 877-738-7874 to speak with a specialist.

64. What is the difference between Legal Insurance and the ID Theft coverage?
Legal Insurance through MetLife gives participants access to a nationwide network of law firms for things such as selling, purchasing, or refinancing a home; wills, living trusts, name changes, premarital agreements; civil litigation defense; debt collection; and more.

ID Theft protects you and your dependents' identity and finances on the internet and mobile devices.

401(k)

65. When will I be eligible for 401(k)?
Employees are eligible for the 401k the first of the month following 2 months from their hire date.

66. How do I change my 401(k) election?
You are auto-enrolled at 6% once eligible. You can change your election or opt-out by logging into **401k.com** or by calling Fidelity at 800-835-5095.

67. Why and How to designate a beneficiary?
Naming a beneficiary for your 401(k) ensures that your retirement savings are passed on quickly and efficiently to the person you choose, without the delays and costs of probate. To make your designation, simply login to **401k.com**.

Qualifying Life Event (QLE)

68. What is a QLE?
A qualifying life event (QLE) makes you eligible for a special enrollment period. It's an event that may trigger a need for health insurance or to make changes to your health plan.

Events such as having a child, losing coverage elsewhere, or getting married/divorced allows you to make changes to your elections within 30 days of the event.

69. How do I request a QLE?
Contact the Benefits Department as soon as you know or think you might have a QLE and we will help guide you through the process. Remember, you only have 30 days from the event to make changes. **Benefits@eastwest.com** or 970-790-3102.

70. What do I need to complete a QLE?
QLEs require proof of the event. The chart below gives some examples of what kinds of documents would be needed for different QLEs.

QLE	Examples	Effective Date	Proof of Eligibility
Birth or adoption	Gaining a new dependent due to a new birth or adoption of a child	Date of birth or adoption	Copy of a birth certificate or adoption papers with effective date
Death of dependent	Passing of a spouse or eligible child	Date of passing	Copy of a certificate of death
Dependent gains benefits elsewhere	Spouse or eligible child starts receiving benefits through an employer or Medicare	Date new insurance becomes active	Letter from new employer or insurance provider stating the date the new coverage begins and the name of your dependent receiving the benefit
Dependent loses coverage elsewhere	Spouse or eligible child separates from an employer and loses coverage	First day dependent does not have coverage. This date can be different from the separation date.	Letter from employer or insurance provider stating the dependent's name and date that coverage ends. COBRA notice with eligibility date will also work
Divorce	Divorce	Date divorce is finalized	Copy of court decree with date of divorce
Marriage	Marriage or common- law marriage	Effective date of marriage	Copy of marriage certificate
Employee Loses coverage elsewhere	Aging out of being a dependent on another plan. Spouse loses coverage on which you are covered as a dependent.	First day that you do not have coverage. This date can be different from the date of aging out or spouse's separation date.	Letter from employer or insurance provider stating the date your coverage ends. COBRA notice with the eligibility date will also work

You have 30 days from the event to provide documentation to the Benefits Department.