

Health and Welfare Plan - Employer Notices Package 2017

Patient Protection Disclosure

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, you may contact the insurance carrier. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, you may contact the insurance carrier.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents

lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact the HR department and/or the Plan Administrator.

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- Get a list of those with whom we’ve shared information.
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues. We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- We can use or share your information for health research.

- **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Our Uses and Disclosures

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers

Women's Health and Cancer Rights Act Enrollment Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, please contact the Plan Administrator.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility -

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hipp_app.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392

	<p>CHIP Website: http://www.njfamilycare.org/index.html</p> <p>CHIP Phone: 1-800-701-0710</p>
LOUISIANA – Medicaid	NEW YORK – Medicaid
<p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</p> <p>Phone: 1-888-695-2447</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/</p> <p>Phone: 1-800-541-2831</p>
MAINE – Medicaid	NORTH CAROLINA – Medicaid
<p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html</p> <p>Phone: 1-800-442-6003</p> <p>TTY: Maine relay 711</p>	<p>Website: https://dma.ncdhhs.gov/</p> <p>Phone: 919-855-4100</p>
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
<p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/</p> <p>Phone: 1-800-862-4840</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/</p> <p>Phone: 1-844-854-4825</p>
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
<p>Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp</p> <p>Phone: 1-800-657-3739</p>	<p>Website: http://www.insureoklahoma.org</p> <p>Phone: 1-888-365-3742</p>
MISSOURI – Medicaid	OREGON – Medicaid
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</p> <p>Phone: 573-751-2005</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html</p> <p>Phone: 1-800-699-9075</p>
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</p> <p>Phone: 1-800-694-3084</p>	<p>Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</p> <p>Phone: 1-800-692-7462</p>

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924	

<p>CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm</p> <p>CHIP Phone: 1-855-242-8282</p>	
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To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Service
EE Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	www.cms.hhs.gov
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Michelle's Law Notice

Michelle's Law, passed in 2008, prohibits group health plans from terminating the coverage of a dependent child who has lost student status as a result of a medically necessary leave of absence. Plans must continue to provide coverage for up to one year, or until coverage would otherwise terminate under the plan.

Newborns' and Mothers' Health Protection Act Model Language

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Genetic Information Nondiscrimination Act (GINA Disclosures)

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

Rescission

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud, or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What Is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Barbara Ford

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Medical Insurance
only

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Bowling Green		4. Employer Identification Number (EIN)	
5. Employer address 304 N Church Street		6. Employer phone number 419-354-6202	
7. City Bowling Green	8. State OH	9. ZIP code 43402	
10. Who can we contact about employee health coverage at this job? Barbara Ford			
11. Phone number (if different from above)		12. Email address Barbara.Ford@bgohio.org	

Here is some basic information about health coverage offered by this employer:

•As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

Employees who work 30 or more hours per week.As defined in the attached from the Health Plan Document.

•With respect to dependents:

We do offer coverage. Eligible dependents are:

As defined in the attached from the Health Plan Document.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

When Your Coverage Begins

Who Is Eligible

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, “you” means the employee.

Who Is Eligible

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an “eligible class,” as defined below; and
- You will need to meet the “eligibility date criteria” described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time employee.
- For the purposes of employee eligibility for coverage under this group medical Plan, the minimum hourly requirement shall be defined as being scheduled to work at least one hundred thirty (130) hours per month and must have worked an average of at least one hundred thirty (130) hours per month in the twelve (12) month look-back period as measured by the employer pursuant to the PPACA.
- All full-time employees and all non-temporary and non-seasonal part-time employees, whether salaried, hourly, or exempt, shall be offered coverage under this Plan if the employee meets the minimum hourly requirement (i.e. scheduled to work at least an average of one hundred thirty (130) hours per month).
- All non-temporary and non-seasonal part-time salaried or exempt employees who do not meet the minimum hourly requirement (previously defined as 130 hours per month), shall be offered coverage under this Plan if their salary is based on a salary of 20 hours or more per pay week, but less than 130 hours per month.
- All non-temporary and non-seasonal part-time hourly employees, who do not meet the minimum hourly requirement (130 hours per month) but who are hired to work a minimum of one thousand two hundred and fifty (1,250) hours per calendar year, shall be offered coverage under this medical Plan.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your eligibility coverage date is the first day of the month following the date of hire.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan. You may enroll the following dependents:

- Your spouse.
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child with whom you have a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent, or
- A dependent of more than one employee.

How and When to Enroll

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by Aetna and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.



**CITY OF BOWLING GREEN
ADMINISTRATIVE INSTRUCTION NO. 33**

FAMILY AND MEDICAL LEAVE ACT

These Administrative Instructions establish City policy with respect to compliance with the Family and Medical Leave Act (FMLA), as defined in the final regulations released by the Department of Labor (DOL).

INSTRUCTIONS

The Family and Medical Leave Act of 1993 establishes the right for "eligible" employees to take up to 12 weeks of unpaid, job-protected leave during a calendar year for certain family and medical reasons. Employees are "eligible" if they have been on the City's payroll for at least twelve months and have worked at least 1,250 hours during the 12 months prior to the commencement of the leave. The 12 months do not have to be consecutive. In determining the hours worked, vacation, personal, sick leave or unpaid leave would not be included. Overtime hours would be considered hours worked. However, an employee's entitlement to leave for the birth or placement of a son or daughter for adoption or foster care shall expire at the end of the 12-month period beginning on the date of such birth or placement.

Eligible employees whose spouse, son, daughter or parent is on covered active duty or called to covered active duty status may use their twelve-week leave entitlement to address certain qualifying exigencies. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single twelve month period.

Reasons for Taking Leave

An eligible employee may be granted leave for any of the following reasons:

1. For incapacity due to pregnancy or prenatal medical care.
2. For the "birth" and/or care of the employee's "son or daughter" (includes natural birth or placement for adoption or foster care).
3. For the care of the employee's parent, spouse, son, or daughter with a "serious health condition."
4. For a serious health condition that makes the employee unable to perform one or more of the essential functions of his position.
5. For a spouse, son, daughter, parent, or next of kin to care for a covered service-member who is recovering from a serious illness or injury sustained in the line of duty on active duty, up to 26 weeks of leave may be taken.

6. For any qualifying exigency related to the employee's spouse, son, daughter, or parent who is a covered servicemember on or called to active duty.

Definition of Terms

"Spouse" means a husband or wife that entered into marriage recognized under the law of the State where married or if married outside of any State, if valid where married and valid in at least one State. This includes a same-sex or common law marriage that either (1) was entered into in a State that recognizes such marriage; or (2) if entered into outside of any State, is valid in the place where entered into and could have been entered into in at least one State as defined under Ohio law.

"Covered servicemember" means: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment recuperation, or therapy for a serious injury or illness.

"Son" or "Daughter" means a biological, adopted, or foster child, a stepchild, or a legal ward that is either under age 18, or age 18 or older and is incapable of self-care because of mental or physical disability, as defined by the Americans with Disabilities Act.

"Parent" means a biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the employee when the employee was a son or daughter as previously defined in this section. This term does not include parents "in-law".

"Serious health condition" means an illness, injury, impairment, or physical or mental condition that renders the employee unable to perform his/her job and involves inpatient care or continuing treatment by a health care provider.

"Serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".

"Health care provider" means a licensed doctor of medicine or osteopathy, or licensed podiatrist, dentist, clinical psychologist, optometrist, chiropractor (with certain limitations), nurse practitioner, or nurse midwife.

“Continuing treatment” involves a period of incapacity:

(1) of more than three consecutive calendar days and any subsequent treatment that also involves at least treatment two or more times by a health care provider; or treatment by a health care provider on at least one occasion which results in a regimen of continuous treatment under the supervision of the health care provider; (2) due to pregnancy, or for prenatal care, or one treatment which results in a regimen of continuing treatment under the health care provider’s supervision; (3) due to a chronic serious health condition requiring treatment by a health care provider over an extended period of time and may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy); (4) permanent or long-term incapacity due to a condition for which treatment may not be effective; (5) any period of absence to receive multiple treatments by a health care provider either for restorative surgery after an accident or injury for a condition such as cancer that would likely result in a period of incapacity of more than three consecutive calendar days without medical treatment. Treatment would not include routine physical examinations.

Substitution of Accrued Leave Time

Whenever an employee has accumulated unused sick leave, vacation, or personal business leave, that time shall be substituted for and counted against the employee’s 12-week FMLA entitlement. Employees will not be required to substitute compensatory time for unpaid FMLA leave; however, they may voluntarily elect to utilize accrued by unused compensatory time in order to remain in a paid status.

Advance Notice

An employee must provide the City with written notice at least 30 days in advance before FMLA leave is to begin if the need for leave is foreseeable based on an expected birth, placement for adoption or foster care, or planned medical treatment for a serious health condition of the employee or immediate family member. Such notice must set forth the reasons for the requested leave, the anticipated starting date of the leave, and the anticipated duration.

If 30-days’ notice is not practicable under the circumstances, for example, because of lack of knowledge of when leave will be required, a substantial change in circumstances, or a medical emergency, notice must be given as soon as possible after the employee becomes aware of the necessary scheduling arrangements.

If an employee fails to give at least 30-days’ notice of a foreseeable leave with no reasonable excuse for the delay, the City may deny the taking of FMLA leave until at least 30 days after the date the employee provides notice to the City of the need for FMLA leave.

Whenever an employee requests FMLA leave to care for a seriously-ill spouse, son, daughter, or parent, or due to the employee’s own serious health condition, the employee must furnish written certification of the serious health condition signed by the employee’s or immediate family member’s health care provider. Such certification should

be submitted at the time the employee requests leave, or in the case of an unforeseen leave, as soon after the leave commences as possible. Certification can be made using Federal Form WH-380 E or F, whichever is applicable.

The City may require a second opinion from another health care provider. If the opinions differ, the City may require a third opinion from a health care provider jointly selected by the City and the employee. The third health care provider's opinion shall be final and binding. The costs of obtaining second or third opinions that have been incurred by an employee or family member shall be reimbursed by the City. Itemized receipts and verification of mileage traveled will be required.

Whenever an employee requests FMLA leave to care for a covered service member, who is a spouse, son, daughter, parent, or next of kin, who is recovering from a serious illness or injury sustained in the line of duty on active duty or for any qualifying exigency related to the employee's spouse, son, daughter, or parent on or called to active duty the employee must furnish written certification of the need for the leave. Such certification should be submitted at the time the employee requests leave, or in the case of an unforeseen leave, as soon after the leave commences as possible. Certification shall be made using Federal Forms WH-384 or WH-385, whichever is applicable.

When accrued sick, vacation, or personal business leave is substituted for unpaid FMLA leave, the employee must submit to the City a completed "Application for Leave" form with medical documentation verifying the necessity for the leave. These documents must be submitted to the City as soon as practicable.

As a condition of restoring an employee, whose FMLA leave was due to his or her own serious health condition, the employee must present written certification from a health care provider that the employee is able to resume work.

Recurring Notice

The City may request recertification of the employee's or family member's condition in accordance with Federal regulations governing FMLA. If the employee provides a statement of intent to return to work, entitlement to leave and maintenance of health benefits continues. However, if the employee gives an unequivocal notice of intent not to return to work, the City is no longer obligated to continue health and dental benefits (other than COBRA requirements) or to restore the employee to his or her job.

Employees who desire to return to work prior to the end of their leave must give the employer reasonable notice (at least two working days).

Work Related Injuries and Illnesses

Where an employee suffers a serious injury or illness at work that makes the employee unable to perform any one or more of the essential functions of the position, the employee could be eligible for both workers' compensation benefits and Family Medical Leave. Time absent from work for work-related accidents and/or illnesses shall be counted concurrently towards both Family Medical Leave and Workers' Compensation.

Intermittent or Reduced Leave

An employee requesting FMLA leave to care for a seriously ill immediate family member, or for such employee's own serious health condition, may take intermittent leave or work a reduced work schedule if medically necessary. Intermittent leave may also be taken as a result of the birth of a child or for the placement of a child for adoption or foster care. If the need for leave is foreseeable based on planned medical treatment, the City may temporarily transfer the employee to an available alternative position with equivalent pay and benefits that better accommodates recurring periods of leave, provided the employee is qualified for the position.

Joint Use of FMLA Leave by Husband and Wife

A husband and wife who work for the City and who are eligible for FMLA leave are permitted to take only a combined total of 12 weeks of leave during any 12-month period if the leave is taken:

1. for the birth and/or care of the child after birth; or
2. for the placement of a son or daughter with the employee for adoption or foster care or to care for the child after placement; or
3. to care for a parent (but not a parent-in-law) with a serious health condition.

Benefits Protection

The City shall maintain the employee's health and dental coverages for the duration of a FMLA leave. Premium payments for medical and dental insurance that are normally the responsibility of the employee shall continue to be paid by him or her through payroll deduction, regardless of whether the employee has accrued paid leave time to cover all or part of the FMLA leave the City will continue to pay its share of the employee's monthly premiums that it would otherwise pay if the employee were on paid leave status or otherwise present for duty.

If a FMLA leave request is foreseeable, the employee must make arrangements with the City Finance Director at the time of requesting FMLA leave as to a payment schedule, or payroll deduction, to cover his or her share of the medical and dental insurance premiums coming due during the requested period of FMLA leave. If the need for leave is unforeseeable, such arrangements must be made with the City Finance Director no later than 15 days after commencement of the FMLA leave period.

If an employee on FMLA leave fails to submit any required premium to the City within 30 calendar days of the date the premium is due, the City may discontinue health and dental insurance for such employee. If the City chooses to discontinue coverage as a result of non-payment of premium(s) after the 30-day grace period, the employee's health and dental benefits will be restored upon the employee's return to work at the same level and terms as were provided when leave commenced.

If an employee fails to return to work after expiration of such employee's FMLA leave entitlement, the City may recover premiums it paid for maintaining group health and dental plan coverages during the FMLA leave period, unless the reason the employee fails to return to work is either (1) the continuation, recurrence, or onset of a serious health condition, or (2) other circumstances beyond the employee's control. The validity of "circumstances beyond the employee's control" will be judged by the City on a case-by-case basis.

Whenever an employee fails to return from FMLA leave due to "the continuation, recurrence, or onset" of a serious health condition, such employee must submit medical certification of the serious health condition to the City. If such an employee fails to furnish the required certification within 30 days, the City may recover the health and dental insurance premiums it paid on such employee's behalf during the FMLA leave period.

Upon return from a FMLA leave the employee shall be restored to the same position that the employee held when the leave started, if available, or if such position is unavailable, to an equivalent position with equivalent benefits, pay, and other terms and conditions of employment.


Richard A. Edwards, Mayor Date