CITY OF FLORENCE

HEALTH REIMBURSEMENT ARRANGEMENT

PLAN DOCUMENT

EFFECTIVE JULY 1, 2012

AS AMENDED AND RESTATED FROM THE ORIGINAL DOCUMENT, ALL AMENDMENTS AND PLAN RE-WRITES PRIOR TO THIS EFFECTIVE DATE

THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE EMPLOYER, ANY PARTICIPATING EMPLOYER, AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT.

City of Florence Health Reimbursement Arrangement

Plan Document

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PURPOSE

The Employer, City of Florence, intends that the Plan qualify as an Employer-provided medical reimbursement Plan under Code §105 and Code §106 and regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The qualified Benefits reimbursed under the Plan are intended to be eligible for exclusion from the participating Employees' gross income under Code §105(b).

SECTION I
Definitions

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

"Accumulator" means the total amount applied to a Covered Person's Deductible and Co-Insurance responsibility. This amount may include expenses applied to one or more Covered Persons in the Health Benefit Plan.

"Affiliated Employer" means:

A. any corporation which is a member of a controlled group of corporations including those within the meaning of section 1563(a) and 414(b) of the Code, determined without regard to Sections 1563(a)(4) and (e)(3)(C), including the Employer;
B. any organization under common control with the Employer within the meaning of Section 414(c) of the Code;
C. any organization which is included with the Employer in an affiliated service group within the meaning of Section 414(m) of the Code; or
D. any other entity required to be aggregated with the Employer pursuant to regulations under Section 414(o) of the Code.

"Benefit Credits" means the amount set aside for Benefits under Section III and credited to the Participant's HRA.

"Benefits" means the Benefits of City of Florence HRA available from time to time as described herein, and as set forth in the Benefit Schedule attached hereto.

"Claims Administrator" means the Individual or Third Party Administrator (TPA) who may be appointed by the Plan Administrator to administer the process of claims review for the Plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, and the same as may be amended from time to time.

"Co-Insurance Expense" means the percentage the Participant is responsible for paying after the deductible has been met.

"Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan.

"Deductible Expenses" means the amount each covered person is responsible for paying before the Health Benefit Plan begins paying Benefits for that covered person.

"Dependent" means that for the purposes of this Plan, any individual who is a defined as a Dependent in the Health Benefit Plan. Notwithstanding the foregoing, the HRA will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

"Effective Date" means July 1, 2012, as amended from time to time.

"Eligible Participant" means any Employee who meets the specific eligibility requirements for the Plan. Employees who meet the eligibility requirements for the Employee Health Benefit Plan and coincidently enroll in the Employee Health Benefit Plan are eligible to participate in this Plan.

An employee who's Spouses have other health benefit coverage through their own employer-sponsored plan and have completely waived coverage under the City of Florence's Health Benefit Plan on or after January 1, 2010 are considered to be an Eligible Participant.

"Employee" means any person who is an Employee of the Employer and regularly scheduled to work for the Employer in an Employee-Employer relationship. The term Employee does not include any temporary or seasonal worker, independent contractor, or sole proprietor, partner in a partnership or more than 2% shareholder in a subchapter S corporation.

"Employer" means City of Florence and any other business organization which succeeds to its business and elects to continue this Plan and which adopts this Plan with the consent of the Board.

"Enrollment Period" means the period upon becoming an Eligible Participant.

"Entry Date" means the same entry date in which the Employee enrolls in the Employee Health Benefit Plan.

"Health Benefit Plan" means the Plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such Plan), providing major medical type Benefits through a group insurance policy or policies.

"Highly Compensated Employee" means any Employee defined as such in section 414(q) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1997, which may be modified or amended at any time.

"HRA" means a Health Reimbursement Arrangement as defined in IRS Notice 2002-45.

"HRA Account Balance" means the amounts remaining for Benefits and credited to the Eligible Participant's HRA minus any claims that have been paid.

"In-Network" means qualified medical services incurred through the Health Benefit Plans Preferred Provider Organization (PPO network).

"Key Employee" means any Employee defined as such in section 416(i)(1) of the Code.

"Maximum Benefit" means accumulated Maximum Benefit.

"Out of Network" means qualified medical services not incurred through the Health Benefit Plans Preferred Provider Organization (PPO network).

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section II, below.

"Participating Employer" means the Employer and any Affiliated Employer, which adopts this Plan with the consent of the Board**.**

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan year following the date on which participation commences and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates.

"Plan" means the City of Florence HRA described herein and as amended from time to time.

"Plan Year" means July through June. The Plan Year will run on a twelve(12) month Plan year basis each year.

"QMCSO" means a qualified medical child support order.

"Qualified Expenses" means Benefits as described in Schedule A attached hereunder.

"Qualified Medical Insurance Carrier" means insurance premium through a Commercial Insurance Carrier.

"Qualified Medical Insurance Premiums" means premiums for accident or health coverage for current Employees, Spouses, tax Dependents and COBRA qualified beneficiaries. The Plan cannot reimburse the Employee, Spouse or tax Dependent's share of premiums or an Employer group health coverage (or individual coverage) if the Employee could pay those costs on a pre-tax basis through an Employers cafeteria Plan. Qualified Medical Insurance Premiums through a Qualified Insurance Carrier of a Spouse or tax Dependent may qualify for the HRA reimbursement, even if such coverage does not cover the Employee.

"Qualified Medical Services" means the medical services must diagnose, cure, mitigate, treat or prevent disease or affect any structure or function of the body. The medical service must be incurred primarily for the prevention or alleviation of a physical or mental defect or illness.

"Qualified Section 213 Expenses" means a medical service that is considered to be medically necessary or prescribed by a licensed practitioner is eligible and the cost of which may be reimbursed or may be reimbursable by any other medical Benefit Plan to the extent available, before Benefits of this Plan are available for reimbursement. The cost of such eligible medical services must be supported by adequate evidence of the incurring or payment of cost, and submitted to the Employer by the Participant or his legal representative. The determination of the qualification of the medical service and the determination of the completeness of submitted request for reimbursement will rest solely on the Employer or person or persons appointed to review all claims. The Employer's decision in this determination will be final.

"Qualified Retirement" means an Eligible Participant who seperates employment from the Employer and immediately begins receiving Benefits from one (1) of the State of Kentucky Retirement programs. The Employee is retired under the conditions of the Plan.

"Spouse" (as used in this Plan) means the person married to a Participant. Marriage is defined as the union of one (1) man and one (1) woman in accordance with laws of a state, and in accordance with the Defense of Marriage Act, (DOMA).

"Summary Plan Description (SPD)" means the document that contains a comprehensive description of the Health Reimbursement Arrangement Plan, including terms and conditions of participation. The SPD provides such information as to when an Employee can begin to participate in the Plan, what Benefits are available in the Plan, when and in what form Benefits are paid, and how to file a claim for Benefits. The SPD is distributed to all Plan Participants.

SECTION II
Participation In The Plan

Commencement of Participation. Each Eligible Employee shall automatically become a Participant in this Plan the same day as their entry date into the Employee Health Benefit Plan, as long as the Employee coincidently enrolls in Employee Health Benefit Plan.

Each Eligible Employee who waives or waived Spousal coverage as of January 1, 2010 shall become a Participant in the Spousal Waiver Plan the same day as the date they waive their Spouse from the Employee Health Benefit Plan, as long as the Employee coincidently enrolls in an Employee Health Benefit Plan.

Procedure for and Effect of Participation. Each Participant shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

Cessation of Participation. A Participant will cease to be a Participant as of the earlier of:

A. the date on which the Plan terminates;
B. the date on which he ceases to be an Eligible Participant; or
C. the date on which a Participating Employer terminates its participation in the Plan.

Nothing in this section shall prohibit the payment of Benefits with respect to claims arising prior to the Participant's termination of participation.

SECTION III
Benefits And Benefit Rules

Benefit Credits. There shall be credited to each Participant's HRA account those Benefit Credits that correspond to the amount of the Employer's funding for the complete Plan Year or for such partial Plan Year, as shown by the amounts set forth on Schedule A attached hereto, and as may be revised by the Employer from time to time. The amount of Benefits actually provided to or for the Benefit of any Participant shall be a charge to the balance of his HRA account.

Nature of Participants HRA account. No money shall actually be allocated to the HRA account. Any such HRA account shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be representative of any identifiable Trust assets. No interest will be credited to or paid to the Participant on amounts credited to a HRA account.

Provision of Benefits. The Employer shall provide such Benefits as indicated under the Plan, in such amounts as do not exceed the amount indicated on the Schedule A of this Plan. Such Benefits shall be subject to the provisions of this Plan, the SPD, contract, or other arrangement setting forth the further terms and conditions pursuant to which such Benefits are provided. No amount shall be applied to provide Benefits under this Plan if such amount would exceed the balance of the Participant's Benefit Credits in the HRA account.

Additional Benefits. If at the end of any Plan Year where there remains any unused Benefit Credits to the Participant's HRA account, such total Benefit Credits will be carried forward into the following Plan Year and may be used to pay for Qualified Expense occurred in the current Plan Year.

Reimbursements. Except as otherwise provided in this Plan, contract or arrangement established to provide Benefits of this Plan, reimbursement of Expenses shall be made at such time and in such amounts as are evidenced by submitted proof of incurring or paying for qualified expenses by the Employer or by any administrator appointed by the Employer, provided sufficient Benefit Credits are available in the account of the Participant. No payment may be made for any expense incurred by the Participant before the Participant's effective date of coverage or incurred or paid on or after the date of actual termination of participation. The Employer who is the sole source of payment of Benefits will determine provisions for reimbursement of expenses by the Employer.

It is understood and agreed to by the Participant that such payment by the Employer of this cost as directed by the Participant will be a debit in the HRA account of the Participant to the extent Benefit Credits are available for any purpose. The Employer or Plan Administrator will be the sole judge as to the manner in which the transfer of Benefits from the HRA account to be used in payment of accident and health insurance will be accomplished.

Nondiscrimination. Benefits under the Plan shall not discriminate in favor of Highly Compensated Employees nor shall the aggregate cost of the Benefits provided to Key Employees exceed 25% of the aggregate of such cost for the Benefits provided to all Employees under the Plan. The Employer may limit or deny any Employee's participation in the Plan to the extent necessary to avoid any such discrimination due to actuarial error in rate calculation shall be the property of and retained by the appropriate participating Employer.

Termination of Employment (other than a Qualified Retirement). If a Participant is no longer an Eligible Participant in the Plan, according to the rules of this Plan, the balance of HRA dollars remaining after all reimbursements have been completed will be forfeited. Department of Treasury rules state that these balances cannot be combined with any other reimbursement account in this or any other Plan, or used for purposes other than for which they are originally intended.

SECTION IV
Administration

Administrator. The Employer shall be the Plan Administrator. The Plan Administrator's Tax ID Number is: 61-6003079. The type of Plan is a Welfare Plan and the type of Administration is Contract Administration.

The Name of this Plan is the Health Reimbursement Arrangement, established by the Employer, City of Florence, whose address is 8100 Ewing Blvd, Florence, KY 41042-7566. The effective date of this Plan is July 1, 2012. The Plan Administrators telephone number is (859) 647-5419.

The Employer has appointed MedBen whose address is 1975 Tamarack Rd, P.O. Box 1096, Newark, OH 43058-1096 and whose telephone number is (800) 297-1829 as Claims Administrator.

Named Fiduciary. The Employer shall be the named fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become

the fiduciary for only that part of the administration, which has been delegated by the Employer, and any references to the Employer shall instead apply to the delegate. However, if the Employer assigns any of the Employer's responsibility to an Employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

Rules of Administration. The Employer shall adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and Participants and their beneficiaries may examine records pertaining directly to themselves.

Services to the Plan. The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical and other services to carry out the provisions of the Plan. The Employer shall pay the costs of services and other administrative expenses.

Funding Policy. The Employer shall periodically at its discretion review and determine the funding policy of the Plan, with the advice of such experts as the Employer deems appropriate.

Claims Procedure. To receive Benefits under the Plan, a Participant must submit written claims for Benefits to the Claim Administrator. The Claim Administrator will review the claim and will advise the Participant of any Benefit to which he is entitled. If a Participant believes he has not been reimbursed in accordance with the Plan, he may submit a written request to the Claim Administrator to provide either an explanation of how Benefits are reimbursed or further information of his Benefits. The Claim Administrator must respond to such a request within a reasonable time. Additionally, the Claim Administrator will provide to every claimant, who is denied a claim for Benefits, a written notice stating, in a format determined to be understood by the claimant,

(i) the specific reason or reasons for the denial;
(ii) a description of any additional material or information necessary for the claimant to perfect the claim; and
(iii) an explanation of the claim review procedure.

Such notice will be given within 30-days after the claim is received by the Claim Administrator (or within 60-days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 30-day period). If such notification is not given within such period, the claims will be considered denied as of the last day of such period, and such person may then request a review of his claim.

Claims Appeals. Participants have a right to appeal claim payment determinations. If Participants disagree with any claim payment determination, then said Participant must submit proof that a claim for Benefits is covered and payable under the Plan's provisions; including (a) all facts and theories supporting the claim, (b) a statement within the referenced Plan provision. If Participant does so, it may be that some or the entire claim will be payable under the Plan. This Plan allows for two appeals of an adverse Benefit determination. Participant will be provided, free of charge, with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, claimant may file an appeal within 180 days following receipt of this notice, which must be in writing and addressed as follows: MedBen SSU Dept, 1975 Tamarack Rd, P.O. Box 1096, Newark OH 43058-1096, Attn: Claims Appeals. If participant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 30 days after receipt of the appeal. A Participant is entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for Benefits.

Roll-Over Benefit. At the end of a Plan Year any remaining unused Benefit Credits will remain in the account and will be carried forward for use in the next Plan Year, if participation is not limited by required cessation of participation as otherwise provided in this Plan document. The Participants account balance cannot exceed at any one (1) time the Maximum Benefit as described in Schedule A.

If a Participant is no longer an eligible participant in the Plan, according to the rules of this Plan, the balance of Benefit Credits remaining after all reimbursements have been completed will be forfeited. Department of Treasury rules state that these balances cannot be combined with any other reimbursement accounts in this or any other Plan, or used for purposes other than for which they are originally intended.

Nondiscriminatory Operation. All rules, decisions and designations by the Employer, Claim Administrator under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

Liability of Administrative Personnel. Neither the Employer nor any of its Employees shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility with the care,

skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like claims.

SECTION V
Protected Health Information

The following describes how medical information about Plan Participants may be used and disclosed and how Plan Participants can get access to this information. Please review it carefully.

PROTECTED HEALTH INFORMATION (PHI) means health information that either identifies an individual, or for which there is a reasonable basis to believe it can be used to identify an individual, and which is one (1) of the following:

A. transmitted by electronic media, including:
   1. the internet;
   2. an extranet;
   3. leased lines;
   4. dial-up lines;
   5. private networks;
   6. those transmissions that are physically moved from one (1) location to another using magnetic tape, disk, or compact disk media;

B. maintained in any electronic media; or

C. transmitted or maintained in any other form or medium.

HEALTH INFORMATION means any information, whether oral or recorded, in any form or medium that:

A. is created or received by this Plan, or a Plan designee; and

B. relates to any of the following:
   1. the past, present or future physical or mental health or condition of an individual;
   2. the provision of health care to an individual; or
   3. the past, present or future payment for the provision of health care to an individual.

SUMMARY HEALTH INFORMATION means information that may be individually identifiable health information that:

A. summarizes the claims history, claims Expenses or type of claims experienced by Eligible Employees under this Plan; and

B. from which the following information has been removed:
   1. names;
   2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;
   3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge;
   4. telephone numbers;
   5. fax numbers;
   6. electronic mail addresses;
   7. social security numbers;
   8. medical record numbers;
   9. Plan identification numbers; or
   10. Other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i).

PRIVACY OF HEALTH INFORMATION. This provision is intended to bring this Plan into compliance with the privacy provisions of the HIPAA, as amended, and the regulations issued hereunder. Such procedures will be in effect for this Plan for all transactions performed on or after April 14, 2004. Health information transmitted or maintained by the Plan will be subject to the provisions described in this article.

USE AND DISCLOSURE OF PHI. PHI will only be disclosed or used by the Plan under one (1) of the following conditions:

A. with the specific consent of the individual who is the subject of the PHI, provided that the Plan obtains any required authorization;

B. for payment of claims submitted to the Plan, or for utilization review activities as described in Section VI, including, but not limited to, the review of any grievances or appeals involved in such activities which are generated by the Participant or his authorized representatives;

C. for other reasonable purposes necessary to operate the Plan, to the extent that such PHI is required for such purposes, including:
   1. quality assessment and improvement activities;

2. evaluation of Plan performance;
3. underwriting and Premium Expense rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
5. business planning and development of the Plan;
6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service, and the resolution of internal grievances; and
7. other health care operations listed under 45 C.F.R. § 164.501.

No other use or disclosure of PHI is permitted by this Plan.

DISCLOSURES OF HEALTH INFORMATION TO THE EMPLOYER. The Plan Administrator will disclose, or permit the disclosure of, health information to the Employer only as described below:

A. for any of the purposes and under the conditions described herein;
B. as summary health information, if requested by the Employer for the following purposes:
   1. obtaining Premium Expense bids from health plans for providing health insurance coverage under the Plan; or
   2. modifying, amending or terminating the Plan; or
C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the Employer for the purpose of performing Plan administrative functions;

Prior to any disclosure of health information to the Employer, such entity must agree:

A. not to use or further disclose the information other than as permitted or required by this Section, or as required by law;
B. that it will ensure that any agents, including subcontractors, employed by the Employer or Plan Administrator for Plan administration or other Plan purposes to whom it provides PHI, including, but not limited to, the benefit manager, any utilization review service or pharmacy benefit manager, agree to the same restrictions and conditions that apply to the Employer with respect to such information;
C. not to use or disclose the PHI for employment-related actions and decisions, or in connection with any other Benefit or Employee Benefit plan sponsored by the Employer; and
D. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this Section of which it becomes aware;
E. that it will make available PHI to the subject of such information, and allow amendment to such information as described herein;
F. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of PHI, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that Section;
G. that it will make available its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;
H. that it will, if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and that it will not retain any copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, that it will limit further uses and disclosures to those purposes which make the return or destruction of the information infeasible; and
I. that it will provide for adequate separation between the Plan and the Employer by implementing the following procedures:
   1. access to PHI will only be provided to the following categories of Employer employees:
      listing of individuals/classes of individuals employed by or under the control of the Employer who receive PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business;
   2. that access to and use by such employees or other persons as described above will be limited to the Plan administration functions that the Employer performs for the Plan; and
   3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the Employer's established Employee discipline and termination procedures.

ACCESS OF PARTICIPANTS TO PHI. A Participant has the right of access to inspect and obtain a copy of PHI about such person as long as such information is maintained by the Plan, except for:

A. psychotherapy notes;
B. information compiled in reasonable anticipation, or for use in, a civil, criminal or administrative proceeding or action; or
C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524.

Any such request must be made to the Plan Administrator in writing and signed by the Participant whose information is being requested. The Plan Administrator will notify the Participant, in writing, as to whether such request is approved or denied, and, if approved, will provide access to the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

AMENDMENT RIGHTS. A Participant has the right to have the Employer amend PHI or other information about such individual as long as such information is maintained by the Plan. The Plan Administrator will deny such a request if:

A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
B. the information is not currently maintained in any record by the Plan;
C. the information would not be available for inspection under the reasons cited; or
D. the information in the Plan's records is accurate and complete.

Any request for amendment of PHI must be provided in writing to the Plan Administrator and signed by the Participant who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Participant, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities which it has knowledge of such entity's receipt of any information which has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial which includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information.

SECURITY OF PHI. The Employer will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI (ePHI) that is created, received, maintained or transmitted on behalf of the Plan, including reasonable and appropriate security measures between the Employer and the Plan to support the requirements of this Section. The Employer will further ensure that any agent, including a subcontractor, to whom it provides access to ePHI agrees to implement reasonable and appropriate security measures to protect the information, and will report any security incident of which it becomes aware of to the Plan Administrator.

SECTION VI
Continuation Of Coverage

In General. The following provisions shall apply to Benefits provided to Eligible Employees and their Dependents under the Plan, but only to the extent that the Benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA).

Continuation of Coverage. A Qualified Beneficiary who would lose coverage under this Plan as a result of a Qualifying Event is entitled to elect continuation coverage within the Election Period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a Qualified Beneficiary who is a covered Employee or Spouse of the covered Employee will be deemed to include an election for continuation coverage under this provision on behalf of any other Qualified Beneficiary who would lose coverage by reason of a Qualifying Event.

If this Plan provides a choice among the types of coverage under this Plan, each Qualified Beneficiary is entitled to make a separate selection among such types of coverage (i.e. single, family, etc.).

Type of Coverage. Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all Qualified Beneficiaries under this Plan in connection with such group.

Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event and ending not earlier than the earliest of the following:

A. in the case of a terminated Employee (except for gross misconduct) or a covered Employee whose hours have been reduced, except as provided in B. and C. below, and his covered Dependents, the date which is 18-months after the Qualifying Event;

B. in the case of a Qualified Beneficiary disabled during the first 60-days following the covered Employee's termination (except for gross misconduct) the date which is 29-months after the Qualifying Event, provided the Qualified Beneficiary provides the Plan Administrator with notice of the Social Security disability determination within 60-days of the disability determination and within 18-months of the Qualifying Event;
C. in the case of a Qualifying Event which occurs during the 18-months after the date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee's hours are reduced, for the covered Dependents, the date which is 36-months after the date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee's hours are reduced;
   (1) in the case of a termination (except for gross misconduct) or reduction in hours of a covered Employee that occurs less than 18-months before the covered Employee becomes subject to Medicare, the date which is the close of the 36-month period beginning on the date the covered Employee became entitled to Medicare.
D. in the case of any Qualifying Event except as described in A., B., C. and D. above, the date which is 36-months after the date of the Qualifying Event;
E. the date on which the Employer or a Participating Employer, if any, ceases to provide any group health plan to any Employee;
F. the date on which the Qualified Beneficiary fails to make timely payment of the required contribution pursuant to this provision;
G. the date on which the Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan as an Employee or Dependent, or otherwise becomes entitled to Benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the Plan will not cease while such preexisting condition limitation under the other group plan remains in effect (taking into account, for Plan Years commencing after June 30, 1997, prior creditable coverage under the portability rules of HIPAA). In no event will coverage continue longer than the coverage period as set forth in this Section**.**

Contribution.

A. A Qualified Beneficiary shall only be entitled to continuation coverage provided such Qualified Beneficiary pays the applicable Premium Expense required by the Employer or a Participating Employer in full and in advance, except as provided in B. below. Such Premium Expense shall not exceed the requirements of applicable federal law. A Qualified Beneficiary may elect to pay such Premium Expense in monthly installments.
B. Except as provided in C. below, the payment of any Premium Expense shall be considered to be timely if made within 30-days after the date due, or within such longer period of time as applies to or under this Plan.
C. Notwithstanding A. and B. above, if an election is made after a Qualifying Event during the Election Period, this Plan will permit payment of the required Premium Expense for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

Notification by Qualified Beneficiary. Each covered Employee or Qualified Beneficiary must notify the Employer or a Participating Employer of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's Spouse, and/or the covered Employee's Dependent child ceasing to be a Dependent child under the terms of this Plan within 60-days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph, which occurs after the date of the enactment of the Tax Reform Act of 1986.

Notification to Qualified Beneficiary. The Employer or a Participating Employer shall provide written notice to each covered Employee and Spouse of such covered Employee of his/her right to continuation coverage under this provision as required by federal law.

The Employer or a Participating Employer shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the Qualifying Event is the divorce or legal separation of the covered Employee from the covered Employee's Spouse or a Dependent child ceasing to be a Dependent child under the terms of this Plan, City of Florence shall only be required to notify a Qualified Beneficiary of his right to elect continuation coverage if the covered Employee or the Qualified Beneficiary notifies City of Florence of such Qualifying Event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60-days after the date of such Qualifying Event.

Notification of the requirements of this provision to the Spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such Spouse at the time notification is made.

Definitions. The terms used in the text of Sections VI and VII are defined as follows:

"Dependents" means an individual who meets the definition of a Dependent under the Participating Employer provided health plan covering the Eligible Employee. For the purposes of the Medical Reimbursement Account, Dependents will also include individuals who are Dependents within the meaning of Section 152(a) of the Code, and as defined in Section I hereof.

No person shall be considered a Dependent of more than one (1) Employee. If both an Employee and an Employee's Spouse are employed by the Employer or a Participating Employer, their Dependent children may be covered by either Spouse, but not by both.

"Election Period" means the 60-day period during which a Qualified Beneficiary who would lose coverage as a result of a Qualifying Event may elect continuation coverage. This 60-day period begins no later than the date of termination of coverage as a result of a Qualifying Event and ends no earlier than 60-days after the later of such date of termination of coverage, or the receipt of notice of the right to elect continuation coverage under this Plan.

"Medicare" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

"Qualified Beneficiary" means an individual who, on the day before the Qualifying Event for a covered Employee, is a Beneficiary under this Plan as the Dependent (as defined in Section I hereof) of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee's gross misconduct) or the reduction in hours of the covered Employee's employment, the term Qualified Beneficiary includes the covered Employee. Effective January 1, 1997, a child who is born to (or placed for adoption with) a Qualified Beneficiary who is a covered Employee during the Coverage Period shall also be a Qualified Beneficiary. The term Qualified Beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the Employer which constituted income from sources within the United States (within the meaning of Code Section 911(d)(2) and Section 861(a)(3)). If an individual is not a Qualified Beneficiary pursuant to this paragraph, a Spouse or Dependent child of such individual shall not be considered a Qualified Beneficiary by virtue of the relationship to such individual.

"Qualifying Event" means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a Qualified Beneficiary:
(i) the death of the covered Employee;
(ii) the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered Employee's employment;
(iii) divorce or legal separation of the covered Employee from such covered Employee's Spouse, as herein defined;
(iv) the covered Employee becoming entitled to Benefits under Title XVIII of the Social Security Act (Medicare);
(v) a Dependent child who ceases to be a Dependent child under the terms of this Plan;
(vi) the Employer's filing for Chapter 11 reorganization, as it would affect retiree coverage.

SECTION VII
Miscellaneous

Amendment and Termination. The Employer or its authorized representative may amend or terminate this Plan at any time by action of the Board. The Employer may amend this Plan retroactively to enable the Plan to qualify as a HRA under the Code. No amendment shall deprive any Participant or beneficiary of any Benefit to which he is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the Benefit of Employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

It is the intention of the Employer that should a termination of the Plan or the amendment of this Plan deprive any Participant of a Benefit Credit that exists upon such termination or amendment that the value of the accounts of the Participant exists upon that date would be paid to the Participant in full.

Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him as a Participant of this Plan.

Alienation of Benefits. No Benefit under this Plan may be voluntarily or involuntarily assigned or alienated.

Facility of Payment. If the Employer deems any person incapable of receiving Benefit to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the Benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete release of the Employer and shall be deemed full payment of the Benefit. Such payments shall, to the extent thereof, discharge all liability of the Employer.

Proof of Claim. As a condition of receiving Benefits under the Plan, any person may be required to submit whatever proof the Employer may require either directly to the Employer or to any person delegated by it.

Status of Benefits. The Employer believes that this Plan is in compliance with the Code and that it provides certain Benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval, and thus there can be and is no assurance that intended tax Benefits will be available. Any Participant, by accepting Benefits under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

Agent for Service of Legal Process. The Employer named on Page 1 is the Agent for Service of Legal Process. The Plan Administrator City of Florence may also be an Agent for Service of Legal Process.

Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Kentucky to the extent not pre-empted by any federal law.

Lost Distributions. Any Benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however that such Benefit shall be reinstated if a claim is made by the Participant for the forfeited Benefit.

Source of Payments. The Employer and any Employer contracts purchased or held by the Employer shall be the sole sources of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary.

Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

Tax Effects. Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether or not payments received by a Participant under the Plan will be treated as includible in gross income for federal or state income tax purposes.

Multiple Functions. Any person or a group of persons may serve in more than one (1) fiduciary capacity with respect to the Plan.

No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to purposes other than for the exclusive Benefit of Plan participants or their beneficiaries, or for defraying reasonable expenses of administering the Plan.

Prior Year Claims. Claims may be submitted up to three (3) months past the end of the Plan Year or date of Participants termination from the Plan, whichever comes first.

Health Reimbursement Arrangement Document

Attest: IN WITNESS WHEREOF, the City of Florence Health Reimbursement Arrangement adopted, by execution hereof, effective as of July 1, 2012.

City of Florence

Executed this Date: ____/____/____

By: _____(Authorized Officer)

City of Florence Health Reimbursement Arrangement Plan Document

SCHEDULE A

Health Benefit Plan Participants

Single Participants - $500.00 per year - $41.66 per month
Family Participants - $1,000.00 per year - $83.33 per month

Spousal Waiver Plan Participants

HRA Spousal Waiver contribution - $1,000.00. This is a one-time benefit only available on the day the Spouse's coverage under the City of Covington's Health Benefit Plan is waived due to other employer-sponsored coverage available to the Spouse.

Eligible Participants

Eligible Participants enrolled in the Health Benefit Plan are eligible to participate in the HRA Plan. Eligible Participants enrolled in the Health Benefit Plan and who waive their Spouses coverage in the Health Benefit Plan is eligible to participate in the Spousal Waiver HRA Plan.

Partial Year Active Employees

If the Employee enrolls in this Plan coincidentally with the City of Florence Health Plan other than on a Plan anniversary, the Employer's annual contribution to the Participant's HRA account will be an amount equal to $1/12^{th}$ of the amounts shown above multiplied by the number of whole months remaining until the end of the Plan Year.

Mid-Year Coverage Level Changes

If the Employee changes coverage level in the City of Florence Health Plan other than on a Plan anniversary, the Employer's annual contribution to the Participant's HRA account will be an amount equal to $1/12^{th}$ of the amounts shown above multiplied by the number of whole months remaining until the end of the Plan Year. (i.e.: switch from Single to Family). If the Participant switches from Family to Single there will be no changes in the contribution amount until the next Plan Year.

Eligible Expenses for Active Employees

Eligible Participants enrolled in the Health Benefit Plan can use the HRA dollars to reimburse In-Network Health Benefit Plan Deductible and Co-Insurance expenses only. No out of network benefits are eligible for reimbursement.

Eligible Expenses for Employees with Spousal Waiver Benefits

Eligible Participants who were eligible to receive the Spousal Waiver contribution can use the HRA dollars to reimburse their Spouses In-Network Health Benefit Plan Deductible and Co-insurance expenses only. No out of network benefits are eligible for reimbursement.

Retired Employees (as defined by the City)

Retired Employees who have a balance left in their HRA account may continue to use the remaining HRA balance for any Section 213 expense as well as COBRA premiums, Medicare Supplemental policies and/or individual health insurance premiums until the funds are exhausted. Once an Employee retires the Employer contributions to the HRA Plan will cease however the total contributions for the year of retirement will be included in the Retired Employees balance.

100% Roll-Over Benefit

At the end of a Plan Year, a maximum of 100% of any remaining unused HRA Benefit credits will remain in the account and will be carried forward for use in the next Plan Year. If a Participant is no longer an eligible participant in the Plan, according to the rules of this Plan, the balance of HRA dollars remaining after all reimbursements have been completed will be forfeited. The Maximum Benefit that can be in a Participants HRA account at one (1) time is $12,000.00.

Substantiation of HRA Claims

The IRS regulations require that an Employee furnish a written statement stating that the expense they are requesting reimbursement on has been incurred and they have not been reimbursed nor will they seek reimbursement under the City of Florence Health Benefit Plan or any other Health Plan, Flexible Spending Plan, HRA Plan, or Health Savings Account Plan. The Participant does not have to prove the services were paid for, they only have to prove the services were incurred during the applicable Plan Year. The participant must provide supporting documentation from an independent third party, which includes the following:

Eligible Participants: Explanation of Benefits (EOB) statement indicating amounts applied to the City of Florence Health Benefit Plan In-Network Deductible and/or Co-Insurance expenses.

Eligible Spousal Waiver Participants: Explanation of Benefits (EOB) from the Spouses Health Insurance Carrier indicating amounts applied to the Spouses Health Benefit Plan In-Network Deductible and/or Co-Insurance expenses. Once the one-time $1,000.00 contribution has been exhausted there will be no additional benefits for this Participant.

Retiree Participants:

- A bill or receipt (including date of service, name of patient, provider name-address, amount, and type of service) from a doctor, dentist, or other supplier;
- A Prescription receipt (including the date Prescription was filled, name of patient, pharmacy name-address, amount, and Prescription name) from a pharmacy;
- Explanation of Benefits (EOB) statement(s) indicating the deductible, co-insurance and amounts not covered by the medical/dental/vision Plan(s) under which the Employee or any eligible dependents are covered;
- A bill or receipt (including coverage period, name of insured, carriers name-address, amount, and type of coverage) from a Qualified Medical Insurance Carrier;
- Store receipts are acceptable for hearing aid batteries, contact lens solution, support braces, reading glasses and other eligible over the counter items. The receipt must have the following information printed on the receipt: Store name, date of purchase, Product name and amount of product
- To obtain reimbursement for over the counter drugs or medications, a copy of the Prescription for the drug or medication must be submitted either prior to or at the time of filing the claim for reimbursement.

Cancelled checks, handwritten receipts, credit/debit card transaction receipts, balance due or previous balance receipts cannot be used to verify an expense.

Services must be incurred in order to receive reimbursement from your account. Expenses are considered to be incurred the day the service is rendered, not when you are billed, charged or pay for the services.

Participants may be reimbursed for Qualified Expenses incurred during any Plan Year as long as the Participant was enrolled in the HRA Plan at the time the services were incurred.

Health FSA Plan

If an HRA Participant is enrolled in the Health FSA plan, the Plan Participate will decide which Plan reimburses the requested benefits after the services have been processed through the Health Benefit Plan. The Participant must submit the correct reimbursement form. Benefit Credit cannot be transferred between the Health FSA and HRA Plan once a payment has been issued.