CITY OF CINCINNATI

INTEGRATED HRA

Actives

Effective: January 1, 2016

Amended and Restated
January 1, 2020

Table of Contents

INTRODUCTION

Plan document and summary plan description. This is the Plan Document for the City of Cincinnati Integrated HRA (which we will simply call the "Plan" or "HRA"). This is an "Employee Welfare Benefit Plan" under the federal Employee Retirement Income Security Act of 1974, as amended. Because this document is written in plain English, it also serves as The Summary Plan Description for the Plan.

Sponsor and administrator. The Plan is sponsored by City of Cincinnati (which we will call "Employer" or "Plan Sponsor"), whose address is 805 Central Avenue, Suite 100, Cincinnati, OH, 45202, and whose Employer identification for federal tax purposes is 31-6000064. The Plan is administered by J & K Consultants, Inc. (which we will call "the Claims Administrator"), whose address is 2605 Nicholson Road, Suite 1140, Sewickley, PA 15143, and telephone number is 877-872-4232.

Ordinary names. Throughout the Plan, we will refer to things by their ordinary name. We will call this Plan simply "Plan." We will call the Employer simply "Employer." When we say "You," we mean you the employee.

Effective date and historical note. This Plan takes effect on January 1, 2016. This edition of the Plan takes effect on January 1, 2020. As of that date, it entirely supersedes and replaces all prior Plans, programs and policies (if any) providing benefits of the same type as the benefits set forth in this Plan.

Plan Year. You will see references to the "Plan Year" in this document. The "Plan Year" is the 12-month period beginning each January 1st.

Questions. If you have questions after you read this Plan, ask the Plan Sponsor for help. O*nly the Plan Sponsor* is authorized to interpret and apply the Plan.

PARTICIPATION

General eligibility rules. This Plan is designed to cover employees who would otherwise be eligible for a City of Cincinnati Anthem Health Plan, but who choose not to participate in a plan because they have alternative group health coverage available. such as through their spouse or equal partner's employer, another employer of the Employee, retiree health benefits (other than Medicare or the Cincinnati Retirement System), or active duty Tricare benefits. However, if the alternate group health coverage is provided through a high deductible health plan (HDHP) with a health saving account (HSA), and the other plan does not allow the HSA to be waived while You are enrolled in the HRA, You are ineligible to participate in this plan.

- An employee is not eligible for the HRA if the alternate group health coverage only *offers* a health plan that solely consists of "excepted benefits" under the Patient Protection and Affordable Care Act ("PPACA")

- An employee is not eligible for the HRA unless the employee, and/or dependents, if applicable, is *actually enrolled* in a health plan that does not solely consist of "excepted benefits" under the Patient Protection and Affordable Care Act ("PPACA"). The HRA is not available to any employee unless the employee and/or dependents is enrolled in non-HRA group coverage, regardless of whether that coverage is sponsored by the City of Cincinnati.

- The HRA does not reimburse any expenses other than co-payments, co-insurance, deductibles and premiums under the non-HRA coverage of the employee and/or dependents, if applicable (see the previous bullet), as well as medical care (as defined under section 213(d) of the Internal Revenue Code) that does not constitute "essential health benefits" under PPACA. This amendment does not require the HRA to actually cover all of the listed expenses; it only re-affirms that the HRA will not cover any *other* expenses.

- An employee is permitted to opt out of the HRA during annual open enrollment or due to a qualifying life event, in accordance with 2013-54 of the IRS Code.

Accordingly, in general, You are eligible to participate in this Plan if and when You meet all of the following requirements:

- First, You must be shown on the books and records of the Employer as an employee. Independent contractors are not employees, nor are individuals whose services are leased from a leasing organization (such as "temps"), so they are not eligible to enroll into the Plan. If you are not shown on the books and records of the Employer as an employee, you are not eligible to enroll into the Plan, regardless of whether the Employer's determination is correct and regardless of how you may be treated for any other purposes (such as employment tax purposes).

- Second, You must be shown on the books and records of the Employer as employed in a classification of active, full-time. Full-time employees are those who work at least 30 hours per week. If you are not shown on the books and records of the Employer as employed, you are not eligible to enroll into the Plan, regardless of whether the Employer's determination is correct and regardless of how you may be treated for any other purposes (such as employment tax purposes).

- Third, if You are employed by the City of Cincinnati and have opted out of a City of Cincinnati Health Plan, you and/or your dependents must enroll in a City of Cincinnati Health Plan for a period of not less than 12 months, after which time, you and only the dependents that were enrolled on the City of Cincinnati Health Plan are eligible for the HRA.

- Fourth, if you are deemed to be ineligible to enroll in your spouse's employer group medical plan due to conflicting eligibility language, you may enroll your eligible spouse and/or any eligible dependents in the Plan. Only your eligible spouse and/or eligible dependents will be eligible for benefits under this Plan.

Enrollment. To participate in the Plan, you must enroll by completing the enrollment process at www.CoCBenefits.com or by calling 4MyBenefits at 866-477-1604.

Please note: A Social Security number is required for enrollment under the Plan. If you do not provide a Social Security number, *you are not enrolled.* This means, for example, that if you have applied for a Social Security number but have not received it yet when you would otherwise be enrolled, you will not be enrolled. You have 90 days to submit your Social Security number to be enrolled retroactively to the date when you would otherwise have been enrolled.

As soon as you meet all of the eligibility requirements, you are eligible to participate in the Plan. Enrollment in this Plan is necessary. That is to say, it is not enough to be eligible, you must also enroll in order to be covered by this Plan. Your enrollment will take effect on the day you satisfy the City's eligibility requirements.

Spouses, equal partners and dependents. Since this Plan merely reimburses you for employee contributions, deductibles, co-pays and co-insurance that you pay for you, your spouse or equal partner, and your dependents under an alternative coverage, your spouse or equal partner and dependents are technically not eligible to enroll in this Plan. Please be assured, though, that this Plan will pay deductibles, co-pays and co-insurance incurred under your alternate coverage for those members of the family who qualify as spouses or equal partners and dependents under a City of Cincinnati Health Plan.

When your participation ends. Your participation in the Plan ends on (1) the last day of the month in which you are no longer actively employed by Employer, (2) if you otherwise cease to meet the City's eligibility requirements for healthcare; or (3) you terminate your participation in the Plan during Open Enrollment or due to a Qualifying Life Event.

Choices available when participation ends. Under some circumstances, you may choose to buy continued coverage under the Plan. This is sometimes known as "COBRA" coverage and it is explained in Appendix B.

PLAN BENEFITS

Integrated HRAs in General. It helps you take advantage of non-City of Cincinnati health care that is available through your spouse's or equal partner's health care coverage, your non-City of Cincinnati provided retiree health care coverage, another employer's health care coverage, by reimbursing you for employee contributions, deductibles, co-pays and co-insurance under that other coverage. We will have to refer to that other coverage from time to time in this section of the Plan. To keep it simple, we'll call that other coverage your "alternate coverage."

Integrated HRA Benefits. Integrated HRA benefits are of two varieties: (a) reimbursement of a portion of the premium that you (or your spouse or equal partner) pay for the alternate coverage and (b) reimbursement of deductibles, co-pays and co-insurance under the alternate coverage.

Reimbursement of a portion of the premium

You are entitled to be reimbursed for a portion of the premium that you (or your spouse or equal partner) pay for the alternate coverage. The maximum amount you are entitled to is shown in a table on Appendix A.

Reimbursement of employee contributions is free from federal income tax and FICA if you have paid the employee contributions for the Alternate Coverage on an after-tax basis. If you have paid the employee contributions for the alternate coverage on a pre-tax basis (such as through a cafeteria or section 125 plan) then the IRS says that you have not really paid the employee contribution, so reimbursement under the Integrated HRA is taxable.

You must verify the premium being paid for your Alternate Coverage with the Claims Administrator during Open Enrollment every year. If documentation is not provided prior to December 31st of each year, premium reimbursements will be terminated until such documentation is provided.

You must notify the Claims Administrator of any increase in the premium being paid for your Alternate Coverage, within 90 days of the increase, regardless of the time of year that change is made. Premium reimbursements will only be given up to 90 days retroactively. Notification within the required timeframe will allow Claims Administrator to adjust the reimbursement back to the effective date of the change.

You must notify the Claims Administrator immediately if there is a premium decrease. A participant's acceptance of a premium reimbursement in excess of the amount of premiums actually paid for alternate coverage shall constitute fraud or intentional misrepresentation.

Reimbursement of deductibles, co-pays and co-insurance

This Plan also reimburses you for deductibles, co-pays and co-insurance incurred under the alternate coverage each Plan Year, up to the annual maximum. The annual maximum amount of reimbursement under this Plan for deductibles co-pays and co-insurance is shown on a table in Appendix A.

A. ***Obtaining Reimbursement. Integrated HRA I.D. Card*** – For doctor's office visits, please present your group health insurance plan card first (i.e. your spouse's or equal partner's health insurance), then present the Integrated HRA card. If your health insurance requires a copay, co-insurance or deductible, you will not be required to pay that at the time of the visit. By presenting the Integrated HRA Card, the provider will bill the Claims Administrator directly. If for some reason a provider is unwilling to accept the ID Card, you can submit an EOB or receipt directly to the Claims Administrator for reimbursement.

Prescription drug copay, coinsurance and/or deductibles are processed at the point of service through the pharmacy, with the exception of CVS, Walgreen's and mail order pharmacies which do not currently accept secondary payor information. Please have the pharmacy submit the insurance first, and then submit the patient's copay through the Integrated HRA, as one transaction.

Paper Claims. To claim reimbursement under the Plan, complete and sign an "Integrated HRA Claim Form," available from the Claims Administrator at coc.jandkcons.com, and return it to the Claims Administrator for the Plan at the address shown on the form or to CinciHRA@jandkcons.com.

Funding. Reimbursements under the Plan are paid by Employer and are not insured by any outside agency or insurance company.

ADMINISTRATION, CLAIMS AND APPEALS

Administration. The Plan Administrator has all rights, duties and powers necessary or appropriate for the administration of the Plan, except to the extent that they are vested in a separate claims authority (as described in this section) or in the appeals authority (as described in the following section).

All of the deadlines for decisions by the Plan Administrator or other decision maker are deadlines which you have a right to insist upon. Nothing in these rules prevents you from giving up that right and voluntarily agreeing to an extension of any deadline for the Plan Administrator or other decision maker.

Notification in writing includes any form of writing. For example, this may include a printed form, a letter, a fax or an e-mail. By contrast, oral notification means notification by means of the spoken voice, either in person or through some other medium such as the telephone.

Claims. Claims should be addressed to the third-party claims administrator as follows:

Claims Administrator

J & K Consultants, Inc.
2605 Nicholson Road
Suite 1140
Sewickley, PA 15143
1-877-872-4232 Phone
1-877-599-3724 – Fax
CinciHRA@jandkcons.com
coc.jandkcons.com

If the Claims Administrator has any special rules for filing and processing claims, they are described in the written materials that are available from the claims administrator, and you should follow them. The rules of the claims administrator must in any event satisfy the minimum standards described in the balance of this section.

Make sure to submit your claims as soon as possible, but in no event later than March 31st each year, for the prior calendar year, or within 90 days after termination. If you fail to submit your claim by the deadline, you are not entitled to reimbursement and your claim will be denied. Any unclaimed reimbursement amounts (i.e., failing to cash a reimbursement check) will be forfeited if not claimed (or cashed) within twelve (12) months after the check is issued.

Denial of claims. If your claim is denied, the Plan Administrator will respond to you in writing within a reasonable period of time, but always within 30 days. As an exception, the plan may take an additional 15 days (for a total of 45) as long as the decision maker concludes that an extension is necessary for reasons outside the control of the decision maker and notifies you, before the original 30 days expire, about why an extension is necessary and when a decision is expected. If the reason for the extension is that you have not provided all of the information necessary to decide on your claim, then the original 30-day clock will stop, beginning on the date when you are sent notification of the extension, until you provide the information.

The written notice will point out the specific reasons and Plan provisions on which the denial is based, describe any additional information needed to complete the claim, and describe the appeal procedure, including time limits. In addition, the notice will include the following information:

- If the plan provisions involve the application of terms such as "medical necessity" or "experimental," you will be offered, upon request and free of charge, an explanation of the scientific or clinical judgment underlying the decision, applying the terms of the plan to your medical circumstances. Alternatively, the decision maker may simply include the explanation with your notification.

- If the decision maker relied on an internal rule, guideline, protocol, or other similar criterion, you will be offered a copy, upon request and free of charge. Alternatively, the decision maker

may simply include a copy with your notification.

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist you.

- The decision on the claim will also be sure to include information sufficient to identify the claim, including, as applicable, the date of service, the health care provider, the claim amount, a statement describing the availability (upon request) of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the denial code and its corresponding meaning.

If your claim is denied and you disagree and want to pursue the matter, you *must* file an appeal in accordance with the following procedures. You *cannot* take any other steps unless and until you have exhausted the appeal procedure. For example, if your claim is denied and you do not use the appeal procedure, the denial of your claim is conclusive and *cannot be challenged, even in court.*

"Rescission" appeals. If your coverage under the plan is "rescinded," meaning that it is cancelled or discontinued with retroactive effect, for any reason other than your failure to pay employee contributions or premiums, that is considered a denial of benefits that triggers a right to appeal.

***Appeals*.** To file an appeal, write to J & K Consultants, Inc. at 2605 Nicholson Road, Suite 1140, Sewickley, PA 15143, email: CinciHRA@JandKcons.com; fax: 877-599-3724 stating the reasons why you disagree with the denial of your claim. You must do this within *180 days after the claim was denied*. You have the right to be represented by anyone else, including a lawyer if you wish.

The appeals authority will never be the same person who denied the claim and will never be subordinate to the person who denied the claim. To assure independence and impartiality, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a member of the appeals committee) will never be based on the likelihood that the individual will support a denial of benefits. The appeals authority will review each appeal without giving any deference to the initial decision that was made on the claim.

Upon request, you will be provided reasonable access to the claim file. You will be provided reasonable access to, and free copies of, all documents, records, and other information that constitute a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for your diagnosis (without regard to whether the decision maker relied on it in making the decision on your claim). And if the decision maker obtained the advice of medical or vocational experts in connection with your claim, you are entitled to know who they are, regardless of whether the decision maker relied on their advice.

If the denial of your claim was based, in any part, on a medical judgment, such as a judgment whether a particular treatment or drug is experimental or medically necessary, the appeals authority will consult with a health care professional who has appropriate training and experience in that field of medicine. This will not be (or be a subordinate of) any health care professional who consulted on the initial denial of your claim.

If you file an appeal, you have the right to submit written comments, documents, records and other information relating to your claim. This may include new information that was not submitted as part of your claim. All such information will be considered in your appeal.

If during the appeal process any new or additional evidence is considered, relied upon, or generated in connection with your claim, it will be provided to you as soon as possible and sufficiently in advance of the time when the appeal decision is due to give you a reasonable opportunity to respond before the appeal decision is made. Before the appeals authority can issue an adverse decision based on any new or additional rationale, you will be advised of the rationale as soon as possible and sufficiently in advance of the time when the appeal decision is due to give you a reasonable opportunity to respond before the appeal decision is made. While the appeals authority is not required to hold a hearing, you will be entitled to present testimony.

The appeals authority will issue a written decision within 60 days, unless special circumstances require more time, in which case you will be advised before the original 60 days have elapsed and the decision will be issued within 120 days. The decision will explain the reasoning of the appeals authority, will refer to the specific provisions of this Plan on which the decision is based, and will remind you once again of your right of reasonable access to, and copies of, all relevant documents.

If you are not granted all that you seek in filing the appeal, you will be given:

- The specific reasons why.
- Specific references to the provisions of the plan on which the decision was based. If those provisions involve the application of terms such as "medical necessity" or "experimental," you will be offered, upon request and free of charge, an explanation of the scientific or clinical judgment underlying the decision, applying the terms of the plan to your medical circumstances. Alternatively, the decision maker may simply include the explanation with your notification.
- If the decision maker relied on an internal rule, guideline, protocol, or other similar criterion, you will be offered a copy, upon request and free of charge. Alternatively, the decision maker may simply include a copy with your notification.
- A statement that you are entitled to receive relevant information.
- A description of available internal appeals and any external review process, including information about how to initiate them and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor office and your state insurance regulatory agency."
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist you.

The decision on the appeal will also be sure to include information sufficient to identify the claim, including, where applicable, the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and (if the decision is adverse) the denial code and its corresponding meaning.

Exhaustion. If the plan fails to adhere to the claim and appeal procedures described above in this section, you *may* be excused from exhausting them and proceed directly to an external appeal (described below) or to a lawsuit. But you are *not* excused from exhausting the regular claim and appeal procedures

if the failure is *de minimis* (a legal term that basically means "insignificant") and does not cause (and is not likely to cause) prejudice or harm to you, as long as the plan demonstrates that the failure was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the plan.

The exception for *de minimis* failures is not available if the violation is part of a pattern or practice of violations by the plan. You may request a written explanation of the failure from the plan, in which case the plan will provide an explanation within 10 days, including a specific description of its bases, if any, for asserting that the failure should not cause the internal claims and appeals process to be considered exhausted.

If you think that exhaustion is excused under this section and proceed directly to external review or a lawsuit, but it turns out that exhaustion was *not* excused after all, you will have the right to resubmit and pursue the internal appeal of the claim. If that happens, then within 10 days after the external reviewer or court rejects your claim of exhaustion, the plan will notify you of the opportunity to resubmit and pursue the internal appeal of the claim. Any deadlines for filing a claim will then begin to run when you get that notice.

External review. External review is available for adverse benefit determinations relating to medical care that involve either medical judgment or rescission of coverage. This includes, but is not limited to, judgment as to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational. This does not include determinations that you are not eligible for the plan.

How. You file a written request for an external review with the plan administrator.

When. You file it within four months after receiving an adverse decision on your appeal. If you are excused from filing an appeal, you file the request for external review within four months after receiving an adverse decision on your claim. (Where there is no date corresponding to four months after receipt of the adverse determination, the deadline is the first day of the fifth month thereafter.)

Preliminary screening. Your request will be screened within five days to be sure that your request is appropriate for external review. The plan administrator will verify that your claim does not relate to eligibility for the plan, that you were in fact covered at the appropriate time, that you have exhausted the appeal process (or are excused from exhausting it), and that you have provided all the needed information.

One day after the screening is complete, you will be notified whether your request for external review has been accepted or, if it has not been accepted, why it was not. If the screening shows that you were not eligible for the plan at the appropriate time, the reasons will be provided, along with the contact information for the Employee Benefits Security Administration of the U. S. Department of Labor. If the screening shows that the request is incomplete, you will be told exactly what more is required, which you can provide within the original four-month period (or within 48 hours after receiving the screening notice, if later).

Referral to independent review organization. If accepted, your request for external review will be forwarded to an independent review organization (which we will call the "IRO") which meets all the requirements of the Employee Benefits Security Administration of the U. S. Department of Labor.

External appeals will be rotated among the IRO's with whom the plan has contracted.

Exchanges of information. Within five business days, the plan administrator will provide the IRO with all information that was considered in making the adverse determination. The IRO will also notify you of your opportunity to submit additional information for the IRO to consider (which it will then provide to the plan administrator, so that the plan may reconsider its decision in light of any new information).

Reversal by the plan. If the plan decides to reverse the denial and provide the benefit, it will notify you and the IRO within one business day. The external review will thereupon be terminated.

Consideration by the IRO. The IRO will consider all the information received and render its decision within 45 days after it was first engaged. It will issue a written decision to you and to the plan that includes all of the information required by the Employee Benefits Security Administration of the U. S. Department of Labor.

Retention of records. The IRO will thereafter retain its records of your external review for six years, during which time it will make the records available for examination by you, the plan, or any state or federal oversight agency (except where disclosure would violate some privacy law).

Compliance. If the IRO reverses the adverse determination, the plan will immediately provide payment for your claim, without regard to whether the plan intends to seek judicial review of the decision of the IRO, unless and until there is a judicial decision otherwise.

CHANGING OR ENDING THE PLAN

Changing the Plan. The Plan Sponsor has the right to change the Plan in any way and at any time and is not required to give a reason for the changes. These changes can be retroactive. All changes to the Plan must be in writing.

The Risk Manager of the City of Cincinnati is authorized to act on behalf of the Employer in this regard as long as the changes do not materially increase the liability of the Employer under the Plan.

Any special arrangement made by the Plan Sponsor for an individual will constitute an amendment to this Plan applicable only to that individual.

Ending the Plan. The Plan has no set expiration date; when it was established, it was not intended to be temporary. Nevertheless, the Plan Sponsor has the right to end the Plan (in whole or in part) at any time and is not required to give a reason for doing so.

MISCELLANEOUS

Subrogation. If the Plan reimburses you for medical or other expenses under this Plan but later you recover some or all of those expenses from a third party, you are required to repay the Plan to that extent. This could happen, for example, if you are in an automobile accident, where the Plan pays for hospital care but later you make a claim against the other driver and recover for those same hospital expenses.

The Plan Sponsor has discretion to enforce this provision by any necessary or appropriate means, which might include (a) withholding payment under the Plan until the outcome of your claim against the third party is known, (b) making payment under the Plan but requiring you to sign a form pledging to repay the Plan to the extent of any recovery from a third party, (c) making payment under the Plan but relying on this provision of the Plan to establish your obligation to repay, (d) intervening in your action against the third party in order to protect the rights of the Plan, (e) taking legal action against you for repayment, and (f) setting off your obligation to repay against future benefits otherwise due under the Plan.

Qualified medical child support orders. If the Plan Sponsor receives a child support order that is (i) a judgment, decree or order of a court (including approval of a settlement agreement) (or else issued through an administrative process established under state law that has the force and effect of law under applicable state law), that (ii) provides for child support for a child of an eligible employee and (iii) either relates to benefits under the Plan or enforces a federally prescribed state law relating to Medicaid recipients, then the Plan Sponsor will notify you and the child that the order has been received and describe the procedure that the Plan Sponsor will follow.

Family and Medical Leave. While on a leave of absence to which you are entitled under the federal Family and Medical Leave Act of 1993, you will not suffer the loss of any "employment benefit" (as defined for the purpose of the Family and Medical Leave Act) under the Plan which had accrued before you took the leave and which would not have been lost if you had remained actively at work. But you will not accrue any additional "employment benefits" under the Plan during the leave, except as specifically set forth in the Plan.

Military service. Upon re-employment in accordance with the federal Uniformed Services Employment and Reemployment Act of 1994 (which has rules about honorable discharge and time limits on returning to work), you regain entitlement to all rights and benefits *which are determined by length of service* that you had under the Plan when the military service began, plus any additional such rights and benefits that you would have accrued if you had remained continuously employed during the military service.

Legal nature of the Integrated HRA. The Integrated HRA is an Integrated HRA under section 105 of the Code.

Fail-safe provisions for compliance with PPACA. The ordinary terms of the Plan, which are set out in this document, fully comply with the Patient Protections and Affordable Care Act of 2010 ("PPACA").

Clerical Error. Any clerical error by the Claims Administrator or an agent of the Claims Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Administrative Exception: Any administrative exception made to the Plan by the Plan Sponsor will be deemed to be an amendment to the Plan for that individual and that individual only.

APPENDIX A -- REIMBURSEMENT LEVELS

Integrated HRA

You will be reimbursed for any additional premium contribution you may incur to add you and/or your dependents to the Alternate Coverage minus your City of Cincinnati premium contribution, subject to the maximums below.

You will be reimbursed for amounts currently charged by the Alternate Coverage as a "surcharge" to add your family to the Alternate Coverage or any incentive paid by the Alternate Coverage to waive coverage, subject to the maximums below.

You can be reimbursed for premium payments, deductibles, co-payments and co-insurance up to the following amounts:

Single coverage	$8,150 PER YEAR
Family coverage	$16,300 PER YEAR

You can be reimbursed for premium payments up to the following amounts:

Single coverage	$5,000 PER YEAR
Family coverage	$10,000 PER YEAR

Any claim not allowed by the Alternative Coverage will not be allowed under this Plan.

APPENDIX B – COBRA CONTINUATION COVERAGE

Introduction. This policy implements the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), as amended to date, with respect to the Plan. In this appendix, the Plan will be referred to interchangeably as either "the Plan" or "the group health Plan."

Every employee covered by the Plan who suffers a qualifying event will be afforded the opportunity to purchase continuation coverage under COBRA in accordance with this policy. Interpretation of this policy will be guided by the intent of the employer to comply fully with COBRA, applicable regulations, and applicable judicial decisions thereunder but not to provide any rights or benefits in excess of the minimum requirements thereof. This policy overrides the COBRA policies of any third-party administrator.

General COBRA notification. Within 90 days after an employee first becomes covered by the Plan, a copy of this COBRA appendix will be sent by mail to the employee at the employee's home address.

As an exception, if a qualifying event occurs and the Plan Administrator is required to provide a COBRA election notice (as explained below) before the general COBRA notification is due, the general COBRA notification will be included with the COBRA election notice.

The Plan Administrator will keep proof of mailing of these notices. Alternately, if the Plan Administrator chooses to use electronic transmission of documents (as explained near the end of this appendix), the Plan Administrator will keep a record of the transmission.

Qualifying events. Qualifying events are any of the following *if the event causes a loss of coverage under the Plan.* Even if coverage is not lost entirely, a loss of coverage will nevertheless be considered to occur if the resulting coverage is in any way inferior to, or more expensive to the individual than, that provided to similarly situated individuals who have not suffered a qualifying event.

An event is a qualifying event regardless of whether the loss of coverage occurs at the same time as the event or is delayed, as long as the loss of coverage will occur before the end of the maximum period of COBRA continuation coverage. The qualifying event is considered to occur when the event occurs, regardless of when coverage under the group health Plan is lost. Any extension of coverage at the employer's expense after such an event will be considered voluntary relief from the COBRA premium requirement rather than a postponement of the qualifying event.

Reduction in hours. Reduction in the employee's hours for any reason, including, for example, layoff, leave of absence, and reduction from full-time to part-time, is a qualifying event for the employee.

Since a leave to which an employee is entitled under the federal Family and Medical Leave Act does *not* result in loss of coverage under any group health Plan, such a leave does not constitute a qualifying event. If the employee fails to return to employment at the end of such a leave, however, the failure to return will cause a loss of coverage and so the failure to return will constitute a qualifying event which occurs at the end of the leave.

Termination of employment. Termination of an employee's employment, whether voluntary or involuntary and including quit and retirement, is a qualifying event for the employee, except that (a) termination of employment does not constitute a qualifying event with regard to coverage that was previously lost (or continued under COBRA) due to a reduction in hours and (b) termination of employment by reason of gross misconduct of the employee will not constitute a qualifying event for the employee.

Notice of qualifying event from employer to Plan Administrator. The employer will notify the Plan Administrator within 30 days after:

- the termination of employment of the employee (other than by reason of gross misconduct), or
- a reduction in the employee's hours that would result in a loss of coverage.

As an exception, if this COBRA appendix provides that the qualifying event will be considered to occur when the employee would otherwise lose coverage, the employer will provide this notice within 30 days after the employee would otherwise lose coverage.

The notice will be sufficient to identify this Plan, the covered employee, the qualifying event, and the date of the qualifying event. There is no requirement about how this notice will be given.

Any qualified beneficiary who claims extended continuation coverage by reason of being disabled during the 60 days after the original qualifying event must notify the Plan Administrator of the disability determination *both* within 60 days after receiving the Social Security determination *and* within the original 18-month period of continuation coverage. As an exception, if the Social Security Administration made the determination of disability before the original qualifying event, notice must be given within 60 days after the original qualifying event (or coverage would otherwise have been lost due to the original qualifying event, if later). A qualified beneficiary receiving extended continuation coverage due to disability must notify the Plan Administrator of any final determination that the person is no longer disabled and must do so within 30 days after receiving the determination.

In all cases, as an exception, if the Plan Administrator has not yet provided either the general COBRA notification or notice of a qualifying event, the deadline period will not begin to run until one of those notices has been provided.

Notice of qualifying event from Plan Administrator to qualified beneficiaries. Within 14 days after receiving notice of a COBRA qualifying event from the employer (as just described), the Plan Administrator will notify the qualified beneficiary of his or her right to elect continuation coverage under COBRA. (Note that, where the employer *is* the Plan Administrator, this affords the Plan Administrator a total of 44 days.)

The notice will identify the Plan; the name, address and telephone number of the person or entity responsible for administering COBRA; the qualifying event; the qualified beneficiary; the COBRA premium; the date on which coverage will terminate if COBRA continuation coverage is not chosen; the date on which COBRA coverage will begin if chosen; the date on which COBRA coverage will end if chosen; and will include a complete explanation of COBRA continuation coverage (such as by including a copy of this COBRA appendix).

Notice will be given to the qualified beneficiary by mail addressed to the qualified beneficiary at the last known address.

If the Plan Administrator receives notice from the employer (as described above) but decides that the qualified beneficiary is not entitled to COBRA (or an extension of COBRA) after all, the administrator will still notify the qualified beneficiary within 14 days but explain the decision (in the same manner as any other denial of benefits under the Plan).

Election of COBRA. *Timing*. After receiving notice from the Plan Administrator, the qualified beneficiary will have 60 days to elect continued coverage under COBRA. (If the notice arrives before the date on which coverage would otherwise have ceased, the qualified beneficiary will have 60 days from the date on which coverage would otherwise have ceased.)

Method. Election of COBRA continuation coverage will be made by returning to the Plan Administrator, properly completed and signed, such form as the Plan administrator may require (and supply with the notice of the qualifying event). The form may be returned at any time during the 60-day period described above.

Even if a qualified beneficiary returns the form during the 60-day period showing an election *not* to take COBRA continuation coverage, the qualified beneficiary may change his or her mind and elect continuation coverage by completing, signing and returning another form within the 60-day period described above.

Though the form supplied by the Plan Administrator is the preferred and usual method for making the election, any other method will be accepted that contains all of the information necessary to process the election.

Please note: Failure to elect COBRA continuation coverage within the 60-day deadline described in this section will constitute a complete, final and permanent waiver of COBRA continuation coverage.

Effect. The coverage offered for election will be the same coverage that the qualified beneficiary had immediately before the qualifying event—no more, no less, no changes.

Upon valid election, coverage will be provided retroactively to the date of the qualifying event, except that, if the qualified beneficiary first completes and returns a form showing an election *not* to take COBRA continuation coverage but later (within the 60-day period) completes and returns another form electing to *take* COBRA continuation coverage, the continuation coverage will be provided prospectively only - from the date when the second form was returned - and not retroactively to the qualifying event.

Regardless of the date as of which COBRA continuation coverage is provided, no claims will be paid for expenses incurred after the qualifying event unless and until the COBRA premium is timely paid (as described below).

Disclosure to health care providers. If an individual is a qualified beneficiary but has not made an election and the election period has not yet expired, health care providers who inquire as to the coverage status of the individual will be told exactly that - that the individual is not presently covered but has a right to elect coverage that will be retroactive to the qualifying event as long as the COBRA premium is timely paid. Likewise, if an individual who is a qualified beneficiary has timely elected continuation coverage but has not yet paid the first COBRA premium, health care providers who inquire as to the coverage status of the individual will be told exactly that - that the individual is not presently covered but has elected continuation coverage, which will be retroactive to the qualifying event if and when the first COBRA premium is timely paid.

Paying for COBRA coverage. COBRA continuation coverage will be provided to the qualified beneficiary only if the qualified beneficiary pays the applicable premium for such coverage plus a 2% administrative charge, with two exceptions:

- Qualified beneficiaries who are receiving an additional 11 months of continuation coverage due to disability will pay during those additional 11 months an amount equal to 150% of the applicable premium (as long as the individual who was disabled is receiving continuation coverage).

- Where the qualifying event is the employee's absence due to service in the uniformed services of the United States (meeting the requirements of the federal Uniformed Services Employment and Reemployment Act of 1994) and the employee performs such service for less than 31 days, the charge for COBRA coverage is limited to the employee contribution required of active employees.

The applicable premium will equal the actual cost to the group health Plan of providing the same coverage to participants of the group health Plan who have not suffered a qualifying event. The applicable premium will be determined on an actuarial basis as provided in COBRA.

Payment for all months up to and including the month in which the qualified beneficiary returns the election form to the Plan Administrator must be made to the Plan Administrator within 45 days after the election form is returned to the Plan Administrator. Payment for months following the month in which the election form is returned to the Plan Administrator must be made by the first of the month for which payment is made. Payment should be made payable Anthem Blue Cross and Blue Shield.

Please note: It is the responsibility of the qualified beneficiary to make timely premium payments. The Plan Administrator does not send bills or reminder notices.

Coverage received on COBRA. A qualified beneficiary who timely elects and pays for COBRA continuation coverage will receive the same coverage as similarly situated participants in the group health Plan who have *not* suffered a qualifying event.

Each such qualified beneficiary also has the same rights as a similarly situated participant who has not suffered a qualifying event to participate in open enrollment period and make changes in his or her coverage.

Duration of COBRA coverage. The maximum period of continuation coverage is 18 months from the date of the qualifying event.

As an exception, if an individual suffers a qualifying event by reason of absence due to service in the uniformed services of the United States as described in the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended by the Veterans Benefit Improvement Act of 2004, the maximum period of continuation coverage is 24 months from the date of the qualifying event.

As another exception, if an employee who is a qualified beneficiary (either because the individual chose continuation coverage or because the 60-day election period has not expired) is determined to have been disabled under Title II or XVI of the Social Security Act at any time during the 60 days after the original qualifying event (and fulfills the notice requirements previously described), then the maximum period of coverage is extended to 29 months from the date of the original qualifying event.

Termination before maximum period has expired. Continuation coverage for a qualified beneficiary will be terminated automatically if and when:

- the qualified beneficiary first becomes covered under any other group health Plan after the date of election (effective June 8, 1998, continuation of other coverage that the qualified beneficiary may have had before the qualifying event, such as coverage as a dependent under the spouse's group health Plan, will not trigger termination under this paragraph), unless the other group health Plan excludes or limits coverage for a pre-existing condition that the qualified beneficiary has and that exclusion or limitation is neither barred nor satisfied by the qualified beneficiary under the federal Health Insurance Portability and Accountability Act of 1996, or

- the qualified beneficiary first becomes covered by Medicare after the date of the election (effective June 8, 1998, continuation of Medicare coverage that the qualified beneficiary may have had before the qualifying event will not trigger termination under this paragraph), or

- the qualified beneficiary is receiving extended coverage by reason of disability and ceases to be disabled, or

- payment of the required COBRA premium is not timely made (including a grace period of at least 30 days, and including the right of the qualified beneficiary to make up any deficiency in a partial payment within 30 days after notification from the Plan Administrator that the payment was not for the full amount due), or

- the employer ceases to provide any group health Plan to any employee.

If the group health Plan under which a qualified beneficiary is receiving COBRA continuation coverage terminates but the employer continues to provide one or more group health Plans, the qualified beneficiary will be afforded the same opportunity as participants with respect to whom a qualifying event has not occurred to participate in an alternate group health Plan of the employer.

Notice of premature termination of COBRA coverage from Plan administrator to qualified beneficiary. If a qualified beneficiary chooses to have COBRA coverage but the COBRA coverage ends before the maximum duration (18 months or 29 months, as just explained), the Plan Administrator will notify the qualified beneficiary, provide the reason, and make note of the date of termination of COBRA coverage, as well as remind the individual about coverage alternates. This will apply, for example, where COBRA coverage is shut off because the qualified beneficiary is not making the required payments. The Plan Administrator will provide this notice as soon as practical after the decision is made.

Miscellaneous provisions. *Health coverage tax credit.* The federal Trade Act of 2002 created a health coverage tax credit, which can be used to help offset the cost of COBRA premiums, for certain individuals who become entitled to "trade adjustment assistance" or who have retired and are receiving pension payments from the federal Pension Benefit Guaranty Corporation. You can get information about the health coverage tax credit by calling the government's Health Coverage Tax Credit Customer Contact Center, toll-free at (866) 628-4282 or visiting www.irs.gov and searching for "HCTC."

Electronic notices. The general COBRA notification given when the employee joins the Plan and the COBRA election provided when a qualifying event occurs may be given electronically, rather than by mail, if all of the following conditions are satisfied.

It is true that access to the employer's electronic information system is an integral part of the employee's duties and the employee has the ability effectively to access electronic documents at any location where the employee is reasonably expected to perform duties.

It is true that:

- the person has affirmatively consented to receiving documents through electronic media (the consent may be in any form) and has not withdrawn consent;
- the person has given or confirmed consent electronically in a way that demonstrates their ability to access information electronically and provided an electronic address;
- before consenting the person was provided with a notice explaining the types of documents to which the consent will apply, that the consent may be withdrawn at any time without charge, the procedures for withdrawing consent and updating the person's electronic address, the right to get a paper copy of any document that is furnished electronically (and the amount of any charge), and any hardware and software requirements for accessing and saving electronic documents;
- after the person gives consent, if a change in hardware or software requirements creates a material risk that the person will be unable to access or save the documents, the person is provided with a statement of the new hardware and software requirements, is given the opportunity to withdraw consent, and again consents as described above.

The Plan Administrator has taken appropriate and necessary measures reasonably calculated to ensure that:

- the system for furnishing documents electronically results in actual receipt of the documents (such as by using return-receipt or notice of undelivered electronic mail features or conducting periodic reviews or surveys to confirm receipt of the documents); and

- the system protects the confidentiality of personal information relating to the individual's accounts and benefits (such as by incorporating into the system measures designed to preclude unauthorized receipt of or access to such information by individuals other than the individual for whom the information is intended);

- the electronically delivered documents are prepared and furnished in a manner that is consistent with the style, format and content requirements applicable to the particular document;

- notice is provided to each intended recipient, in electronic or non-electronic form, at the time a document is furnished electronically, that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted and of the right to request and obtain a paper version of the document; and

- upon request, the person is furnished with a paper version of the documents.

Change of address. It is important that all individuals who are, or may become, qualified beneficiaries keep the Plan Administrator up to date with their correct mailing address.

Questions. If you have questions about continuation coverage under COBRA, you should get in touch with the COBRA Benefits Department City of Cincinnati Integrated HRA, City of Cincinnati Office of Risk Management, 805 Central Avenue, Suite 100, Cincinnati, Ohio 45202

Alternately, you may get in touch with the Employee Benefits Security Administration of the U.S. Department of Labor. You can find the telephone number for the nearest office of the EBSA in the phone book or on the EBSA website, which is www.dol.gov/ebsa.

Correction of mistakes. If at any time it is determined that a mistake has been made with regard to administration of COBRA continuation coverage, regardless of whether the mistake is favorable or detrimental to the employee, all feasible steps will be taken as soon as reasonably possible to correct the mistake by returning all affected parties to the position that they would have been in if the mistake had not occurred, including, if necessary, retroactive collection or refund of COBRA premiums and retroactive provision or denial of coverage.

APPENDIX C -- PRIVACY UNDER HIPAA

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the City of Cincinnati Integrated HRA (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your Employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

1) your past, present, or future physical or mental health or condition;
2) the provision of health care to you; or
3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plan Sponsor.

EFFECTIVE DATE
This Notice is effective October 3, 2015

OUR RESPONSIBILITIES
We are required by law to:
- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION
Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we may share your protected health information with a utilization review or precertification service provider.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Plan Sponsor protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by

someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law- enforcement official in response to a court order, subpoena, warrant, summons, or similar process;

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- and about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

OTHER DISCLOSURES

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice / authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. In most situations, we send mail to the employee / member. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the Plan Sponsor. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan Sponsor.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the City of Cincinnati Office of Risk Management, 805 Central Avenue, Suite 100, Cincinnati, Ohio 45202. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy;
- or is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Sponsor. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to City of Cincinnati Office of Risk Management, 805 Central Avenue, Suite 100, Cincinnati, Ohio 45202. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply -- for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to City of Cincinnati Office of Risk Management, 805 Central Avenue, Suite 100, Cincinnati, Ohio 45202. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, contact the Plan Sponsor.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the City of Cincinnati Office of Risk Management, 805 Central Avenue, Suite 100, Cincinnati, Ohio 45202. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

POTENTIAL IMPACT OF STATE LAWS

The HIPAA Privacy Regulations generally do not 'preempt' (or take precedence over) state privacy or other application laws that provider individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV, or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights.