

Hamilton County Medical Expense Reimbursement Plan

Effective: 1-1-12

MEDICAL EXPENSE REIMBURSEMENT PLAN

1. PURPOSE

Hamilton County hereby establishes the Hamilton County Medical Expense Reimbursement Plan (the "Plan") effective January 1, 2012. The purpose of this Plan is to help provide reimbursement for certain medical expenses incurred by eligible employees (and their spouses and dependents) who choose not to participate in Hamilton County's group medical insurance plan, but who have alternate medical insurance coverage as set forth in this Plan. The Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The health care expenses reimbursed under the Plan are intended to be eligible for exclusion from the participant's gross income under Section 105 of the Internal Revenue Code of 1986, as amended (the "Code") and the regulations issued thereunder. Employer identification for federal tax purposes is 31-6000063.

Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Section 2. Unless otherwise indicated by the context, whenever used in this Plan, the masculine gender shall include the feminine and the plural shall include the singular.

2. DEFINITIONS

- a. Alternate Coverage – means (i) group medical insurance coverage (other than the coverage provided by Hamilton County under Hamilton County Policy Section 5.2) available to an Employee such as through the Employee's spouse or another employer of the Employee, or (ii) group coverage available to the Employee from any other source including but not limited to retiree benefit programs (other than Medicare).
- b. Appeals Authority – means an authorized representative of the Plan Administrator and an authorized representative of the Claims Administrator who have authority under the Plan to review and determine the outcome of appeals from Participants.
- c. Claims Administrator – means a third party administrator hired by the Plan to make reimbursements to Participants.
- d. COBRA – means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- e. Code – means the Internal Revenue Code of 1986, as amended.

- f. Coverage Period – with respect to any Plan Year, means the Plan Year. For any Employee who becomes a Participant after the start of the Plan Year, the initial Coverage Period shall mean the period commencing on the effective date of such Participant's eligibility and extending through the remainder of the Plan Year.
- g. Dependent – means any individual who is considered an Eligible Dependent on the County's medical insurance plan, as defined in Hamilton County Board of County Commissioners Human Resources Policy 5.2
- h. Effective Date – means January 1, 2012.
- i. Employee – means employees eligible for medical benefits as identified in Hamilton County Board of County Commissioners Human Resources Policy 5.2.
- j. Employer – means Hamilton County, Ohio.
- k. Health Care Expense – means any expense incurred by a Participant, his Spouse or Dependents for "medical care," as defined in Section 213(d) of the Code and as allowed under Section 105 of the Code and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code.
- l. Participant – means an Employee who has elected to participate in the Plan according to Section 4 of this plan document. For purposes of Sections 9 and 10 of this Plan, a Participant shall also mean a Spouse or Dependent who is covered by this Plan.
- m. Plan – means the Hamilton County Medical Expense Reimbursement Plan as set forth in this document.
- n. Plan Administrator – means the Employer, or any individual or committee appointed or designated by the Employer to carry out administration of the Plan.
- o. Plan Benefits – means the reimbursements provided under this Plan as described in Section 8 of this plan document.
- p. Plan Year – means the calendar year (i.e., the 12-month period commencing on January 1 and ending on December 31).
- q. Qualifying Event – means any event recognized as a qualifying event under the provisions of COBRA.
- r. Spouse – means the legally married husband or wife of a Participant as determined under Ohio law.

3. ELIGIBILITY AND EFFECTIVE DATE OF PARTICIPATION

Any Employee who is enrolled in Alternate Coverage in a Plan Year shall be eligible to participate in this Plan during such Plan Year. Such Employee may elect to participate in this Plan in accordance with Section 4 below, effective as follows:

- a. For eligible Employees who elect coverage under this Plan during the annual open enrollment process, coverage is effective on the first day of the Plan Year (i.e., January 1).
- b. For Employees who become eligible to participate after the Plan Year begins, coverage under this Plan will be effective based on Hamilton County Board of County Commissioners Human Resource Policy 5.2.

4. PARTICIPATION

To participate in the Plan, an Employee must enroll using the method prescribed by Hamilton County whether that is through on-line enrollment or through a paper application. Such enrollment must be submitted to the Plan Administrator prior to the date in which participation will commence. The enrollment form must identify the Spouse and Dependents whose Health Care Expenses may be submitted to the Plan. The Employee must submit documentation from an independent third party that demonstrates that the Employee (and his Spouse and Dependents if he is enrolling his Spouse and Dependents) have Alternate Coverage. Enrollment in this Plan will not be effective until proof of Alternate Coverage is submitted and verified.

Participation in the Plan will cause the enrolled individual to be ineligible to contribute to a health savings account (commonly referred to as an HSA) because coverage under the Plan is non-high deductible health plan coverage. If an Employee enrolls his Spouse or Dependent in the Plan, such Spouse or Dependent would be ineligible to contribute to an HSA while enrolled in the Plan.

During an approved leave of absence, coverage under this Plan can be continued based on Hamilton County Board of County Commissioners Human Resources Policy 5.2.

An election to participate in the Plan is irrevocable until the next Plan Year, except as provided in Section 5.

5. CHANGE OF ELECTION

A Participant may change elections under this Plan should the Participant have a change in status such as: marriage, divorce, birth or adoption of a child, death of a Spouse or Dependent, loss of Dependent status, commencement or termination of employment of a Spouse, or gain or loss of Alternate Coverage. A change in status

means any of the reasons listed in Section 4.04 of the Freedom of Choice Plan Document, as amended.

Such election must be made within 31 days of the change in status, except as noted in the paragraph below. The change requested must be consistent with the change in family status.

If a Participant, Spouse, or Dependent is entitled to a special enrollment right, as required by section 9801(f) of the Code, the Participant shall be permitted to make a change to his election under this Plan provided the election corresponds with such special enrollment right and only to the extent required by section 9801(f) of the Code.

6. WHEN PARTICIPATION ENDS

A Participant, Spouse, and Dependent will cease to be a Participant in this Plan or covered by this Plan upon the earlier of:

- a. Termination of this Plan;
- b. The last day of the month in which the Participant terminates employment, retires or otherwise separates from service with the Employer, or becomes ineligible due to a change in employment status;
- c. The date that a Participant, Spouse, or Dependent ceases to be enrolled in Alternate Coverage. Such termination will only apply to the individual(s) who cease to be enrolled in Alternate Coverage, unless it is the Participant who is no longer enrolled in Alternate Coverage, in which case, the coverage of the Participant, Spouse, and Dependent will be terminated on the date that the Participant is no longer enrolled in Alternate Coverage.
- d. The date that the Employee, Spouse or Dependent commits an act (or an omission to act) that constitutes fraud or intentional misrepresentation as determined by the Plan Administrator based on all of the relevant facts and circumstances.

A Participant who no longer has Alternate Coverage for any reason must promptly notify the Plan Administrator prior to loss of Alternate Coverage, or if prior notice is not feasible, as soon as possible after loss of Alternate Coverage. If a Participant notifies the Plan Administrator within 31 days of loss of Alternate Coverage, the Participant will be entitled to enroll in other group health plan sponsored by Hamilton County under Hamilton County Human Resources Policy Section 5.2, if otherwise eligible. A Participant's failure to notify the Plan Administrator of loss of Alternate Coverage for either himself, Spouse, or Dependents, or submitting reimbursements for Plan Benefits incurred after such loss of Alternate Coverage, may constitute fraud or intentional representation, and the Plan Administrator shall have the right to retroactively cancel

coverage under this Plan for the Participant, Spouse, and Dependents and seek repayment of Plan Benefits incurred after the loss of Alternate Coverage.

7. CONTINUATION OF COVERAGE

This Plan is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

A qualified beneficiary under COBRA law means an Employee, Spouse or Dependent if covered by this Plan on the day before the Qualifying Event. A qualified beneficiary under COBRA law also includes a child born to the Employee during the Coverage Period or a child placed for adoption with the employee during the Coverage Period.

An Employee covered by this Plan has the right to elect continuation coverage if coverage is lost due to one of the following Qualifying Events:

- a. Termination (for any reasons other than gross misconduct, as defined by the Employer) of the Employee's employment or reduction in the hours of Employee's employment.

A Spouse covered by this Plan has the right to elect continuation coverage if the coverage is lost due to one of the following Qualifying Events:

- b. The death of the Employee;
- c. Termination of the Employee's employment (for reasons other than gross misconduct, as defined by the Employer) or reduction of the Employee's hours of employment with the Employer;
- d. Divorce or legal separation from the Employee; or
- e. The Employee becomes entitled to Medicare.

A Dependent covered by this Plan has the right to continuation coverage if coverage is lost due to one of the following Qualifying Events:

- a. The death of the Employee parent;
- b. The termination of the Employee parent's employment (for reasons other than gross misconduct, as defined by the Employer) or reduction of the Employee's hours of employment with the Employer;
- c. The Employee parent's divorce or legal separation;
- d. Ceasing to meet the requirements to be a Dependent under this Plan; or
- e. The Employee parent becomes entitled to Medicare benefits.

Coverage under the Plan is lost in connection with the foregoing Qualifying Events when a covered Employee, Spouse or Dependent ceases to be covered under the same Plan terms and conditions as in effect immediately before the Qualifying Event.

This Plan provides that coverage terminates for a Spouse due to legal separation or divorce or for a Dependent when the child loses Dependent status. Under the law, the Employee or qualified beneficiary has the responsibility to inform the Plan Administrator if one of the Qualifying Events has occurred.

Initial COBRA notification will be provided, within 90 days after an Employee first becomes covered by the Plan, to the Employee's home address. If the Employee's Spouse and Dependents are covered by the Plan, the notices will be addressed to all Participants and mailed to the Employee's home address. Separate notices are required when there are separate addresses, and a notice to a Spouse is considered sufficient for notifying all Dependents residing with the Spouse.

Upon notification that a Qualifying Event has occurred, notification will be provided to all qualified beneficiaries of their right to coverage continuation. The covered Employee, his or her Spouse and Dependent each have an independent right to elect continuation coverage.

After receiving notice from the Plan Administrator, each qualified beneficiary will have 60 days to elect continued coverage under COBRA.

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that would otherwise have been lost. If coverage is waived before the end of the 60-day election period and the waiver is revoked before the end of the 60-day election period, coverage will be effective on the date the election of coverage is sent to the Plan Administrator.

The coverage offered for election will be the same coverage that the qualified beneficiary had immediately before the Qualifying Event.

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% administration charge with exception that 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.

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 subject to any grace period required by COBRA law.

The maximum coverage period is:

- a. 18 months for an Employee, Spouse and/or Dependent whose coverage ended due to termination of the Employee's employment or reduction in hours;
- b. 36 months for a Spouse whose coverage ended due to the death of the Employee, divorce or the Employee becoming entitled to Medicare at the initial qualifying event;
- c. 36 months for a Dependent whose coverage ended due to the divorce of the Employee parent, the Employee becoming entitled to Medicare at the time of the initial qualifying event, the death of the Employee, or the Dependent ceasing to qualify under this Plan;
- d. An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last until at least the end of the 18-month period of continuation coverage. The qualified beneficiary must provide written notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage.

An 18-month extension of coverage will be available to Spouses and Dependents who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months.

Continuation coverage will terminate before the end of the maximum coverage period for any of the following reasons:

- a. The Employer no longer offers the Plan to any of its Employees;
- b. The premium for continuation coverage is not paid timely;
- c. The individual on continuation coverage becomes covered under another group health plan (as an employee or otherwise); however, if the new plan contains any exclusion or limitation with respect to any pre-existing condition, then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior creditable coverage satisfies the exclusion or limitation;
- d. The individual on continuation coverage becomes entitled to Medicare benefits;
or
- e. If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination.

8. PLAN BENEFITS

There are two types of benefits available under this Plan:

- a. Premiums. Participants are entitled to reimbursement of a portion of the premiums paid for Alternate Coverage based on the following schedule:

Single coverage – If the Participant is enrolled in Alternate Coverage that covers the Employee only, the Participant will be reimbursed for amounts he pays for such coverage that exceed the current employee contribution rate set by the Board of County Commissioners for single coverage under Coverage First 2500, up to a maximum of \$150 per month.

Double coverage – If the Participant is enrolled in Alternate Coverage that covers the Employee plus his Spouse, or the Employee plus one Dependent, the Participant will be reimbursed for amounts he pays for such coverage that exceed the current employee contribution rate set by the Board of County Commissioners for double coverage under Coverage First 2500, up to a maximum of \$200 per month.

Family coverage – If the Participant is enrolled in Alternate Coverage that covers the Employee plus his Spouse and one or more Dependents, or the Employee plus two or more Dependents, the Participant will be reimbursed for amounts he pays for such coverage that exceed the current employee contribution rate set by the Board of County Commissioners for family coverage under Coverage First 2500, up to a maximum of \$400 per month.

Spousal surcharge – If the Participant is enrolled in Alternate Coverage that includes a spousal surcharge (i.e., the Alternate Coverage charges an increased or additional premium if the employee's spouse has employer-provided health coverage available to him or her), the Participant will be reimbursed for amounts he pays as a spousal surcharge for such coverage that exceeds the spousal surcharge set by the Board of County Commissioners for the medical plan offered by Hamilton County under its Human Resources Policy 5.2.

It is the current position of the Internal Revenue Service that such reimbursement of employee contributions is free from federal income tax and Medicare taxes if the Participant, Spouse, or Dependent has paid the employee contributions for the Alternate Coverage on an after-tax basis, however, if the Participant, Spouse, or Dependent has paid the employee contributions for the Alternate Coverage on a pre-tax basis (such as through a cafeteria or Section 125 plan), such reimbursements under this Plan are taxable.

- b. Health Care Expenses. Participants are entitled to reimbursement for the following amounts paid with respect to Health Care Expenses incurred by the Participant (and his Spouse and Dependents, as applicable) while enrolled in this

Plan: (i) deductibles, co-pays and co-insurance paid under the Alternate Coverage; and (ii) amounts with respect to Health Care Expenses that are excluded from coverage under the terms of such Alternate Coverage. Expenses under (i) and (ii) of this Section 8(b) will only be reimbursed to the extent that such Health Care Expenses otherwise would have been covered under the terms of the applicable comparable medical plan offered by Hamilton County under its Human Resources Policy 5.2 (i.e., employee only, employee plus one, family, etc.) had the Participant elected to participate in such Hamilton County plan.

9. CLAIMS FOR REIMBURSEMENTS

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 authority, as described in this section.

Premiums

Upon initial enrollment in this Plan and during each open enrollment period, each Participant must submit information satisfactory to the Plan Administrator verifying his enrollment in Alternate Coverage and his premium expense for such Alternate Coverage. This information verifying premium expense will constitute the Participant's claim for reimbursement for premiums under Section 8(a) above. Applicable premium reimbursements will be paid to the Participant no later than the last day of each calendar month.

If the premium amount of the Alternate Coverage changes during the Plan Year, the Participant must submit a change form to the Claims Administrator as soon as the Participant is aware of the changed premium amount, but in no event later than the date the first premium reimbursement amount after the change is in effect will be received by the Participant. 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 under Section 6 above.

Health Care Expenses

There are two means for obtaining reimbursement under the Plan.

a. MERP I.D. Card –Participants should provide his/her Alternate Coverage identification card as Primary coverage, and the MERP I.D. as secondary coverage to the Provider at the point of service. If the Alternate Coverage (Primary Coverage) requires a co-pay, coinsurance or deductible, the Provider will bill J & K directly, therefore, the Participant will not be required to make payment at the point of service. In situations where a Provider does not accept the MERP I.D. card, the Participant may need to submit a paper claim, as defined below, in order to obtain reimbursement for a co-payment, co-insurance and/or deductible.

b. Paper Claim. A Participant may submit a paper Health Care Expense for reimbursement by completing a "Medical Expense Reimbursement Claim Form," available from the Plan administrator, and returning it to the Claims

Administrator for the Plan at the address shown on the form. Such claims must be submitted no later than March 31 following the close of the Plan Year in which the Health Care Expense was incurred and must set forth:

- a. the individual(s) on whose behalf Health Care Expenses have been incurred;
- b. the nature and date of the Health Care Expenses so incurred;
- c. the amount of the requested reimbursement; and
- d. a statement that such Health Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Any claims for reimbursement that are submitted for a Plan Year beyond March 31 of the year following the close of the Plan Year will be denied.

The application shall be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Health Care Expenses have been incurred and the amounts of such Health Care Expenses, together with any additional documentation that the Claims Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least \$25.

Claims for benefits paid by the Plan should be addressed to the third party Claims Administrator shown below:

J & K Consultants, Inc.
2605 Nicholson Road, Suite 140
Sewickley, PA 15143
1-877-872-4232 Toll Free Number
724-934-3328 Fax Number
joyk@jandkcons.com

If the Claims Administrator has any special rules for filing and processing claims, they are described in written materials that are available from the Claims Administrator and Participants are required to follow them.

The Claims Administrator will process any claims received within 30 days of receipt. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Claims Administrator. If the extension is necessary because of a Participant's failure to submit the information necessary to decide the claim, the Claims Administrator will notify the Participant regarding what additional information he is required to submit, and he will be given at least 45 days

after such notice to submit the additional information. If the Participant does not submit the additional information, the Claims Administrator will make the decision based on the information that it has.

10. APPEALS

Should a claim for a reimbursement of a Health Care Expense be denied, the Claims Administrator will send a notice to the Participant that will include the following information:

- a. The specific reasons for the denial;
- b. A reference to the specific plan provision on which the denial was based;
- c. A description of any additional information that is required to complete the claim and an explanation of why such information is necessary;
- d. A description of the internal and external review procedures and the time limits applicable to such procedures; and
- e. Either a copy of any internal rule, guideline, protocol, or similar criteria used in making the determination, or a statement that such a rule, guideline, protocol, or similar criterion was used and that a copy of such will be provided to the Participant upon request.

If a claim is denied and a Participant disagrees, the Participant must file an internal appeal in accordance with the following procedures. To file an appeal, a Participant should write to the Claims Administrator stating the reasons why he disagrees with the denial of the claim. An appeal must be filed within 180 days after the claim was denied. Anytime before the appeal deadline, the Participant may submit copies of all relevant documents, records, written comments, testimony, and other information to the Claims Administrator in support of the appeal.

Appeals will be heard by the Appeals Authority. If the Appeals Authority receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that was provided by the Participant, the Participant will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the decision on the appeal. Similarly if the Appeals Authority identifies a new or additional reason for denying the claim, that new or additional reason will be disclosed to the Participant and the Participant will be given a reasonable opportunity to respond to that new rationale before the due date for the decision on the appeal.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is not the individual who made the original determination, an individual who is a subordinate of the individual who made the initial

determination, or an individual whose terms and conditions of employment are affected by the results of the decision.

Appeals Authority will issue a written decision with 60 days. Should an appeal be denied, the Appeals Authority will send a notice to the Participant that will include the following information:

- a. The specific reason for the denial upon review;
- b. A reference to the specific Plan provision on which the denial was based;
- c. A statement that the Participant is required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
- d. Either a copy of any internal rule, guideline, protocol, or similar criteria used in making the determination, or a statement that such a rule, guideline, protocol, or similar criterion was used and that a copy of such will be provided to the Participant upon request; and
- e. A statement of the Participant's right to bring an external appeal.

Upon denial of an appeal, a Participant has the right to an external review of the appeal decision, unless the denial was based on the Participant's, Spouse's or Dependent's failure to meet the Plan's eligibility requirements. A request for an external review must be filed by a Participant within 4 months of the date the Participant received the Appeals Authority decision.

External review of medical claims. External review is available for adverse benefit determinations relating to medical care (except in relation to the provision of "excepted benefits" under Part 7 of Title I of ERISA), with the exception of determinations that you are not eligible for the plan (or at least the medical feature of the plan).

How. Participant files a written request for an external review with the plan administrator.

When. Participant files the request within four months after receiving an adverse decision on your appeal. If Participant is excused from filing an appeal, the Participant files the request for external review within four months after receiving an adverse decision on a 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. Participant's request will be screened within five days to be sure that the request is appropriate for external review. The plan administrator will verify that the claim does not relate to eligibility for the plan, that Participant was in fact covered at the appropriate time, that Participant exhausted the appeal process (or is

excused from exhausting it), and that Participant provided all the needed information.

One day after the screening is complete, Participant will be notified whether the request for external review has been accepted or, if it has not been accepted, why it was not. If the screening shows that Participant was 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, Participant will be told exactly what more is required, which Participant 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, the request for external review will be forwarded to an independent review organization (IRO) which meets all the requirements of Technical Release 2010-01, issued by the Employee Benefits Security Administration of the U. S. Department of Labor.

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 the Participant of the Participant's 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 Participant 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, specifically including all of the items listed in Technical Release 2010-01, and render its decision within 45 days after it was first engaged. It will issue a written decision to Participant and to the plan that includes all of the information required by Technical Release 2010-01.

Retention of records. The IRO will thereafter retain its records of the external review for six years, during which time it will make the records available for examination by Participant, 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 coverage or payment for the claim.

Expedited external review. If an initial adverse determination involves a medical condition of Participant's for which the standard timeframe would seriously jeopardize Participant's life or health or would jeopardize Participant's ability to regain maximum function, Participant may request an *expedited* external review. Or if an adverse determination on an appeal involves the same risk or it concerns an admission,

availability of care, continued stay, or health care item or service for which Participant received emergency services (and Participant has not been discharged from the facility), Participant may request an *expedited* external review.

In the case of an *expedited* external review, the following changes will apply to the procedure:

- ▶ The preliminary screening will be as soon as possible, not merely within five days, and the results of the screening will be communicated to Participant immediately, not merely within one day.

- ▶ The plan will provide information to the IRO electronically or by telephone or facsimile or some other expeditious method.

- ▶ The IRO must make its decision as expeditiously as possible, and in no event later than 72 hours after the request is complete.

- ▶ If the IRO communicates its decision other than in writing, it will follow up with written notification within 48 hours thereafter.

The appeal process outlined in this Section 10 will also apply to any appeal by a Participant relating to rescission of coverage under this Plan due to fraud or intentional misrepresentation.

11. FUNDING

Reimbursements under the Plan are paid from the general assets of the Employer. They are not funded or insured in any way. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made.

12. HIPAA

The Plan shall not disclose Protected Health Information, as described in 42 CFR § 160.103, to the Employer except as stated in this Plan. The Plan may disclose to the Employer information on whether an individual is a Participant in the Plan.

The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan. "Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Unless otherwise permitted by law, the Plan may disclose a Participant's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Participant's Protected Health Information will be subject to and consistent with the provisions of this Section 12 (including, but not limited to, the restrictions on the Employer's use and disclosure described below) and the specifications and requirements of the administrative simplification provisions of HIPAA and its implementing regulations at 45 CFR Parts 160–164.

The Employer is restricted from using Protected Health Information in the following ways:

- a. Employer will neither use nor further disclose a Participant's Protected Health Information, except as permitted or required by the Plan document, or as required by law.
- b. Employer will ensure that any agent, including any subcontractor, to which it provides a Participant's Protected Health Information or Electronic Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to the Protected Health Information or Electronic Protected Health Information, respectively.
- c. Employer will not use or disclose a Participant's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.
- d. Employer will report to the Plan any use or disclosure of a Participant's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document promptly upon learning of such inconsistent use or disclosure.
- e. Employer will make Protected Health Information available to the Plan or to the Participant who is the subject of the information in accordance with 45 CFR §164.524.
- f. Employer will make a Participant's Protected Health Information available for amendment, and will on notice amend a Participant's Protected Health Information, in accordance with 45 CFR §164.526.

- g. Employer will track disclosures it may make of a Participant's Protected Health Information that are accountable under 45 CFR §164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR §164.528.
- h. Employer will make its internal practices, books, and records relating to its use and disclosure of a Participant's Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 CFR Part 164, Subpart E.
- i. Employer will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Protected Health Information of a Participant, in whatever form or medium, received from the Plan or any health insurance issuer or business associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the Protected Health Information, when the Participant's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Participant's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.
- j. Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 CFR §164.504(f)(2)(iii), is satisfied.

Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Participant's Protected Health Information or Electronic Protected Health Information received from the Plan or a business associate servicing the Plan:

- privacy official;
- Employees in the Employer's human resources department;
- Employees in the Employer's legal counsel; and
- Any other class of employees designated in writing by the Privacy Official.

The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a Participant's Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on the Plan's behalf.

The Employer will report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Employer's information systems, of which the Employer becomes aware.

13. SUBROGATION

If the plan reimburses a Participant, Spouse, or Dependent for medical or other expenses under this Plan but later the Participant, Spouse, or Dependent recover some or all of those expenses from a third party, the Participant is required to repay the Plan to that extent of the recovery amount. Recovering an expense from a third party includes, but is not limited to, insurance payments even if from the insurance of the Participant, Spouse, or Dependent, reimbursements, cash payments and monies paid by way of a judgment, settlement, or other type of recovery. This right of reimbursement also applies when a Participant, Spouse, or Dependent is entitled to recover under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

As a condition of participation in this Plan, the Participant must recognize the Plan's right to subrogation and reimbursement and agree to cooperate with the Plan fully to permit the plan to recover the amounts it has paid or will pay on behalf of the Participant, Spouse, or Dependent for an injury caused by a third party. These rights provide this Plan with first priority over any proceeds (regardless of whether such funds fully or partially compensate the Participant, Spouse, or Dependent for their losses) paid by or on behalf of any party or any insurance company to the Participant, Spouse, or Dependent relative to an injury or sickness for which benefits are advanced by this Plan, including a priority over any claim for attorney fees, or other costs and expenses. The Plans' right to refund shall not be reduced under any common fund or similar claims or theories. In other words, the make-whole doctrine shall not apply. The Participant must timely inform the Plan Administrator of any settlement offers. As an additional condition of participation, the Participant must agree to hold in a plan accessible trust for the Plan's benefit under these subrogation provisions any and all proceeds of a settlement, arbitration award or judgment.

The Plan Administrator has discretion to enforce this provision by any necessary or appropriate means, which include:

- a. Withholding payment under the Plan until the outcome of a Participant, Spouse, or Dependent's claim against the third party is known,
- b. Making payment under the Plan but requiring a Participant 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 the Participant's obligation to repay,
- d. Intervening in a Participant, Spouse, or Dependent's action against the third party in order to protect the rights of the Plan,
- e. Taking legal action against the Participant, Spouse, or Dependent for repayment; and

- f. Setting off the Participant's obligation to repay against future benefits otherwise due under the Plan.

14. CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan 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.

If due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a right to recover the overpayment and the Participant will be required to return any amount that is overpaid. If such amount is not repaid, the Plan Administrator will offset any future reimbursements the Participant is entitled to under the Plan.

15. AMENDMENT & TERMINATION

The Employer, at any time or from time to time, may amend any of all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of reducing any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with federal (or local) law, statute or regulations. The Employer also reserves the right to terminate the Plan, in whole or in part, at any time.

16. PLAN INTERPRETATION

This Plan document sets forth the provisions of the Hamilton County Medical Expense Reimbursement Plan. This Plan shall be read in its entirety and not severed except as described in Section 20.

17. NON-ALIENATION OF BENEFITS

The right of any Participant to receive any reimbursements under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever.

18. LIMITATION OF EMPLOYEE RIGHTS

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- a. To give any person any legal or equitable right against the Employer or the Plan Administrator, except as expressly provided herein or provided by law; or
- b. To create a contract of employment with any Employees, to obligate the Employer to continue the service of any Employee or to affect or modify his terms of employment in any way.

19. GOVERNING LAW

This plan is governed by the Internal Revenue Code and the regulations issued thereunder (as they might be amended from time to time). To the extent not preempted by federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Ohio.

20. SEVERABILITY

If any provision of the Plan is ruled invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

21. NO GUARANTEE OF TAX CONSEQUENCES

In no event does the Employer or Plan Administrator guarantee that any amounts paid to a Participant under this Plan will be excludable from the Participant's gross income for federal, state, and local income tax purposes. It shall be the obligation of the Participant to determine whether each payment under the Plan is excludable from gross income for tax purposes and to notify the Employer if the Participant knows or has reason to believe that such payment is not excludable from income.

22. INDEMNIFICATION OF EMPLOYER

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

23. HEADINGS

The headings contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope of intent of the Plan, nor in any way shall affect the Plan or the construction of any provisions thereof.

IN WITNESS WHEREOF, Hamilton County has executed this Plan document this _____ day of _____, 2011.

By: _____
County Administrator on behalf of the Hamilton
County Board of County Commissioners

Approved as to form by the
Hamilton County Prosecutor's Office _____