

City of Minneapolis

Minneflex Plan

MASTER PLAN DOCUMENT

Effective April 1, 1987

Amended and Restated Effective August 1, 2004

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City of Minneapolis

Minneflex Plan

Effective April 1, 1987

Amended and Restated Effective August 1, 2004

Article 1. The Plan

Section 1.1 Establishment. The City of Minneapolis (hereinafter the “City”), hereby amends and restates, effective August 1, 2004 the City of Minneapolis Minneflex Plan (the “Plan”), which is a plan of flexible compensation for the exclusive benefit of Eligible Employees of the City and Independent Boards and Agencies that adopt the Plan with the City’s consent.

Section 1.2 Purpose. The purpose of the Plan is to increase the social insurance protection of Eligible Employees by making available to those employees different combinations of medical benefits, dental care benefits, life insurance benefits, disability insurance benefits, dependent care benefits and direct compensation. The Plan is intended to comply with the provisions of Sections 105 (accident and health plans), 79 (group term life plans), 104 (compensation for sickness & injuries), 125 (cafeteria plans) and 129 (dependent care plans) of the Internal Revenue Code of 1986, as amended.

Article 2. Definitions

Section 2.1 Definitions. Whenever used in the Plan, the following words and phrases shall have the meanings set forth below unless the context plainly requires a different meaning, and when the defined meaning is intended, the term is capitalized:

- (a) “Code” means the Internal Revenue Code of 1986, as amended, and any successor tax code. References to a Code section shall be to that section as it now exists and to any successor provision.
- (b) “City” means City of Minneapolis.
- (c) “Compensation” of a Participant means the total base salary or wages paid to an employee including vacation pay, sick pay, and holiday pay.
- (d) “Dependent” means an individual who qualifies as a dependent under the terms of Section 152 of the Code (without regard to the gross income test for medical plans).
- (e) “Effective Date” means the effective date of this amendment and restatement, which is August 1, 2004.
- (f) “Eligible Employee” means an employee of the City or Employer who is employed in the United States, and who is eligible for the City sponsored health, dental, disability and/or life plan(s), including bargaining unit employees who negotiate eligibility to participate in the Minneflex Plan.
- (g) “Employer” means the City of Minneapolis and the Independent Boards and Agencies who have adopted and not terminated the City sponsored Plans.

- (h) “Employment Related Dependent Care Expense” means an “employment-related expense,” as defined in Section 21(b) of the Code. As of the Effective Date of the Plan, this means an amount paid for expenses of a Participant for household services or for the care of a Qualifying Individual, to the extent that such expenses are incurred to enable the Participant to be gainfully employed, within the meaning of Section 21(b)(2) of the Code, for any period for which there are one (1) or more Qualifying Individuals with respect to such Participant; provided, however, that (i) if such amounts are paid for expenses incurred outside the Participant’s household, they shall constitute Employment Related Dependent Care Expenses only if incurred for a Qualifying Individual who is a Dependent under the age of thirteen (13) for whom the Participant is entitled to an exemption under Section 151(c) of the Code or for a Qualifying Individual who regularly spends at least eight (8) hours per day in the Participant’s household; (ii) if the expense is incurred outside the Participant’s home at a facility that provides care for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and (iii) Employment Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred for services provided by (A) a child of such Participant who is under the age of nineteen (19) or (B) an individual who is a Dependent of that Participant or the Participant’s spouse.
- (i) “Medical Reimbursement Charge” means the cost to a Participant for coverage under the medical reimbursement plan described in paragraph 5.2.2 hereof.

- (j) “Medical Care” means the diagnosis, cure, mitigation, treatment, or prevention of sickness, injury, or physical or mental defect. Expenses for Medical Care shall consist of expenses for medical care as defined in Sections 213(d)(1)(A) and (B) of the Code, and shall include, but not be limited to, payments for the purpose of affecting any structure or function of the body, for any hospital or nursing charges, optometrical, ophthalmological, or auditory care, dental care, psychiatric care, prescription drugs, insulin, eyeglasses, hearing aid appliances, and similar prosthetic devices, and medical related transportation expense; provided, however, that Medical Care shall not include any cosmetic procedure that is not medically necessary.
- (k) “Participant” means an Eligible Employee of the City or Employer who has satisfied the participation conditions of Article 3. A person who becomes a Participant shall remain a Participant until all benefits due the Participant under the provisions of the Plan have been paid to the Participant or otherwise have been satisfied.
- (m) “Payment and Health Care Operations” Payment means activities undertaken by the plan sponsor to obtain premiums or determine or fulfill its responsibility for coverage and provisions of plan benefits that relate to an individual to whom health care is provided. Based on whether the Plan is fully-insured or self-insured, payment activities may include, but are not limited to, the following:
- i. Eligibility determinations, coverage and cost determinations including co-pays, plan maximums, and sharing of premium amounts;
 - ii. Coordination of benefits determinations;

- iii. Adjudication of health benefits claims including appeals and other payment disputes;
- iv. Establishing employee contributions;
- v. Subrogation of health benefit claims;
- vi. Billing and collection activities related to health care data processing
- vii. Obtaining payment under a contract for reinsurance including stop-loss and excess of loss insurance;
- viii. Claims management and related health care data processing including auditing payments, investigating and resolving payment disputes, and responding to participant inquires regarding payment;
- ix. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- x. Utilization review, including precertification, preauthorization, concurrent review, and retrospective review;
- xi. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement. The following protected health information (PHI) may be disclosed for payment purposes; date of birth, Social Security Number (except where prohibited by state law), payment history, account number and name, and address of the health care provider or health plan;
- xii. Reimbursement to the plan.

Health care operations include, but are not limited to the following:

- i. Quality assessment;

- ii. Population-based activities relating to improving health care or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- iii. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- iv. Underwriting, premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims including stop-loss insurance and excess of loss insurance;
- v. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- vi. Business planning and development, such as conducting cost-management and planning-related analyses related to management and operating the plan, including formulary development and administration, development or improvement of payment or coverage policies;
- vii. Business management and general administrative activities of the plan, including, but not limited to:
 - a. Management activities relating to the implementation of and compliance with HIPAA privacy rules and Administrative Simplification requirements, or

- b. Customer service, including the provision of data analysis for policyholders, plan sponsors, or other customers;
- viii. Resolution of internal grievances; and Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” subject to the HIPAA privacy rules or, following completion of the sale or transfer, will become a covered entity subject to the HIPAA privacy rules.
- (n) “Period of Coverage,” with respect to any Plan Year, means the Plan Year; provided that, (i) for any Eligible Employee who becomes a Participant after the start of a Plan Year, the Period of Coverage shall mean the period commencing on the effective date of the Eligible Employee’s participation, (ii) the Period of Coverage for any Participant shall end upon termination of employment or the Participant ceasing to be an Eligible Employee, except (A) with respect to dependent care reimbursement coverage under paragraph 5.2.3 or (B), in the case of medical reimbursement coverage under paragraph 5.2.2, if the Employee continues coverage in a manner consistent with this Plan, and (iii) with respect to medical reimbursement coverage under paragraph 5.2.2, the Period of Coverage shall not include any portion of the Plan Year for which the Participant does not pay the applicable Medical Reimbursement Charge.
- (o) “Plan” means the “City of Minneapolis Cafeteria Benefits Plan” as set forth herein and as amended or restated from time to time.
- (p) “Plan Year” means the twelve-month period ending December 31.

- (q) “Qualifying Individual” means a “qualifying individual” as defined in Section 21(b) of the Code, which includes, on the Effective Date of this Plan, (i) a Dependent of a Participant who is under the age of thirteen (13), with respect to whom the Participant is entitled to an exemption under Section 151(c) of the Code, and (ii) a Participant’s Dependent or spouse who is physically or mentally incapable of caring for himself or herself.
- (r) “Status Change” with respect to a Participant means a change in the Participant’s marital status or number of Dependents, a commencement or termination of employment of a Participant’s spouse, a change in the employment status of the Participant or the Participant’s spouse from full-time to part-time or vice versa, an unpaid leave of absence of the Participant or the Participant’s spouse, a family or medical leave as described in Section 3.5, a significant change in the health coverage of the Participant or the Participant’s spouse that is beyond the control of the Participant or the Participant’s spouse and is related to the employment of Participant’s spouse, or such other changes in circumstances that the City administratively defines as Status Changes, so long as any such definition is consistent with applicable law and regulations and is applicable to Participants on a uniform basis.

Section 2.2 Gender and Number. Pronoun references in the Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.

Article 3. Eligibility and Participation Conditions

Section 3.1 Participation Conditions. As a condition to participation and receipt of benefits under this Plan, an Eligible Employee agrees to:

- (a) To comply with the provisions in 3.2 (a);
- (b) Furnish to the City a timely notification to participate provided for in Section 3.2 (b);
- (c) Designate a portion of his/her Compensation as Pay Conversion Contributions in accordance with the provisions of Section 4.2;
- (d) Observe all rules and regulations implementing this Plan;
- (e) Submit to the Claims Administrator, or such other agent as the City may designate, all reports, bills, and other information which the City may reasonably require; and
- (f) Consent to inquiries by the Claims Administrator with respect to any physician, hospital, or other provider of Medical Care or other services involved in a claim under this Plan.

Section 3.2 Notification to Participate.

(a) Eligible Employees that have elected to participate in the City's health and/or dental plan(s) shall be deemed to have elected to participate in the premium portion of this Plan and to have the employee portion of the premiums for coverage under the City's health, dental, disability and/or life plan(s) paid for on a pre-tax basis under this Plan. Because the City utilizes this automatic election feature, Eligible Employees shall have

the right to waive participation in the City's health, dental, disability and/or life plan(s) and, take any contributions they would have made, as taxable cash compensation.

(b) As a condition of participation, in the Medical Reimbursement and/or Dependent Care portions of this Plan, each Eligible Employee shall provide notice in a timely fashion to the City's Benefit Office to elect participation in the Plan and the Eligible Employee will designate the required amount of Compensation for the Plan Year in question as Pay Conversion Contributions as described in Section 4.2, and supply any other pertinent information that the City reasonably requires.

Section 3.3 Commencement of Participation. An employee may become a Participant on the first day they are eligible to participate in the City's health, dental, disability and/or life plan(s).

Section 3.4 Continuation Coverage. A Participant whose employment is terminated or who takes a leave of absence, including a Family or Medical Leave under Section 3.5 or a military leave as defined in Section 3.7 shall be entitled to continue coverage as provided in this Plan or as may otherwise be required by applicable law. Other persons shall be entitled to commence or continue coverage as required by applicable law.

Section 3.5 Family or Medical Leaves. If the Family and Medical Leave Act of 1993 applies to the City or Employer and a Participant employed by the City or that Employer takes a Family or Medical Leave as those terms are defined under the Family and Medical Leave Act of

1993, the Participant may continue to participate in this Plan consistent with one of the following provisions:

(a) the Participant shall agree to make all required contributions for the benefits he or she has selected under the Plan on an after-tax basis during the Family or Medical Leave at such times as the City may require pursuant to reasonable rules established by the City, or

(b) prior to the beginning of such leave, the Participant shall pay all contributions required for the benefits he or she has selected under the Plan for the duration of the leave, (i) on an after-tax basis or, (ii) if the Participant has Compensation from which such payment may be deducted, on a pre-tax basis but only through the end of the Plan Year.

Notwithstanding the foregoing, if the City continues to provide or maintain coverage under any benefit selected by a Participant during a Family or Medical Leave in circumstances where the Participant has elected to continue such coverage and has not made the required contributions during their Family or Medical Leave, the City shall have the right to recover the cost of such coverage from the Participant's Compensation upon return from Family or Medical Leave, or, if the participant does not return, at the end of the Family or Medical Leave to the fullest extent authorized by the Family and Medical Leave Act of 1993 and pursuant to any method authorized by the Family and Medical Leave Act of 1993.

Section 3.6 Qualified Medical Child Support Orders.

(a) Procedures. The City shall establish reasonable procedures to determine the qualified status of Medical Child Support Orders (“Orders”), and to administer the provision of benefits under such Orders. Such procedures shall be in writing and shall be deemed a part hereof. When the City receives an Order, it shall promptly notify the Participant, and each Alternate Recipient of the receipt of such Order and the Plan’s procedures for determining the qualified status of such Orders. Such notice shall be in writing and shall be mailed to each person entitled to notice at the address included in the Order. An Alternate Recipient may designate a representative for receipt of copies of any and all notices either in the Order or by a writing addressed to the City. Within a reasonable period after receipt of such Order, the City shall determine whether such Order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient (or his or her designee) of such determination.

(b) Definitions. For purposes of this section, the following terms have the following meanings:

- (i) “Medical Child Support Order” means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which (i) provides for child support with respect to a child of a Participant under the Plan or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates (or arguably may relate) to benefits under the Plan or (ii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to the Plan.

(ii) “Alternate Recipient” means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment or benefits under the Plan with respect to such Participant.

(iii) “Qualified Medical Child Support Order” means a medical child support order which (i) creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to receive benefits for which a Participant or beneficiary is eligible under the Plan, (ii) clearly specifies (A) the name and the last known mailing address (if any) of the Participant and the name and address of each Alternate Recipient covered by the Order, (B) a reasonable description of the type of coverage to be provided by the Plan and each such Alternate Recipient, or the manner in which such type of coverage is to be determined, (C) the period to which such period applies, and (D) each plan to which such order applies, and (iii) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of the law relating to medical child support described in Section 1908 of the Social Security Act.

Section 3.7 Rights Upon Reemployment After Military Leave of Absence. A Participant whose coverage under a “Health Plan” (as that term is defined under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) offered through this Plan was terminated during a military leave of absence (as defined under USERRA), shall be entitled to reinstate coverage under such Health Plan consistent with the USERRA.

Article 4. Plan Contributions and Benefit Costs

Section 4.1 Benefit Costs. The cost of any benefit elected by a Participant shall be paid for through the Participant's Pay Conversion Contributions as described below.

Section 4.2 Pay Conversion Contributions. Each Participant shall designate a portion of the Participant's Compensation as Pay Conversion Contributions to cover the employee cost of all benefits that are elected by the Participant under this Plan. Except as otherwise provided by the City, Pay Conversion Contributions shall reduce the Participant's Compensation ratably on each day during the Plan Year following the effective date of the Participant's participation. The election to participate in the City sponsored health, dental, disability and/or life plan(s) shall authorize the appropriate payroll deductions.

Section 4.3 Benefit Selection. A Participant's initial benefit election shall be made as part of the application to participate. Thereafter, subject to such reasonable restrictions, if any, as the City may impose on a uniform basis, a Participant may change his or her election for a subsequent Plan Year by providing notice in a timely fashion to the City's Benefit Office, to elect or waive participation in the City sponsored health, dental and/or life plan(s). The City or any provider of benefits hereunder may impose restrictions on the election of benefits under the Plan. The City utilizes an "automatic election" for the health, dental, long-term disability and basic life plan premium contributions. An automatic election assumes that the Participant desires to make premium contributions on a pre-tax basis. Because the City utilizes this automatic

election feature, Eligible Employees shall have the right to waive participation in the City's health, dental and/or life plans and, take any pay conversion contributions they would have made, as taxable cash compensation. Automatic elections shall not be used for medical expense reimbursement under Section 5.2.2 or dependent care reimbursement under Section 5.2.3. The election to participate in the City sponsored health, dental, disability and/or life plan(s) shall authorize the appropriate payroll deductions.

Section 4.4 Revocation or Changes in Benefit Elections. A Participant's benefit election for any Plan Year shall be irrevocable during the Plan Year, except that (a) the City may limit or reduce a Participant's contributions allocable to certain benefits in accordance with Section 4.7, and (b), if there is a Status Change, a Participant shall be entitled to change the Participant's election of benefits in a manner that is consistent with the Status Change by providing notice thereof to his or her Employer, in a manner prescribed by the City, either prior to or after the Status Change, but not later than thirty (30) days after the occurrence of the Status Change; provided, however, that a Participant may not make any change that would reduce the Participant's level of medical reimbursement coverage under paragraph 5.2.2 to an amount that would be less than the amount of benefits claimed under such coverage as of the date the change would become effective. Any such change shall be effective for the first pay period for which the Employer can process the change, or, if later, the actual date of the Status Change. Notwithstanding the foregoing, any Participant whose benefit election has been revoked for such Plan Year pursuant to Section 4.5 below shall be entitled to make a new benefit election for such Plan Year, consistent with the law relating to such re-instatement or re-enrollment, and a Participant who has elected to pay for a benefit solely through after-tax payroll deductions rather

than through Pay Conversion Contributions, if permitted by the City, may make election changes with respect to such benefit in accordance with rules established by the City. If there is a change in cost of coverage for a benefit provided by an independent third party, the City may, on a reasonable and consistent basis, automatically adjust the Participant's election and automatically increase or decrease, as the case may be, all affected Participant's Pay Conversion Contributions. To the extent provided by the City on a uniform basis, if coverage under a health, dental, disability and/or life plan provided by an independent third party is significantly curtailed or ceases during a Period of Coverage, affected Participants may revoke their elections under such health, dental, disability and/or life plan, and, in lieu thereof, elect to receive on a prospective basis coverage under another health, dental, disability and/or life plan with similar coverage.

Section 4.5 Termination of Employment. In the event of the termination of a Participant's employment, the Participant's Pay Conversion Contributions will cease at such time as the Participant ceases to receive Compensation for employment services. To the extent permitted under Section 3.4 or Section 3.5 such a Participant may elect to continue to make contributions for benefits under this Plan other than through Pay Conversion Contributions. Except as provided in Section 3.5 or Section 3.7, if the Participant should return to service with the City or Employer during the Plan Year, the Participant may make a new benefit election for the remaining portion of the Plan Year, or under certain circumstances may be permitted by the City to be re-instated to their previous election. All re-instatements or re-enrollments must be consistent to the related law.

Section 4.6 Cessation of Required Contributions. A Participant's election to receive a benefit under this Plan shall be automatically revoked effective the first day of any period for which such Participant fails to make a contribution required by the City for such benefit for such period.

Section 4.7 Adjustments to Prevent Discrimination. If the City believes that the Plan or any of its benefits might otherwise be deemed discriminatory under any provision of the Code, it may, in its absolute discretion, limit or reduce the amount of Pay Conversion Contributions of such Participants allocable to such benefits described herein in such amounts as are necessary, in its good faith judgment, to avoid such discrimination; provided that any such limitation imposed by the City shall apply on a uniform basis among the affected Participants.

Section 4.8 Available Benefits. The City shall maintain and make available to Participants accurate lists and descriptions of the respective types, amounts, and costs of benefits available through the Plan. Each Participant shall be notified in writing if there is (a) a change in the cost of a benefit or (b) a change in the type, nature, or amount of any benefit.

Article 5. Plan Benefits

Section 5.1 Available Benefits. Except as otherwise provided in this Article, and subject to any open enrollment or other provisions of contracts with third party benefit providers, a Participant may use Pay Conversion Contributions to pay for the benefits described in Section 5.2 that the Participant has elected to receive. Benefits shall be provided under such insurance policies, plans, programs or other arrangements as obtained or established by the City. All benefits are subject to the terms and conditions of the plans, policies, programs or other arrangements obtained or established by the City to fund or provide those benefits.

Section 5.2 Benefits.

5.2.1 Health Coverage. Payment of the employee cost of single or dependent coverage under the City of Minneapolis Health Plan and under such policies or programs as the City elects to make available to the Participant.

5.2.2 Medical Reimbursement. A Participant may elect to receive medical reimbursement benefits under the terms and conditions of this paragraph 5.2.2.

(a) Medical Reimbursement Coverage. Participants may elect to receive medical reimbursement coverage of up to a maximum coverage of 100% of gross compensation per Plan Year.

(b) Medical Reimbursement Charge. Prior to the commencement of each Plan Year, the City shall determine and communicate to Participants the annual rate of the Medical Reimbursement Charge for each dollar of medical reimbursement coverage for the forthcoming Plan Year. A

Participant's Medical Reimbursement Charge shall be payable from the Participant's Pay Conversion Contributions on a monthly or other periodic basis during the Plan Year as determined by the City and communicated to Participants.

(c) Medical Reimbursement Benefits. Subject to limitations contained in other provisions of this Plan, a Participant who incurs expenses for Medical Care attributable to the Participant or the Participant's spouse or Dependents during the Participant's Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the maximum amount of coverage elected by the Participant for that Plan Year. The Claims Administrator shall pay all such expenses to the Participant upon the presentation of documentation of such expenses in a form prescribed by the Claims Administrator, which shall include satisfactory third party evidence of the amount of the expense and the date(s) incurred. In addition, upon presentation of a claim, a Participant shall expressly represent that the item for which a claim is made is not subject to reimbursement under any policy described in paragraph 5.2.2(d) or from any other source. In its discretion, the Employer may pay any of such expenses directly, in which event it shall be relieved of all further responsibility with respect to that particular expense. These expenses shall be paid periodically during the Plan Year upon receipt of a claim complying with Plan requirements, and no later than ninety (90) days

following the close of a Plan Year upon receipt of a claim (no minimum) complying with Plan requirements.

(d) Limitations on Medical Reimbursement Benefits. Anything in the Plan to the contrary notwithstanding, no Participant shall be entitled to benefits under this paragraph 5.2.2:

(i) In the event and to the extent that the reimbursement or payment is covered under any insurance policy or policies, whether paid for by the Employer or the Participant, or under any other health and accident plan by whomever maintained. If there is such a policy or plan in effect providing for reimbursement or payment, in whole or in part, then to the extent of the coverage under that policy or plan, the Plan shall be relieved of any liability; or

(ii) To the extent that the expense has been submitted for reimbursement from the Participant's Dependent Care Reimbursement Account.

(e) Forfeiture of Unused Benefits. If, following the final payment of reimbursement benefits for eligible expenses incurred during the Period of Coverage for any Plan Year, there is an amount remaining in a Participant's Medical Reimbursement Account for that Plan Year, the Participant shall forfeit such amount the Plan and shall have no further claim to that amount.

(f) Separate Written Plan. For purposes of the Code, paragraph 5.2.2 shall constitute a separate written plan providing for the reimbursement of

Medical Care expenses. To the extent necessary, other provisions of the Plan are incorporated by reference in paragraph 5.2.2.

(g) HIPAA Privacy. Definitions of capitalized terms in this paragraph are taken from the statute and regulations of the Health Insurance Portability and Accountability Act of 1996 found in 45 CFR §164.401 et al. The HIPAA Privacy Rules stated in this section will become effective for the Plan when required under the applicable statutes and regulations. Therefore, the effective date could be as soon as April 14, 2003, or may be April 14, 2004 if the Plan is a small plan as defined under the regulations found in 45 CFR §164.401 et al., or the effective date may be further changed by the appropriate government agency. Additionally, definitions of capitalized terms in this paragraph are taken from the statute and regulations of the Health Insurance Portability and Accountability Act of 1996, cited above. The plan will use and disclose “protected health information” (PHI) for purposes related to health care treatment, payment for health care services, and health care operations. The plan will use or disclose PHI for any other purpose only upon receipt of an authorization from the individual. The Plan will not disclose “protected health information” (PHI) to the plan sponsor until the Plan has received certification from the plan sponsor that the plan documents have been amended to incorporate the following provisions: As plan sponsor the City agrees to

- (i) not use or further disclose “protected health information” (PHI) other than as permitted or required by the plan document or as required by law;

(ii) ensure that any agents, including a subcontractor, to whom it provides PHI agree to the same restrictions and conditions that apply to the plan sponsor with respect to PHI;

(iii) not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the City;

(iv) be vigilant of any use or disclosure of PHI and report to the plan any use or disclosure that is inconsistent with the permitted or required uses or disclosures;

(v) make available PHI to individuals;

(vi) provide individuals with the opportunity to amend PHI;

(vii) provide individuals with an accounting of the disclosure of their PHI;

(viii) make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the Department of Health and Human Services; for compliance purposes;

(ix) return or destroy all PHI, if feasible, if not feasible then limit further uses and disclosures to those purposes that make the return or destruction infeasible;

(x) ensure that adequate separation exists between employees who are authorized to use PHI and those who are not the Plan Sponsor will; identify those employees or classes of employees to be given access to PHI; restrict the access to and use by these employees; provide an

effective mechanism for resolving any issues of noncompliance by persons who have access to PHI.

(h) In accordance with the HIPAA Privacy rules, the following employees, or class of employees, will have access to PHI: employees with medical flexible benefit oversight responsibility.

(i) the individuals described in (h) above will have access to use and disclosure of PHI for plan administration functions that are performed by the Plan Sponsor for the Plan.

(j) the plan sponsor will provide a mechanism for resolving noncompliance issues for any individual described in (h) above who does not comply with the plan document, or improperly uses or discloses PHI, including disciplinary procedures.

5.2.3 Dependent Care Reimbursement. A Participant may elect to receive dependent care reimbursement for eligible dependent care expenses under the terms and conditions of this paragraph 5.2.3.

(a) Dependent Care Reimbursement Accounts. A Dependent Care Reimbursement Account shall be established for each electing Participant for each Plan Year. Each Dependent Care Reimbursement Account shall initially contain Zero Dollars (\$0.00).

(b) Increases in Dependent Care Reimbursement Accounts. A Participant's Dependent Care Reimbursement Account shall be increased each relevant pay period by such whole dollar amount of the Participant's Pay

Conversion Contributions as the Participant has elected to apply toward the Participant's Dependent Care Reimbursement Account; provided that the annual contribution to a Participant's Dependent Care Reimbursement Account attributable to a Participant's Pay Conversion Contributions shall be a minimum of \$100 per Plan Year and the maximum Pay Conversion Contributions shall never exceed the IRS limit as defined in the Code per Plan Year. See 26 USC 129(a)(2) (A) and 26 USC 129(b).

(c) Decreases in Dependent Care Reimbursement Account. A Participant's Dependent Care Reimbursement Account shall be reduced by the amount of any benefits paid to or on behalf of a Participant pursuant to paragraphs 5.2.3(d) or 5.2.3(e).

(d) Dependent Care Benefits. Subject to limitations contained in other provisions of this Plan, and to the extent of the amount contained in the Participant's Dependent Care Reimbursement Account, a Participant who incurs Employment Related Dependent Care Expenses shall be entitled to receive from his or her Employer full reimbursement for the entire amount of these expenses incurred during the Period of Coverage for a Plan Year to the extent of the amount contained in the Participant's Dependent Care Reimbursement Account for that Plan Year; provided that no reimbursement shall be paid pursuant to this paragraph 5.2.3 to the extent that an expense has been submitted for reimbursement as a Medical Care expense under paragraph 5.2.2. The Claims Administrator shall pay all such expenses to the Participant upon the presentation Claims Administrator documentation of these expenses in a form prescribed by

the Claims Administrator. These expenses shall be paid periodically during the Plan Year upon receipt of a claim complying with Plan requirements, and no later than ninety (90) days following the close of the Plan Year upon receipt of a claim (no minimum) complying with Plan requirements.

(e) Forfeiture of Unused Benefits. If, following the final payment of reimbursement benefits for eligible expenses incurred during the Period of Coverage for any Plan Year, any amount remains in a Participant's Dependent Care Reimbursement Account for that Plan Year, the Participant shall forfeit such amount to the Plan, and shall have no further claim to that amount.

(f) Annual Statement of Benefits. On or before January 31 of each calendar year, Employers shall furnish to each Participant who received benefits under paragraph 5.2.3 during the preceding calendar year, a statement of all such benefits paid to or on behalf of the Participant during the prior calendar year.

(g) Separate Written Plan. For purposes of the Code, paragraph 5.2.3 shall constitute a separate written plan providing a program of dependent care assistance. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in paragraph 5.2.3.

5.2.4 Dental Coverage. Payment of the employee cost of single or dependent coverage under the City of Minneapolis Dental Plan and under such policies or programs as the City elects to make available to the Participant.

5.2.5 Life Insurance. Payment of the employee cost of coverage for the first \$50,000 of coverage under the City of Minneapolis Life Insurance Plan. This life insurance plan is described in the Life Insurance Plan Certificate of Coverage.

5.2.6 Long-Term Disability Insurance. Payment of the employee cost of coverage under the Long-Term Disability Plan.

Section 5.3 Taxable Cash Compensation. The Plan is a choice for the participant between benefits and taxable compensation, therefore the amount of any Pay Conversion Contributions not used by a Participant for benefits, shall be paid to the Participant as taxable cash compensation at the time the contributions constituting such Pay Conversion Contributions would be paid without regard to this Plan. Elections to the medical and dependent care reimbursement portions of this Plan, Section 5.2, are considered the purchase of benefits. Any remaining balances after the end of the Plan Year in these accounts will be considered unused benefits and are subject to the provisions listed in 5.2.2 and 5.2.3. Taxable cash compensation under this Section 5.3 shall be deemed a benefit.

Article 6. Claims Procedure

Section 6.1 Written Claim for Benefits. Benefit payments shall not be made under this Plan until the appropriate Claims Administrator has received a claim for benefits that satisfies all requirements of the separate benefit plan under which such benefit is claimed to be due.

Section 6.2 Claims Procedure. The Plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures).

If the claimant or the claimant's representative fail to follow the claims procedures set out by the Plan, the claimant will be notified of such failure as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

If a claim is wholly or partially denied, the Claims Administrator will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90- day period. In no event shall such extension exceed a period of 90 days from the end of such initial

period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

In the case of a post-service claim (i.e., the claimant has already received service), the Claims Administrator will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

For purposes of this section, the time periods will begin at the time a claim is filed without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted under this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

The notification shall set forth either upon the initial determination or upon review, in a manner calculated to be understood by the claimant –

- (i) The specific reason or reasons for the adverse determination;
- (ii) Reference to the specific Plan provisions on which the determination is based;
- (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (iv) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review;
- (v) In the case of an adverse benefit determination, (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or (B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- (vi) In the case of an adverse benefit determination review, the following statement shall be included: “The claimant and the Plan may have other voluntary

alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

For a group medical claim, the claimant will have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. The appeal process requires the Plan to

- (i) provide for a review that does not afford deference to the initial adverse benefit determination;
- (ii) provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- (iii) provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- (iv) provide that the health care professional engaged for purposes of a consultation under this section shall not be an individual who was consulted in connection with

the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

The Claims Administrator shall notify the claimant of the Plan's benefit determination on review. In the case of a post-service claim, the Claims Administrator will notify the claimant of the Plan's benefit determination on review within a reasonable period of time, not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

If the Plan fails to establish or follow claims procedures consistent with the requirements of this section, the claimant will be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Article 7. Administration and Finances

Section 7.1 Administration. The City shall be the administrator of the Plan, and, as such, has total and complete discretionary authority to determine conclusively for all parties all questions arising in the administration of the Plan. The City shall have all powers necessary to administer the Plan, including, without limitation, powers:

- (a) to interpret the provisions of the Plan;
- (b) to establish and revise the method of accounting for the Plan and to maintain the accounts;
- (c) to establish rules for the administration of the Plan and to prescribe any forms required to administer the Plan; and
- (b) to change plans, contracts or policies and/or insurers or other providers of benefits described in Sections 5.2 of the Plan.

Section 7.2 Delegation. The City shall have the power to delegate specific duties and responsibilities. Such delegations may be to other employees of the City or Employers or to other individuals or entities. Any delegation by the City, if specifically stated, may allow further delegations by the individual or entity to whom the delegation has been made. Any delegation may be rescinded by the City at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for the exercise of those duties or responsibilities and shall not be responsible for the acts or failure to act of any other individual or entity.

Section 7.3 Reports and Records. The City and those to whom the City has delegated duties and authority under the Plan shall keep records of all their proceedings and actions, and shall maintain all books of account, records, and other data necessary for the proper administration of the Plan and to comply with applicable laws.

Section 7.4 Actions of the City. Subject to the claims procedures of Article 6, all determinations, interpretations, rules, and decisions of the City shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

Section 7.5 Finances. The costs of the Plan shall be borne as provided herein. For purposes of the Plan, Pay Conversion Contributions shall be deemed contributions by the Employer of each Participant.

Section 7.6 Indemnification. To the extent permitted by law and required by contractual agreements, the City, Employers, the Claims Administrator and others to whom the City has delegated duties and authority pursuant to Section 7.2 shall indemnify and hold harmless their employees performing administrative duties under this plan from any loss, claim, or suit arising out of the performance of obligations imposed hereunder and not arising for such employee's willful neglect or misconduct, or gross negligence. To the extent permitted by law, neither the City, Employers, Claims Administrator, others to whom the City has delegated duties and authority pursuant to Section 7.2, nor any other person shall incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of this Plan.

Article 8. Amendments and Termination

Section 8.1 Amendments. The City shall have the right at any time and from time to time, by City Council action, to amend the Plan, in full or in part, the amendment to be effective at the time stated therein. Any such amendment shall be filed with the Plan documents.

Section 8.2 Benefits Provided through Third Parties. In the case of any benefit provided pursuant to an insurance policy or other contract with a third party, the City may amend the Plan by changing insurers, policies, or contracts without changing the language of the Plan, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are informed of the effects of any changes.

Section 8.3 Termination. The City expects the Plan to be permanent, but necessarily must, and hereby does, reserve the right to terminate the Plan at any time. Any such termination shall be by resolution of the City Council. Neither the City nor any Employer, or employees shall have any further financial obligations under the Plan from and after termination of the Plan except those that have accrued up to the date of termination and have not been satisfied.

Article 9. Miscellaneous

Section 9.1 No Guaranty of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the City, or any Independent Board or Agency, and any employee. Nothing contained in the Plan shall give any employee the right to be retained in the employ of the City or any Independent Board or Agency or to interfere with the right of the City or any Independent Board or Agency to discharge any employee at any time, nor shall it give the City or any Independent Board or Agency the right to require any employee to remain in its employ or to interfere with the employee's right to terminate employment at any time.

Section 9.2 Limitation on Liability. Neither the City nor any Independent Board or Agency guarantees benefits payable under any insurance or health maintenance organization policy or contract described in the Plan, and any benefits payable thereunder shall be the exclusive responsibility of the insurer or health maintenance organization that is obligated under the contract or policy.

Section 9.3 Non-Alienation. No benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Section 9.4 Applicable Law. The Plan and all rights under it shall be governed by and construed according to the laws of the State of Minnesota, except to the extent those laws are preempted by the laws of the United States of America.

Section 9.5 Benefits Provided Through Third Parties. In the case of any benefit provided through a third party, such as an insurance company, pursuant to a contract or policy with that third party, if there is any conflict or inconsistency between the description of benefits contained in the Plan and the contract or policy, the terms of the contract or policy shall control.

City of Minneapolis

By: _____

Title: _____