AMENDMENT NO. 1
FOR
CITY OF BOWLING GREEN
MEDICAL FLEXIBLE SPENDING ACCOUNT PLAN

I. The section “BENEFITS” shall be amended as follows:

The subsection “Amount of Reimbursement” shall be deleted in its entirety and the following substituted therefore:

**AMOUNT OF REIMBURSEMENT**

A participant shall be entitled to benefits under the Plan for a plan year in an amount that does not exceed the participant’s medical reimbursement benefits. The amount of a participant’s medical reimbursement benefits shall be uniformly available during the plan year. In no event shall the Plan reimburse qualified expenses during a plan year for an amount exceeding the maximum annual dollar limitation established by the IRS ($2,500 for 2014) plus the applicable carryover amount set forth in the Plan.

II. The section “PAYMENTS” shall be amended as follows:

The following subsection shall be added after the subsection “Payment of Benefits”:

**CARRYOVER OF BENEFITS**

In the event any balance remains in the participant’s benefits account at the end of a plan year, there applies a carryover of up to $500. The amount that may be carried over to the following plan year is equal to the lesser of (i) any unused amounts from the immediately preceding plan year, or (ii) the carryover amount specified under the Plan. So long as a claim for benefits is timely filed (see Claims Procedure section below), (i) reimbursements for qualified expenses incurred during the prior plan year and not previously reimbursed shall be made from the prior plan year’s benefits account until the balance is exhausted and (ii) reimbursements for qualified expenses incurred during the current plan year shall be made first from the current plan year’s benefits account until that balance is exhausted and then from the carryover amount to the extent necessary.

In no event shall a participant be reimbursed for qualified expenses during a plan year for an amount exceeding the annual dollar limit established by the IRS ($2,500 for 2014) plus the lesser of (i) any unused amounts from the immediately preceding plan year; or (ii) the carryover amount specified under the Plan.

III. The section “PAYMENTS” shall be amended as follows:

The subsection “Forfeiture of Benefits” shall be deleted in its entirety and the following substituted therefore:

**FORFEITURE OF BENEFITS**

A participant forfeits any balance reflected in the benefits account that exceeds the Plan’s allowable carryover amount for a plan year to the extent not paid under a claim for qualified expenses incurred that is provided to the plan administrator within ninety (90) days after the earlier of: (i) the last day of the plan year or (ii) the last day of participation in the Plan. Upon such forfeiture, the participant’s benefits account shall be reduced to any allowable carryover amount. At the direction of the employer, forfeitures
of benefits under the Plan may be reallocated to participants in any reasonable manner. Forfeitures of benefits may also be applied towards the cost of administering the Plan. In no event shall any forfeitures be subject to the claim of any current or former participant, spouse or dependent or any of their successors or assigns. In addition, any benefit payments that are unclaimed (uncashed benefit checks) by the end of the sixth month following the end of the plan year in which the qualified expense was incurred shall be forfeited and applied as described in this section.

Effective: January 1, 2014

Received and accepted for – City of Bowling Green

By: ________________

Title: John S. Fawcett, Municipal Administrator

Date: March 27, 2014
CITY OF BOWLING GREEN

MEDICAL FLEXIBLE SPENDING ACCOUNT PLAN

PLAN DOCUMENT

Effective Date: January 1, 2013
INTRODUCTION

CREATION AND TITLE

The City of Bowling Green hereby amends and restates this Plan under the terms and conditions set forth in this document. The Plan is to be known as City of Bowling Green Medical Flexible Spending Account Plan.

EFFECTIVE DATE

The provisions of the Plan, as amended, shall be effective as of January 1, 2013. The Plan was originally effective January 1, 2001.

PURPOSE

The purpose of the Plan is to allow participating employees to use pretax dollars to receive reimbursements for eligible out-of-pocket health care expenses incurred by them (and/or their spouse or eligible dependents) and not otherwise covered by a group health plan sponsored by the employer. The employer intends that the Plan qualify as a nondiscriminatory flexible spending arrangement under Section 125 of the code (and application regulation) and a nondiscriminatory accident and health plan under Section 105(e) of the code.
DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in **bold and italics** throughout the document.

**Benefits Account**

The administrative account established by the plan administrator under the Plan for each participant based on which medical reimbursement benefits shall be paid.

**Claims Processor**

CoreSource, Inc.

**Code**

The Internal Revenue Code of 1986, as amended from time to time.

**Compensation**

All the earned income, salary, wages, and other earnings paid by the employer to a participant, including any amounts contributed by the employer pursuant to a salary reduction agreement, which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the code.

**Dependent**

An individual who is a dependent (within the meaning of Section 152(a) of the code) of a participant in the Plan.

**Effective Date**

The provisions of the Plan, as amended, shall be effective as of January 1, 2013. The Plan was originally effective January 1, 2001.

**Eligible Employee**

An employee who has met the eligibility requirements of the Plan as set forth herein.

**Employee**

An individual employed by the employer who is regularly scheduled to work at least forty (40) hours per work week.

A non-temporary part-time salaried or exempt individual if their salary is based on 50% of the salary for a full-time hire into the same or similar position. A non-temporary part-time hourly individual who was hired to work a minimum of 1,250 hours per calendar year.

This does not include: (i) an employee who owns on any day during the plan year more than two percent (2%) of the total combined voting power of all stock of the employer if the employer is an S corporation as defined in Section 1361(a)(1) of the code, and (ii) an individual who is a self-employed individual or an owner-employee within the meaning of Section 410(c) of the code.
**Employer**

City of Bowling Green or any successor by merger, consolidation, or purchase of substantially all of its assets and shall also include any of its affiliates, successors or assignors which adopt the Plan with the approval of City of Bowling Green.

**Entry Date**

For each employee, the first day of the month coincident with or next following the day that the employee becomes eligible to participate in the Plan.

**Incurred or Incurred Date**

For purposes of the Plan, a medical expense is incurred on the date when the underlying services or products giving rise to the medical expense are performed or supplied and not on the date that the services or products are billed by the provider or paid by the participant.

**Medical Reimbursement Benefits**

For any plan year, the amount available to a participant as benefits under the Plan in the form of reimbursements of qualified expenses.

**Over-the-Counter Drugs**

Items which are legally procured without a prescription and which are generally accepted as falling within the category of medicine and drugs. Over-the-counter drugs do not include toiletries or similar preparations (such as toothpaste, shaving lotion, shaving cream, etc.), cosmetics (such as face creams, deodorants, hand lotions, etc. or any similar preparation used for ordinary cosmetic purposes), or dietary supplements that are merely beneficial to the general health of the individual (such as vitamins, etc.). The plan administrator has the sole discretionary authority to implement additional restrictions on the type or amount of items that qualify as over-the-counter drugs for purposes of this Plan.

**Participant**

Any employee who has met the eligibility requirements of the Plan and has elected to participate in the Plan by providing the plan administrator with a completed participation agreement.

**Participation Agreement**

The agreement by an eligible employee that sets forth the employee’s: (i) election to participate in the Plan, (ii) election of the amount of medical reimbursement benefits to be made available to the participant for a plan year as reimbursement for qualified expenses, and (iii) authorization of the employer to reduce the employee’s compensation while a participant during the plan year and to credit the participant’s benefits account by such amount under the Plan.

**Plan**

City of Bowling Green Medical Flexible Spending Account Plan, as described herein.

**Plan Administrator**

The employer or such other person or committee as may be appointed by the employer to administer the Plan.

**Plan Sponsor**

The plan sponsor is City of Bowling Green.
**Plan Year**

The twelve (12) consecutive month period beginning on January 1st and ending on December 31st.

**Privacy Rule**

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and any amendments thereto; and the HIPAA Security and Privacy rule, 45 CFR Parts 160 and 164, and any amendments thereto; as well as other applicable federal and state privacy and confidentiality rules.

**Qualified Expenses**

The medical expenses *incurred* during a *plan year* by a *participant*, the *participant's spouse*, or the *participant's dependents*, and that qualify as expenses for “medical care” within the meaning of Section 213(d) of the *code*. *Qualified expenses* do not include premium expenses for other health coverage, including (i) premiums paid for health coverage under a plan maintained by the employer of the *employee's spouse* or *dependent* or (ii) premiums for an individual health insurance policy. Expenses *incurred* for *over-the-counter drugs* cannot be considered *qualified expenses* unless such *over-the-counter drugs* (other than insulin) are prescribed by a physician.

**Required By Law**

The same meaning as the term “required by law” as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

**Spouse**

An individual who is legally married to a *participant*, but shall not include an individual separated from a *participant* under a decree of legal separation.
FACTS ABOUT THE PLAN

Name of Plan:
City of Bowling Green Medical Flexible Spending Account Plan

Name, Address and Phone Number of Employer/Plan Sponsor:
City of Bowling Green
304 N. Church St.
Bowling Green, Ohio 43402
419-354-6208

Employer Identification Number:
34-6400148

Group Number:
172

Type of Plan:
Flexible spending arrangement under Section 125 of the code offering medical expense reimbursement accounts and cash. The Plan is also an accident and health plan under Section 105(e) of the code.

Type of Administration:
Contract administration: The processing of claims for benefits under the terms of the Plan is provided through a company contracted by the employer and shall herein be referred to as the claims processor.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:
City of Bowling Green
304 N. Church St.
Bowling Green, Ohio 43402
419-354-6208

Legal process may be served upon the plan administrator.

Eligibility Requirements:
For detailed information regarding a person's eligibility to participate in the Plan and the events and circumstances upon which participation terminates, refer to the Participation section of the Plan.

Source of Plan Contributions:
Contributions for Plan expenses are obtained from the employer in accordance with elections of employees pursuant to participation agreements. The employer evaluates the costs of the Plan based on the participation agreements and determines the amount to be contributed by the employer.
Funding Method:

The employer pays Plan benefits and administration expenses directly from general assets. Participants, spouses and dependents shall have no legal or equitable rights, claims or interests in any specific property or assets of the employer. No assets of the employer shall be held in any way as collateral security or otherwise dedicated for payment of benefits under this Plan. Any and all of the employer’s assets shall be, and remain, the general unpledged, unrestricted assets of the employer. The employer’s obligation under the Plan shall be that of an unfunded and unsecured promise of the employer to meet the Plan’s obligations. No Plan provision concerning allocation or accounting of credits shall be construed as requiring any separate funding.

Ending Date of Plan Year:

December 31st

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, Claims Procedure.

The designated claims processor is:

CoreSource, Inc.
1811 Rahling Road, Suite 100
Little Rock, Arkansas 72223
PARTICIPATION

ELIGIBILITY

Each employee, as defined herein, shall be eligible to participate in the Plan on the first day of the month following the date of hire.

COMMENCEMENT OF PARTICIPATION

An eligible employee shall become a participant in the Plan after providing the plan administrator with a completed participation agreement setting forth the benefits to be made available to the eligible employee for the immediately following plan year or remaining portion of the plan year. As part of the participation agreement, the participant shall authorize the employer to reduce the participant’s compensation for the plan year (or the remaining portion thereof) by a fixed amount not more than $2,500 and not less than $100 that the participant elects to have credited to his or her benefits account under the Plan. The participant must, before the end of the first plan year of participation and, before the end of each subsequent plan year, provide the plan administrator with a newly executed participation agreement. Each new participation agreement shall specify the amount of medical reimbursement benefits to be made available to the participant for the immediately following plan year or remaining portion of the plan year.

TERM OF PARTICIPATION

Each participant shall be a participant in the Plan for the entire plan year or the portion of the plan year remaining after the participant’s entry date, if later than the first day of the plan year. A participant shall cease to be a participant in the Plan on the earliest of:

1. the date the participant dies, resigns or terminates employment with the employer, subject to the provisions in the section below entitled Participation By Rehired Employees;

2. the date the participant fails to make required contributions under the Plan;

3. the date the participant ceases to be an employee or otherwise becomes no longer eligible to participate under the terms of the Plan; or

4. the date the Plan terminates.

PARTICIPATION BY REHIRED EMPLOYEES

Each participant in the Plan who separates from service with the employer shall suspend participation under this Plan for the period from the date of termination to the last day of the plan year in which termination occurred. During such period of suspension, any contributions pursuant to a participation agreement shall cease. Participation in the Plan shall terminate on the first day of the next plan year, provided the terminated employee has not been rehired by the employer on such date. If a terminated employee should later be rehired by the employer in the same plan year as the plan year in which he or she separated from service, such employee may elect to resume participation in the Plan under the terms of the participation agreement in effect on the date of termination of employment.
BENEFITS

PROVISION OF BENEFITS

Benefits under the Plan shall take the form of reimbursement of qualified expenses incurred by a participant, the participant’s spouse and/or dependents during the plan year. Benefits under the Plan shall be available solely for qualified expenses incurred during the participant’s participation in the Plan.

AMOUNT OF REIMBURSEMENT

A participant shall be entitled to benefits under the Plan for a plan year in an amount that does not exceed the participant's medical reimbursement benefits. The amount of a participant's medical reimbursement benefits shall be uniformly available during the plan year.

CHANGE IN PARTICIPATION AGREEMENT

A participant may not change the amount of medical reimbursement benefits to be made available for a plan year during that plan year, except in accordance with the rules for changes in elections as set forth in the section below entitled Election Changes.

FAMILY AND MEDICAL LEAVE ACT

For any leave, and solely to the extent the provisions of the Family and Medical Leave Act of 1993 (“FMLA”) apply and such leave qualifies as a FMLA leave, the participant may remain a participant and shall be entitled to receive the same benefits as before the start of the FMLA leave, subject to the continued payment of any required contributions under the Plan. Solely to the extent required under FMLA, a participant whose medical reimbursement benefits have been suspended or terminated while on an FMLA leave (whether due to revocation, nonpayment of premiums or otherwise) may have such medical reimbursement benefits reinstated on return from the FMLA leave on the same terms as prior to taking the FMLA leave, subject to any changes in benefit levels that may have taken place during the period of FMLA leave.

NONDISCRIMINATORY BENEFITS

The Plan, in accordance with applicable provisions of the code, is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and/or benefits. The plan administrator may take such actions as it deems appropriate or necessary to ensure that the Plan is not deemed a discriminatory plan under applicable provisions of the code, which actions may include excluding certain highly compensated individuals from participation in the Plan.
PAYMENT

PARTICIPANTS’ ACCOUNTS

The plan administrator shall establish a separate benefits account for each participant in the Plan. The plan administrator shall credit a participant's benefits account with the amount of medical reimbursement benefits to be made available to the participant pursuant to the participant’s participation agreement. The plan administrator shall charge a participant's benefits account in the amount of any reimbursement made to the participant. The plan administrator may also establish a minimum reimbursement amount below which requests for reimbursement shall not be made until the end of the plan year or, if earlier, until the last day of participation in the Plan.

PAYMENT OF BENEFITS

Reimbursement shall only be made under the Plan on the basis of qualified expenses incurred by the participant, the participant's spouse or the participant's dependents, as presented to the plan administrator on a written form specified by the plan administrator and as evidenced by a written statement from a third party. It shall be the duty of the plan administrator to determine whether or not an expense constitutes a qualified expense. To make the determination that a qualified expense subject to reimbursement has been incurred, the plan administrator may require proper evidence of any or all of the following:

1. the name of the person or persons for whom the expenses have been incurred;
2. the nature of the expenses incurred;
3. the incurred date;
4. the amount of the requested reimbursement; and/or
5. that the expenses have not been otherwise paid or reimbursed from another source.

If the plan administrator determines that an expense is a qualified expense subject to reimbursement, the plan administrator shall reimburse the participant for the qualified expense within a reasonable time. The plan administrator shall be the sole arbiter of what constitutes a qualified expense subject to reimbursement under the Plan.

In the event of the death of the participant prior to the payment of any claims, payment shall be made in the following priority:

1. Executor of the Estate of the deceased participant;
2. Spouse;
3. Family member held responsible for payment of deceased’s medical bills;
4. Spouse or dependent with COBRA continuation rights.

FORFEITURE OF BENEFITS

A participant forfeits any amount of medical reimbursement benefits under the Plan for a plan year if a claim for reimbursement is not provided to the plan administrator within ninety (90) days after the last day of the plan year or the last day of participation in the Plan, if earlier. Upon such forfeiture, the participant's benefits account shall be reduced to zero. At the direction of the employer, forfeitures of benefits under the Plan may be reallocated to participants in any reasonable manner. Forfeitures of benefits may also be applied towards the cost of administering the Plan. In no event shall any forfeitures be subject to the claim of any current or former participant, spouse or dependent or any of their successors or assigns. In addition, any benefit payments that are unclaimed (uncashed benefit checks) by the end of the sixth month following the end of the plan year in which the qualified expense was incurred shall be forfeited and applied as described in this section.
ELECTION CHANGES

No participant in the Plan shall be allowed to alter or discontinue the participant's elected benefits under the Plan during a plan year except as follows:

1. An election change that is on account of and corresponds with any of the following status change that affects eligibility for coverage under the Plan:
   a. Change in employee's legal marital status;
   b. Change in number of dependents;
   c. Termination or commencement of employment by the employee, spouse or dependent;
   d. Change in employment status for the employee, spouse or dependent that results in change of eligibility under the Plan or other employee benefit plan of the employer of the employee, spouse or dependent;
   e. An event that causes an individual to satisfy (or cease to satisfy) dependent eligibility requirements on account of age, student status or any similar circumstance; or
   f. Change in residence or worksite of the employee, spouse or dependent.

2. An election change in connection with taking or returning from a leave of absence under the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA).

3. An election change that is pursuant to a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires coverage for an employee’s child or for a foster child who is a dependent of the employee.

4. An election change to cancel, reduce, commence, or increase coverage under the Plan to correspond with enrollment in, or loss of coverage under, Medicare, Medicaid or a state child health insurance program (CHIP).

5. Upon a COBRA qualifying event, an election to increase payments under the Plan to pay for continuation coverage.

A mid-year election change as permitted above can only be effectuated by the participant filing a new participation agreement, which will serve to revoke the participant's previous participation agreement. The new participation agreement, if determined by the plan administrator to be timely submitted and consistent with other requirements of this Plan, shall only be effective prospectively and after the effective date of the new participation agreement.
CLAIMS PROCEDURE

GENERAL

No benefit shall be paid hereunder unless the claims processor has received from the participant, spouse or dependent (as applicable) (or authorized representative) a written claim for benefits in accordance with the provisions of this section, except as provided in the section, Payment.

FILING A CLAIM

Claims for benefits under this Plan must be submitted to the claims processor at the following address:

CoreSource, Inc.
P. O. Box 8215
Little Rock, Arkansas 72221-8215

All claims for benefits under this Plan must be submitted on an approved form and include such evidence as the claims processor may deem reasonably necessary to administer the claim, including such evidence that substantiates the nature, the amount, and timeliness of any expenses that may be reimbursed.

Claims for benefits under this Plan must be received by the claims processor within ninety (90) days of the close of the plan year in which the relevant expense was incurred. Notwithstanding the foregoing, all claims for reimbursement of expenses incurred by an individual whose coverage under the Plan has been terminated must be received by the claims processor not later than ninety (90) days after the date of termination of coverage. All claims that are not timely received shall be denied.

NOTICE OF AUTHORIZED REPRESENTATIVE

A participant, spouse or dependent may provide the claims processor with a written authorization that (i) designates and authorizes another person or entity to act on his or her behalf and (ii) consents to the communication of information related to him or her to the authorized representative with respect to a claim for benefits or an appeal of a denied claim. Authorization forms may be obtained from the plan administrator.

BENEFIT DETERMINATION

After receipt by the claims processor of a completed claim for benefits under this Plan, the claims processor shall complete its determination of the claim within thirty (30) days unless an extension is necessary due to circumstances beyond the Plan's control. If additional information is needed for determination of the claim, the claims processor shall provide the claimant (or authorized representative) with a notice detailing the information needed. The notice shall be provided within thirty (30) days of receipt of the completed claim and shall state the date as of which the Plan expects to make a decision. The claimant shall have forty-five (45) days to provide the information requested, and the claims processor shall complete its determination of the claim within fifteen (15) days of receipt of the requested information. Failure to respond in a timely and complete manner shall result in the denial of benefit payment.

If a claim for benefits under this Plan is denied, the claims processor shall provide the claimant (or authorized representative) with a written notice of benefit denial within the time-frame for determination as described in this section.
**APPEALING A DENIED CLAIM**

If a claim for benefits under this *Plan* is denied, the claimant (or authorized representative) may request a review of the denied claim by making a written request to the *claims processor* within one hundred eighty (180) days from receipt of the notification of the denial and stating the reasons the claimant feels the claim should not have been denied. The *claims processor* shall provide the claimant (or authorized representative) with a written notice of the appeal decision within sixty (60) days of receipt of a written request for the appeal.

The following describes the review process and rights of the claimant:

1. The claimant has the right to submit documents, information and comments;
2. The claimant has the right to receive and access, free of charge, information relevant to the claim for benefits;
3. The review must take into account all information submitted by the claimant, even if it was not considered in the initial benefit determination;
4. The review shall not afford deference to the original denial; and
5. The reviewer shall not be the individual who originally denied the claim, nor a subordinate to the individual who originally denied the claim.

**NAMED FIDUCIARY FOR CLAIM APPEALS**

The *claims processor* shall be the “named fiduciary” for purposes of reviewing a claim for benefits upon appeal, as described in U.S. Department of Labor Regulation 2560.503-1 (issued November 21, 2000).
CONTINUATION OF COVERAGE

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a covered person to lose coverage under this Plan or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date coverage would otherwise terminate:

1. Death of the employee.
2. The employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for coverage under the Plan.
3. Divorce from the employee.
4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the employee informs the employer that he or she will not be returning to work.
7. The call-up of an employee reservist to active duty.

For purposes of this Continuation of Coverage section, the term “dependent” will be used to refer to the employee’s spouse and/or dependents. Notwithstanding any provision in this document to the contrary, none of the above events shall be considered a qualifying event unless, as of the date of such event, the maximum amount of benefit that may become available to the employee or the dependent (as applicable) during the remainder of the plan year pursuant to this Continuation of Coverage section exceeds the maximum amount that the Plan is permitted to require to be paid for continuation coverage for the remainder of the plan year.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must submit a completed Qualifying Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   a. The date of the event;
   b. The date on which coverage under this Plan is or would be lost as a result of that event; or
   c. The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.

A copy of the Qualifying Event Notification form is available from the plan administrator (or its designee). In addition, the employee or dependent may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.
Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the plan administrator (or its designee) will notify the employee or dependent of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation coverage results from any qualifying event under this Plan other than the ones described in Paragraph 1 above, the plan administrator (or its designee) will furnish an Election Notice to the employee or dependent not later than forty-four (44) days after the date on which the employee or dependent loses coverage under this Plan due to the qualifying event.

3. In the event it is determined that an individual seeking continuation coverage (or extension of continuation coverage) is not entitled to such coverage, the plan administrator (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the Plan on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the employee or dependent chooses to have continuation coverage, he must advise the plan administrator (or its designee) of this choice by returning to the plan administrator (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the plan administrator (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the Plan would otherwise end; or
   b. The date the person receives the Election Notice from the plan administrator (or its designee).

5. Within forty-five (45) days after the date the person notifies the plan administrator (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

Cost of Coverage

1. The Plan requires that covered persons pay the entire cost of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the plan administrator (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an employee or as a spouse, the cost of coverage is the amount applicable to an employee if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an employee.

When Continuation Coverage Begins

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.
FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or dependent child newly acquired during continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. The last day of the plan year in which the qualifying event occurred.

2. The end of the period for which contributions are paid if the covered person fails to make a payment by the date specified by the plan administrator (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

3. The date coverage under this Plan ends and the employer offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

4. The date the covered person first becomes entitled, after the date of the covered person's original election of continuation coverage, to Medicare benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

5. The date the covered person first becomes covered under any other employer’s group health plan after the original date of the covered person’s election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the covered person’s pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this Plan must, at minimum, contain sufficient information so that the plan administrator (or its designee) is able to determine from such notice the employee and dependent(s) (if any), the qualifying event, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this Plan, any notice required to be provided by any individual who is either the employee or a dependent with respect to the qualifying event may be provided by a representative acting on behalf of the employee or the dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

a. A single notice addressed to both the employee and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the Plan, the spouse resides at the same location as the employee; and
b. A single notice addressed to the employee or the spouse will be sufficient as to each dependent child of the employee if, on the basis of the most recent information available to the Plan, the dependent child resides at the same location as the individual to whom such notice is provided.

**PRE-EXISTING CONDITIONS**

In the event that a covered person becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an applicable exclusion or limitation regarding coverage of the covered person’s pre-existing condition, the covered person’s continuation coverage under the Plan will not be affected by enrollment under that other group health plan. This Plan shall be primary payer for the qualified expenses that are excluded or limited under the other employer sponsored group health plan and secondary payer for all other expenses.

**MILITARY MOBILIZATION**

If an employee is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the employee and employee's dependent may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the employee and employee's dependent may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the plan administrator (or its designee) may require the employee and employee's dependent to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty and subject to premium contribution requirement and other applicable requirements as described in the Participation section, coverage for the employee and the employee's dependent will be reinstated without pre-existing conditions exclusions or a waiting period, regardless of their election of COBRA continuation coverage.

**PLAN CONTACT INFORMATION**

Questions concerning this Plan, including any available continuation coverage, may be directed to the plan administrator (or its designee).

**ADDRESS CHANGES**

In order to help ensure the appropriate protection of rights and benefits under this Plan, participants should keep the plan administrator (or its designee) informed of any changes to their current addresses.
HIPAA PRIVACY

The following provisions are intended to comply with applicable Plan amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DISCLOSURE BY PLAN TO PLAN SPONSOR

The Plan may take the following actions only upon receipt of a plan amendment certification:

1. Disclose protected health information to the plan sponsor.

2. Provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO with respect to the Plan.

USE AND DISCLOSURE BY PLAN SPONSOR

The plan sponsor may use or disclose protected health information received from the Plan to the extent not inconsistent with the provisions of this HIPAA Privacy section or the privacy rule.

OBLIGATIONS OF PLAN SPONSOR

The plan sponsor shall have the following obligations:

1. Ensure that:
   a. Any agents (including a subcontractor) to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information; and
   b. Adequate separation between the Plan and the plan sponsor is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

2. Not use or further disclose protected health information received from the Plan, other than as permitted or required by the Plan documents or as required by law.

3. Not use or disclose protected health information received from the Plan:
   a. For employment-related actions and decisions; or
   b. In connection with any other benefit or employee benefit plan of the plan sponsor.

4. Report to the Plan any use or disclosure of the protected health information received from the Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the Plan, as and to the extent required by the privacy rule:
   a. For access to the individual;
   b. For amendment and incorporate any amendments to protected health information received from the Plan; and
   c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule.
7. Return or destroy all protected health information received from the Plan that the plan sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information received from the Plan only to those individuals, under the control of the plan sponsor who perform administrative functions for the Plan; (i.e., eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information received from the Plan for any reason other than for Plan administrative functions nor to release protected health information received from the Plan to an unauthorized individual.

9. Provide protected health information received from the Plan only to those entities required to receive the information in order to maintain the Plan.

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the plan sponsor on behalf of the Plan. Specifically, such safeguarding entails an obligation to:

   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
   b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
   c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
   d. Report to the Plan any security incident of which it becomes aware.

**EXCEPTIONS**

Notwithstanding any other provision of this HIPAA Privacy section, the Plan (or a health insurance issuer or HMO with respect to the Plan) may:

1. Disclose summary health information to the plan sponsor if the plan sponsor requests it for the purpose of:

   a. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
   b. Modifying, amending, or terminating the Plan;

2. Disclose to the plan sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan;

3. Use or disclose protected health information:

   a. With (and consistent with) a valid authorization obtained in accordance with the privacy rule;
   b. To carry out treatment, payment, or health care operations in accordance with the privacy rule; or
   c. As otherwise permitted or required by the privacy rule.
PLAN ADMINISTRATION

PLAN ADMINISTRATOR

The plan administrator shall be responsible for the administration of the Plan.

PLAN ADMINISTRATOR’S DUTIES

In addition to any rights, duties or powers specified throughout the Plan, the plan administrator shall have the following rights, duties and powers:

1. to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

2. to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the Plan;

3. to determine the rights of any participant, spouse or dependent or beneficiary to benefits under the Plan;

4. to develop appellate and review procedures for any participant, spouse, dependent or designated beneficiary with regard to denied benefits under the Plan;

5. to provide the employer with such tax or other information it may require in connection with the Plan;

6. to employ any agents, attorneys, accountants or other parties (who may also be employed by the employer) and to allocate or delegate to them such powers or duties as are necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof are in writing;

7. to report to the employer, or any party designated by the employer, after the end of each plan year, regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might ensure the efficient administration of the Plan.

However, nothing in this section is meant to confer upon the plan administrator any powers to amend the Plan or change any material administrative procedure or adopt any other material procedure involving the Plan without the express written approval of the employer. Notwithstanding the preceding sentence, the plan administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of Sections 105 and/or 125 of the code.

INFORMATION TO BE PROVIDED TO PLAN ADMINISTRATOR

The employer, or any of its agents, shall provide to the plan administrator any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the plan administrator may need for the proper administration of the Plan. Any participant, spouse or dependent entitled to benefits under the Plan shall furnish to the plan administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the plan administrator might reasonably request to ensure the proper and efficient administration of the Plan.
DECISION OF PLAN ADMINISTRATOR FINAL

Subject to applicable State or Federal law and the provisions of this Plan, any interpretation of any provision of this Plan made in good faith by the plan administrator as to any rights or benefits of a participant, spouse or dependent under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the plan administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the plan administrator as he considers equitable and practicable.

RULES TO APPLY UNIFORMLY

The plan administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all participants similarly situated under the Plan.
GENERAL PROVISIONS

EMPLOYER OBLIGATION

The employer, upon adopting the Plan, shall have the obligation to pay, or to have paid on its behalf, the contributions required for payment of benefits under the Plan in respect of its employees.

AMENDMENT AND TERMINATION

City of Bowling Green may amend, modify, or terminate this Plan at any time, to any extent, and for any reason, all in its sole discretion. Any amendment may be made effective retroactively to the extent not prohibited by ERISA and the Internal Revenue Code. Coverage upon termination shall be governed by the terms of the Plan.

NONASSIGNABILITY

Any benefits under this Plan shall be nonassignable and for the exclusive benefit of participants, spouses, and dependents. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

MEDICAL CHILD SUPPORT ORDERS

To the extent applicable, the plan administrator shall adhere to the terms of any judgment, decree or court order (including a court's approval of a domestic relations settlement agreement) which

1. relates to the provision of child support related to health benefits for a child of a participant of a group health plan;
2. is made pursuant to a state domestic relations law; and
3. which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a participant or other beneficiary is entitled to receive benefits.

The plan administrator shall promptly notify the participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the plan administrator shall determine whether such order is a Qualified Medical Child Support Order (QMCSO) as defined in Section 609 of ERISA or National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998 and shall notify the participant and each alternate recipient of such determination. If the participant or any affected alternate payee objects to the determination of the plan administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The plan administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Any such QMCSO or NMSN must clearly specify the name and last known mailing address of the participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO or NMSN shall not require the Plan to provide any type or form of benefits, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1983 (OBRA '93).

Upon determination that a medical child support order is a QMCSO or NMSN, the Plan must recognize the QMCSO or NMSN by providing benefits for the participant's child in accordance with such order.
NOT AN EMPLOYMENT CONTRACT

By creating this Plan and providing benefits under the Plan, the employer in no way guarantees employment for any employee. Participation in this Plan shall in no way assure continued employment with the employer.

TAX EFFECTS

Neither the employer nor the plan administrator makes any warranty or other representation as to whether any payments made hereunder will be treated as includable or excludible in gross income for federal or state income tax purposes.

ADDRESS, NOTICE AND WAIVER OF NOTICE

Each participant shall furnish the employer with his correct post office address. Any communication, statement or notice addressed to a participant at his last post office address as filed with the employer will be binding on such person. The employer or plan administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

SEVERABILITY

In any case where any provision of the Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

CLERICAL ERROR

Clerical error, inadvertent delay or omission in keeping any records pertaining to the coverage, whether by the employer, plan administrator, plan sponsor or by the claims processor, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error, inadvertent delay or omission is not prejudicial to the employer, plan administrator, plan sponsor or Plan and is rectified promptly upon discovery.

APPLICABLE LAW

The Plan shall be construed under the laws of the State of Ohio, to the extent not preempted by any Federal law.