CARLYLE
ILLINOIS

Employee Benefits Guide

PLAN YEAR: April 1, 2024 - March 30, 2025

ECG

Contact Information

Vendors	Member Services	Website / Email
Medical: *BlueCross BlueShield* Policy Number: PM4246	800.541.2767	www.bcbsil.com
Dental: *MetLife* Policy Number: 5585640	800.275.4638	www.metlife.com/dental
Vision: *Delta Vision* Policy Number:37063	800.323.1743	www.deltadentalil.com

Benefit Contacts	Phone	Email
City of Carlyle *Staci Dannaman*	618.594.2468	sdannaman@carlylelake.com

Benefits at a Glance

OPEN ENROLLMENT:

- Medical
- Dental
- Vision

Understanding Eligibility:
You are eligible to enroll if you are a City of Carlyle employee regularly scheduled to work at least 30 hours per week. You can enroll yourself, your legal spouse*, and your children up to age 26 regardless of student or marital status.

Qualified Life Events:
Once you elect your benefit options, your elections remain in effect for the plan year. You may change coverage if you experience a qualified life event such as:

- Changes in marital status, number of dependents, employment, or if a dependent ceases to satisfy eligibility.
- Loss of other coverage
- COBRA exhaustion
- FMLA special requirements
- Changes due to judgment, decrees, or court order
- Entitlement to Medicare or Medicaid

Enrollment forms for qualified events must be submitted within 30 days of the event date.

*Spouses who are offered medical insurance through their employer are not eligible for enrollment on the City's plan.

How to Enroll

Enrollment forms are included in the back of this booklet.

If you need additional copies of these forms, you can request by emailing Jessica at Einstein Consulting Group at jessica@ecgins.com.

All new hire benefit enrollments must be made within **30 days** of your hire date. You will not be able to change your selections until open enrollment next year unless you have a qualifying event. Examples of qualifying events are found on page 2.

New Hire Waiting Period

New employees do not have a waiting period and are effective on the date of hire.

Open Enrollment

Open enrollment for Medical, Dental, and Vision plan begin in February, for a 4/1 effective date.

BlueCross BlueShield of Illinois

Medical Benefits

BlueCross BlueShield is your health insurance carrier for the 2024 - 2025 plan year. Your medical policy has a deductible of $5,000 which qualifies for reimbursement through a HRA (Health Reimbursement Account). **Your portion of this deductible is $500 per person, or $1,000 for employee's with dependents each year, beginning January 1st.**

More details of your HRA benefits are on the following pages.

Health Insurance Program
Health Reimbursement Arrangement (HRA)

Plan Benefits	In-Network	Out-Network
Insurance Provider	BCBS of IL	
Calendar Year Deductible: Deductible Single Deductible Family	 $500 per person $1,000 per family	 $1,500 per person $3,000 per family
Co-Insurance	0%	30%
Out of Pocket Max Single Family (includes deductible)	 $7,000 $14,000	 $21,000 $42,000

Physician Services		
Office Visit	$15 copay	Deductible then co-insurance
Specialist Office Visit	$45 copay	Deductible then co-insurance
Telehealth	$0 copay	
Labs at Health Dept.*	$0	

Hospital Services		
Inpatient Hospital Care	Deductible	Deductible then co-insurance
Outpatient Hospital Care	Deductible	Deductible then co-insurance
Urgent Care Facility	$75 copay	Deductible then co-insurance
Emergency Room Visit	$150 copay	Deductible then co-insurance

Prescription Drugs	
Generic	$5 Copay
Preferred Brand	$40 Copay
Non Preferred Brand	$50 Copay
Preferred Specialty	$100 Copay
Non Preferred Specialty	50% up to $400

Labs at Clinton County Health Department*: Have your doctor provide your lab orders to the health department via fax or by bringing it with you when you go for lab services. The health department will bill the City directly and you will pay $0 for these services.

HOW AN **HRA** WORKS

An HRA , or Health Reimbursement Arrangement, is a type of Health Spending Account provided by an employer. The money in this account pays for qualified health expenses such as medical and pharmacy as determined by the plan sponsor.

The payment process for most members who have an HRA is easy. When you get care, we get a copy of the EOB and use funds from the HRA to pay your providers directly. You will see the payments listed on the monthly HRA report.

All requests for reimbursement under an HRA must be substantiated. The most common form of substantiation is the EOB (Explanation of Benefits) provided by the employee's health insurance program. If you have primary or secondary coverage elsewhere, including Medicare or Medicaid, you will be required to submit a copy of those EOB's as well to qualify for reimbursements or before payments will be made from the HRA.

STEP 1:
Employer determines how much to contribute for the employee's use.

STEP 2:
Employee goes to their care provider (Hospital, Doctor, Pharmacy, etc.)

STEP 3:
Doctor or Pharmacy submits claim for services to the insurance carrier.

STEP 4:
Pharmacy charges copay at pick up. Doctor / Hospitals either charge the copay or sends a bill 30-45 days after claim has been submitted, dependent on insurance coverage.

STEP 5:
HRA either pays provider directly or the employee is responsible for paying until they have reached a certain out of pocket amount. (See Plan Design below.)

How to submit Explanation of Benefits (EOBs):

Each time a hospital or doctor's office sends a claim to your insurance carrier, an EOB is generated to show you how your claim was processed. This EOB is used by the City's HRA to determine how much will be paid on your behalf. Without the EOB, no payment can be made.

You should submit copies of your EOBs to HRA@ecgins.com, these may be scanned copies or you can take a picture with your smartphone and email the photo for submission. Claims should be submitted within 90 days from the date made available to you from the insurance carrier.

If you are unable to submit your EOBs via email, please let the City know and accommodations can be discussed.

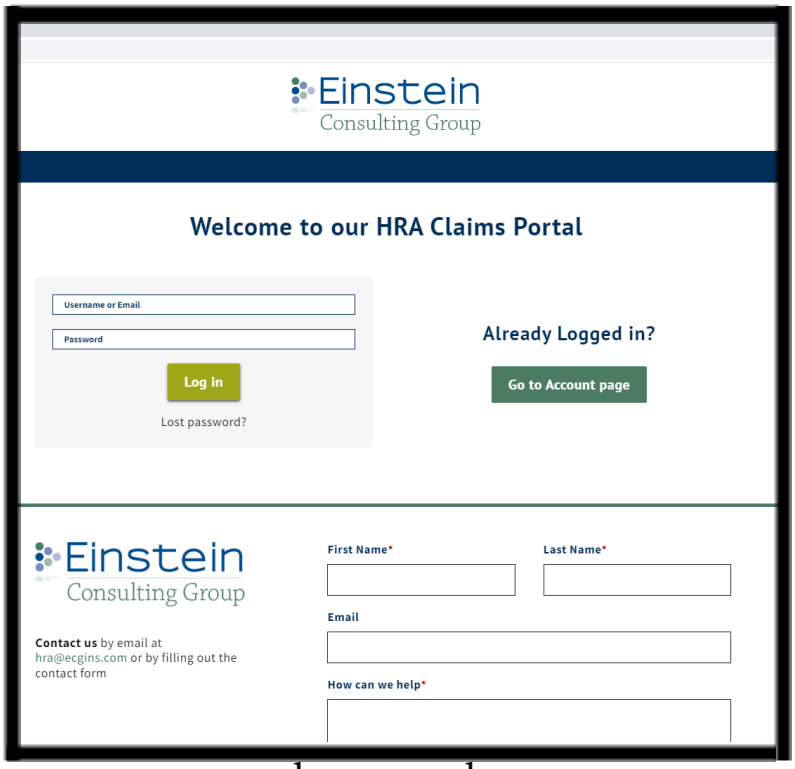
How to get your Explanation of Benefits (EOBs):

When an EOB is generated, a copy will be mailed to your home address. You can also register at www.myuhc.com for online access to your BCBS account. On this website you can view, download, or print your EOBs.

You may use the www.bcbsil.com online access to locate in network providers.

Access Your Health Reimbursement Report Anytime

Step 1: Go to myhraclaims.com

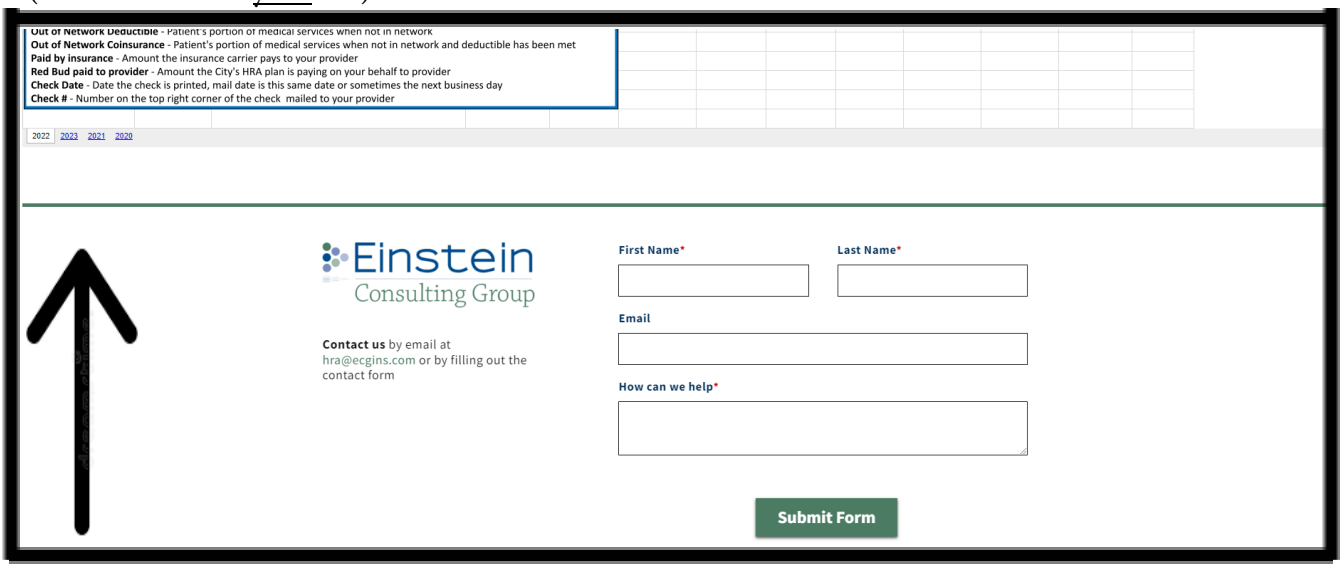


Step 2: Enter your username and password

username: firstnamelastname

password: carlyleXXXX

("Xs" are last 4 of your ssn)



Step 3: Review your claims. You can select previous years by clicking the links.

Claims questions? Fill out the form at the bottom of the page and hit ***submit.***

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsil.com/member/policy-forms/2023 or by calling 1-800-541-2768. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Participating $5,000; Non-Participating $10,000 Family: Participating $10,000; Non-Participating $20,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Out-of-Network Inpatient $300.There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Individual: Participating $7,000; Non-Participating $21,000 Family: Participating $14,000; Non-Participating $42,000	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-541-2768 for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Virtual Visits: 20% coinsurance. See your benefit booklet* for more details.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.bcbsil.com/rx-drugs/drug-lists/drug-lists**	Preferred generic drugs	Preferred – 10% coinsurance Non-Preferred - 20% coinsurance	Retail: 20% coinsurance	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall price of the drug. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copayment/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $100, when obtained from a Preferred Participating or Participating Pharmacy.
	Non-preferred generic drugs	Preferred – 10% coinsurance Non-Preferred - 20% coinsurance	Retail: 20% coinsurance	
	Preferred brand drugs	Preferred – 20% coinsurance Non-Preferred - 30% coinsurance	Retail: 30% coinsurance	
	Non-preferred brand drugs	Preferred – 30% coinsurance Non-Preferred - 40% coinsurance	Retail: 40% coinsurance	
	Preferred specialty drugs	40% coinsurance	40% coinsurance	
	Non-preferred specialty drugs	50% coinsurance	50% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2023

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$300/visit plus 40% coinsurance	Preauthorization required. Preauthorization penalty: $1,000 or 50% of the eligible charge. See your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	20% coinsurance	$300/visit plus 40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	$300/visit plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Habilitation services	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Skilled nursing care	20% coinsurance	$300/visit plus 40% coinsurance	Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization may be required.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2023

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2023

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (for children 1 per ear every 24 months, for adults up to $2,500 per ear every 24 months)
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (only in connection with diabetes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 or visit http://insurance.illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$5,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$5,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,100**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$5,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Prescription Benefits

TrueRx will remain your pharmacy benefits manager for the 2023 - 2024 plan year. If the pharmacy is asking you to pay more than your normal copay, please ensure they are using the TrueRx pharmacy card and not your BlueCross medical card. If you choose to use the BlueCross card, you will be charged the full retail cost of the medication.

More details about TrueRx benefits are on the following pages.

FOR PATIENTS

trueRx
HEALTH STRATEGISTS

WHAT TO EXPECT WHEN YOUR INSURANCE CHANGES

The word "change" probably elicits some uncomfortable feelings. In this case, a change in your insurance is actually a good thing. We're a team of pharmacists and strategists helping you get the medication you need at a price everyone can afford.

The trueDifference :

YOU'RE OUR PATIENT
not just another customer number. Our motivation is your health and quality of life.

SMART MEDICATION CHOICES
made by ethical health care providers. Our formularies are designed to keep you healthy and productive.

AFFORDABLE SPECIALTY
If you take a specialty medication, your dedicated case manager will reach out to you soon.

OUR MOBILE APP
lets you compare prices at different pharmacies, set up refill reminders, and access your medication history.

Here are your next steps:

1. **LOOK** for your new insurance card in the mail.
2. **TAKE** your new card to your pharmacy.
3. **CREATE** your account at truerx.com/member-portal.
4. **DOWNLOAD trueApp**

How do I continue my mail order service?

If your employer offers home delivery options, you will need to contact Postal Prescription Services as soon as possible at www.ppsrx.com or 800-552-6694.

Is True Rx Health Strategists a pharmacy?

No, we're not a pharmacy. We're your pharmacy insurance provider. You will continue to receive medications at your local pharmacy while we work in the background to make sure you're getting prescriptions with ease and accuracy.

How do I get my prescriptions filled?

Soon, you will receive your new insurance card in the mail. Simply take your new insurance card to your local pharmacy. You can also access your card on your phone with **true**App.

How much will my medication cost?

With **true**App, not only can you find the cost of your medication, you can also compare prices at different pharmacies in your area. You will also see your deductible and other specific information based on your insurance plan.

What should I do if my claim is delayed or denied?

The first thing you should do is take your new insurance card to the pharmacy to make sure they have your new insurance information. If you're still having difficulties, please give us a call. Our customer service representatives are experts in your pharmacy benefit plan.

We're here to answer any additional questions.
Reach us at hello@truerx.com or 866-921-4047.

trueRx HEALTH STRATEGISTS

Enrollment Forms and General Notices

Spousal Waiver Employee Statement

_____

Employee Name

The City of Carlyle allows you to enroll qualified dependent children up to age 26, and spouses who do not have an option to receive health insurance coverage through their own employer or other sponsor.

1. Eligible employee's spouse maintains full time employment and is eligible for an employer sponsored health plan

Please check **only one** of the coverage options below:

☐ *Spousal Waier Does Not Apply**

My spouse is self-employed, (or)
My spouse is employed part-time, (or)
My spouse is not employed

I attest to the fact that my spouse does not have access to employer-sponsored medical coverage and/ or is not eligible for such coverage. Should these circumstances change, and my spouse does become eligible for employer-sponsored coverage under another employer, I must notify the City within 30 days of such occurrence. My spouse will be required to seek medical coverage under his/her current employer's plan at that time he/she becomes eligible.

I agree to notify the City regarding my spouse's eligibility for another employer-sponsored medical plan, and I attest to the truth regarding my spouse's current eligibility.

☐ *Spousal Waiver Applies**

I acknowledge that my spouse is eligible for coverage with her/his current employer. I will not cover my spouse as a dependent under my City medical insurance policy

I agree to notify the City immediately if my above circumstances changes (i.e.: marriage, divorce, spouse becomes eligible for coverage elsewhere, etc.). I understand if I fail to notify the City of my change in eligibility status, I may be subject to termination from the plan.

_____ _____

Employee Signature Date

BlueCross BlueShield of Illinois

Dearborn National*

ENROLLMENT APPLICATION AND POLICY CHANGE

① ENROLLEE: **New Enrollment:** ☐ Timely ☐ Special **Open Enrollment:** ☐ New Member ☐ Plan Change ☐ Add Dependents

② EFFECTIVE DATE OF BENEFITS: ___/___/____ Group #: Section #: Identification #:
☐ Completion of Other Eligibility Requirements

③ EMPLOYEE/FORMER EMPLOYEE STATUS
☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date ___/___/____

④ COBRA / ILLINOIS CONTINUATION

☐ COBRA:
Start Date ___/___/____ Projected End Date ___/___/____

☐ IL Continuation Privilege:
Start Date ___/___/____ Projected End Date ___/___/____

Previously covered with group as:
☐ 1. Employee (termination of employment, reduction in hours, other)
☐ 2. Spouse (divorce** from employee, death of employee, other)
☐ 3. Dependent (reach age limit, other)
☐ 4. Spouse and Dependents (divorce** from employee, death of employee, other)

⑤ COVERAGE APPLIED FOR: Check all that apply (add one Medical, Dental, Life, if applicable).
After checking coverage applied for or making changes to existing membership, complete Plan #, Group #, Section #, Name and Social Security #.

Small Group 1-50 Affordable Care Act Plans
☐ PPO
☐ Blue Choice Preferred PPO℠
☐ Blue Options℠
☐ Blue Precision HMO℠
☐ BlueCare Direct℠
☐ Plan #: _____

Small Group 1-50 Grandfathered and Grandmothered/Transitional Plans
☐ Blue Advantage Entrepreneur PPO℠
☐ Blue Choice Select PPO℠
☐ BlueEdge Select HSA℠
☐ BlueEdge HSA℠
☐ BlueEdge HCA Direct℠
☐ PPO Value Choice
☐ Blue Advantage HMO℠
☐ Blue Advantage HMO Value Choice℠
☐ Community Participation Organization (CPO)
☐ CPO Value Choice
☐ Plan #: _____

Mid-Market & Large Group Standard Plans 51+
☐ PPO
☐ Blue Advantage HMO
☐ Blue Advantage HMO Value Choice
☐ Blue Choice Options℠
☐ Blue Choice Select PPO
☐ BlueEdge HSA
☐ BlueEdge Select HSA
☐ Plan #: _____

Large Group Custom Plans 151+
☐ Traditional
☐ PPO
☐ CPO
☐ CPO Value Choice
☐ HMO Illinois® ☐ w/HCA
☐ Blue Advantage HMO ☐ w/HCA
☐ Blue Choice Options
☐ Blue Choice Select PPO
☐ BlueEdge HCA℠
☐ BlueEdge HSA
☐ BlueEdge HCA Direct
☐ BlueEdge Select HCA℠
☐ BlueEdge Select HSA
☐ BlueEdge Select HCA Direct℠
☐ Vision
☐ Hearing
☐ Medicare Supplement

Dental
☐ BlueCare Dental PPO℠ ☐ BlueCare Dental HMO℠
☐ Individual / Employee ☐ Employee & Spouse
☐ Employee & Child(ren) ☐ Family
☐ Employee & Party to a Civil Union or Domestic Partner
Gender: ☐ Male ☐ Female
Enter Dental Group # if different than Medical Group policy #.
Dental Group #: _____

Life
Dearborn National Group #: _____

Previous BCBSIL or HMO Membership
Group #: _____
Section #: _____
Identification #: _____

⑥ CHANGES TO EXISTING MEMBERSHIP: Check all that apply.

CHANGES
Date ___/___/____
☐ HMO Medical Group/IPA†
☐ PCP and/or WPHCP†
☐ Name ☐ Address
☐ Telephone ☐ Reinstate
☐ From PPO to HMO
☐ From HMO to PPO
☐ From HMO Illinois to Blue Advantage HMO
☐ From Blue Advantage HMO to HMO Illinois
☐ Medicare Coverage
☐ FDL Beneficiary
☐ Other: _____

ADD DEPENDENTS
Date ___/___/____
☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other: _____

CANCEL DEPENDENTS
Date ___/___/____
☐ Divorce**
☐ Age Limit
☐ Other: _____

NOTE:
Only list dependents to be added or dropped in the Family Coverage Information Section ⑧.

CANCEL (Check all that apply)
Date ___/___/____
☐ Terminate Coverage
☐ Waive Coverage‡
☐ Leave/Layoff
☐ Out of Service Area Move
☐ Other:
_____
_____
_____
_____
_____
_____
_____

† After checking the appropriate physician change, circle reason: ☐ PCP ☐ WPHCP
A. Availability B. PCP moved office C. Location
D. PCP added to Network E. Dissatisfied with PCP F. PCP office/facility undesirable
G. Staff H. Other _____

‡ If not electing coverage, please read, complete and sign Section ⑫.

* Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) and certain of its affiliates. Dearborn National® Life Insurance Company is a separate company that does not provide Blue Cross and Blue Shield of Illinois products or services.

** The term "divorce" in Section 4 includes legal divorce and the comparable termination of a civil union or domestic partnership.

⑦ **EMPLOYEE INFORMATION:**	Company Name:	Group #:
Employee Last Name:	Employee First Name:	Mid. Initial
Email Address:	Cell Phone #:	
Street Address:	Apt. #:	
City:	State:	ZIP code:

Date of Birth: ___/___/____ Are You Eligible for Family Coverage: ☐ No ☐ Yes

Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Party to a Civil Union or Domestic Partner ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security #: _____ — _____ — _____

Employee Identification # (if known): _____

Telephone #: Business: (_____) _____ Home: (_____) _____ Date of Hire: ___/___/____

Dept. #: _____ Payroll Location: _____ Employee Clock #: _____

If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____

PCP #: _____ PCP Name: _____

WPHCP Medical Group/IPA #: _____ WPHCP Medical Group Name: _____

WPHCP (Physician) #: _____ WPHCP (Physician) Name: _____

If CPO/CPO Value Choice, Network #: _____ If BlueCare Dental HMO, Office ID #: _____

Employment Status: ☐ Actively at Work ☐ COBRA/IL Continuation ☐ Retired If retired, retirement date: ___/___/____

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/____	Start Date: ___/___/____	Start Date: ___/___/____
Start Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____

⑧ **FAMILY COVERAGE INFORMATION:** List all eligible dependents.

⑧Ⓐ ☐ Spouse ☐ Domestic Partner ☐ Party to a Civil Union

Gender: ☐ Male ☐ Female

Last Name (only if different): _____ Date of Birth: ___/___/___

First Name: _____ Social Security #: _____ — _____ — _____

If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____

WPHCP Medical Group/IPA #: _____

PCP #: _____ PCP Name: _____

WPHCP Medical Group Name: _____

WPHCP (Physician) #: _____ WPHCP (Physician) Name: _____

If BlueCare Dental HMO: Office ID #:_____

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/____	Start Date: ___/___/____	Start Date: ___/___/____
Start Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____

⑧ FAMILY AND DEPENDENT COVERAGE INFORMATION:

List all eligible dependents: *If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form. If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application.*

⑧Ⓑ ☐ SON ☐ DAUGHTER Date of Birth: ___/___/____

Last Name (only if different): ______________________ First Name: ________________

☐ ELIGIBLE MILITARY PERSONNEL ☐ DISABLED DEPENDENT

Address (if different from employee's address): ______________________________

Social Security #: ________ — ________ — __________ **If HMO:** Medical Group/IPA #: __ __ __ __ __ __ __ __ __ __

Medical Group/IPA Name: PCP #: __ __ __ __ __ __ __ __ __ __ PCP Name: ______________________

WPHCP Medical Group/IPA #: __ __ __ __ __ __ __ __ __ __ WPHCP Medical Group Name: ______________________

WPHCP (Physician) #: __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*: ______________________

If BlueCare Dental HMO: Office ID #: ____________________

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? ☐ No ☐ Yes
If Yes, the section below <u>must</u> be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/____	Start Date: ___/___/____	Start Date: ___/___/____
Start Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____

☐ SON ☐ DAUGHTER Date of Birth: ___/___/____

Last Name (only if different): ______________________ First Name: ________________

☐ ELIGIBLE MILITARY PERSONNEL ☐ DISABLED DEPENDENT

Address (if different from employee's address): ______________________________

Social Security #: ________ — ________ — __________ **If HMO:** Medical Group/IPA #: __ __ __ __ __ __ __ __ __ __

Medical Group/IPA Name: PCP #: __ __ __ __ __ __ __ __ __ __ PCP Name: ______________________

WPHCP Medical Group/IPA #: __ __ __ __ __ __ __ __ __ __ WPHCP Medical Group Name: ______________________

WPHCP (Physician) #: __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*: ______________________

If BlueCare Dental HMO: Office ID #: ____________________

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? ☐ No ☐ Yes
If Yes, the section below <u>must</u> be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/____	Start Date: ___/___/____	Start Date: ___/___/____
Start Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____

☐ SON ☐ DAUGHTER Date of Birth: ___/___/____

Last Name (only if different): ______________________ First Name: ________________

☐ ELIGIBLE MILITARY PERSONNEL ☐ DISABLED DEPENDENT

Address (if different from employee's address): ______________________________

Social Security #: ________ — ________ — __________ **If HMO:** Medical Group/IPA #: __ __ __ __ __ __ __ __ __ __

Medical Group/IPA Name: PCP #: __ __ __ __ __ __ __ __ __ __ PCP Name: ______________________

WPHCP Medical Group/IPA #: __ __ __ __ __ __ __ __ __ __ WPHCP Medical Group Name: ______________________

WPHCP (Physician) #: __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*: ______________________

If BlueCare Dental HMO: Office ID #: ____________________

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? ☐ No ☐ Yes
If Yes, the section below <u>must</u> be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/____	Start Date: ___/___/____	Start Date: ___/___/____
Start Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____	End Date: ___/___/____

⑨ OTHER INSURANCE INFORMATION:

If you or any of your family members have OTHER GROUP COVERAGE, Check all that apply.

☐ Health: Policy #: _____ ☐ Dental: Policy #: _____

☐ Prescription Drug Coverage: Policy #: _____ ☐ Vision: Policy #: _____

☐ Hearing: Policy #: _____

If Yes: Is the other insurance: ☐ Single Coverage ☐ Family Coverage

EMPLOYED BY: _____ Insured's Name: _____

Date of Birth: ___/___/____

Insurance Company Name: _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone #: _____

⑩ DEARBORN NATIONAL:

The group Term Life & AD&D, STD and LTD products are underwritten by Dearborn National® Life Insurance Company.

Employee Job Title: _____ Class Type: _____

Basic Salary: $ _____ ☐ Hourly ☐ Weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

Check Coverage Applied For: Term Life/AD&D: ☐ No ☐ Yes $ _____ Dependent Life: ☐ No ☐ Yes $ _____

Weekly Income: ☐ No ☐ Yes $ _____ Supplemental Life: ☐ No ☐ Yes $ _____

Long Term Disability: ☐ No ☐ Yes $ _____ ☐ Voluntary AD&D: $ _____ ☐ Single ☐ Family

Permanent Life Insurance: ☐ No ☐ Yes $ _____

If Yes: ☐ Automatic Premium Loan or ☐ Replaces An Existing Policy

Beneficiary: Note: If more than one Beneficiary, interest will be equal unless otherwise indicated.

Last Name: _____ First Name: _____

Relationship: _____

⑪ **I APPLY FOR COVERAGE AS INDICATED ABOVE**, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical, dental coverage and health maintenance coverage), and/or Dearborn National (providing the life and disability insurance) (the Company). I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Date Signed: ___/___/____ Signature of Applicant: _____

⑫ If you are declining enrollment for yourself and/or eligible dependents (children, spouse, party to a civil union or domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, 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, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company. Not enrolling in:

Medical for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Dental for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Vision for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Basic Life for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Dependent Life for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Voluntary Life for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Short-Term Disability for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Long-Term Disability for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents

Reason: ☐ Covered under spouse's* employer-based health insurance plan (complete "Other Insurance Information" in Section ⑨)

☐ Covered under a Medicare supplement plan ☐ Other (please explain)_____

Date Signed: ___/___/____ Signature of Applicant: _____

* The use of the term "spouse" in Section 12 includes a legal spouse, domestic partner or party to a civil union. All of the provisions of this section of the form that pertain to a spouse also apply to a domestic partner or party to a civil union unless specifically noted otherwise.

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your group's benefits administrator or Einstein Consulting Group.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Your group's benefit administrator or Einstein Consulting Group at jessica@ecgins.com .

that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact your Human Resources Department for further information. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the Employee Health Care Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on _____ and decided:

_____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

___ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c)**.**

[Part A – NOTICE OF ELIGIBILITY]

TO: _____
Employee

FROM: _____ _____
Employer Representative

DATE: _____ _____

On _____, you informed us that you needed leave beginning on _____ for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

_____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.

_____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

_____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.
_____ You have not met the FMLA's hours of service requirement.
_____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact Jessica Mancini at 314-578-4848 or Jessica@ecgins.com or view the FMLA poster located in _____.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ____**is/**____ **is not** enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed (such as documentation for military family leave): _____

_____

_____

____ No additional information requested

CONTINUED ON NEXT PAGE

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid _____ **sick**, _____ **vacation**, and/or _____**other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

  _____ the calendar year (January – December).

  _____ a fixed leave year based on _____.

  _____ the 12-month period measured forward from the date of your first FMLA leave usage.

  _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have **____ sick, ____vacation,** and/or **___ other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  ____For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

  ____Applicable conditions for use of paid leave:_____

  _____

  _____

  _____

  _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Einstein Consulting Group