## CITY OF MINNEAPOLIS MINNEFLEX PLAN

(including the following component plans:
City of Minneapolis Medical Plan,
City of Minneapolis Dental Plan,
City of Minneapolis Medical Expense Reimbursement Plan,
City of Minneapolis Dependent Care Expense Reimbursement Plan, and
City of Minneapolis Group Term Life Plan)

Effective April 1, 1987 Amended and Restated Effective January 1, 2007

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### ARTICLE I.

- 1.1 **Establishment**. The City of Minneapolis (hereinafter the "Employer"), hereby amends and restates, effective January 1, 2007, the City of Minneapolis Minneflex Plan (the "Plan"). The Plan is for the exclusive benefit of Eligible Employees of the Employer and Independent Boards and Agencies that adopt the Plan with the Employer's consent.
- 1.2 **Purpose**. The purpose of the Plan is to provide Participants with a choice between certain "qualified benefits" as defined in Section 125 of the Code. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code so that Optional Benefits a Participant elects to receive under the Plan will be eligible for exclusion from the Participant's gross income to the fullest extent possible under the Code.
- 1.3 **HIPAA Privacy and Security Rules**. Portions of this Plan are "covered entities" for purposes of the Privacy Rules and the Security Rules.
- 1.4 **Gender and Number**. Pronoun references in this Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.
- 1.5 **Not ERISA Plan**. Neither this Plan, nor any of the Optional Benefits made available through it, is an employee welfare benefit plan for purposes of ERISA. Any resemblance of the Plan to an ERISA plan shall not bind the Plan to comply with ERISA.

### ARTICLE II. DEFINITIONS

The following words and phrases are used in this Plan and shall have the meanings set forth in this Article unless a different meaning is clearly required by the context or is defined within an Article.

- 2.1 **Authorized Representative** means, for the claims and appeal procedures, the person entitled to act on behalf of the claimant with respect to a benefit claim or appeal. In order for the Plan to recognize a person as an Authorized Representative, written notification to that affect signed by the claimant and notarized must be received by the Plan. An assignment for purposes of payment is not designation of an "Authorized Representative."
- 2.2 **Change in Status** means the situations recognized by this Plan and permitted under applicable law, as reflected in Section 5.3, that permit a Participant to make a change in his or her Election mid-Plan Year.
- 2.3 **City** means the City of Minneapolis.
- 2.4 **Claims Administrator** means the entity described under Section 6.1(c).
- 2.5 **Code** means the Internal Revenue Code of 1986, as amended from time to time.
- 2.6 **Compensation** means all of an Employee's earnings from the Employer which are subject to withholding for federal income tax purposes.
- 2.7 **Covered Individual** means a person, including a Participant, a Dependent of a Participant, a Spouse of a Participant, and any other person, appropriately covered under an Optional Benefit subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").
- 2.8 **Dependent** means (i) a son, stepson, daughter, or stepdaughter of a Participant who is a "qualifying child" under Section 152 of the Code determined without regard to Subsections (b)(1) and (b)(2) thereof, and (ii) an individual for whom the Participant or the Participant's Spouse is a legal guardian, provided the individual is the Participant's "qualifying relative" under Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.
- 2.9 **Effective Date** means the effective date of this amendment and restatement, which is January 1, 2007.
- 2.10 **ePHI** means PHI maintained or transmitted in electronic media including, but not limited to, electronic storage media (i.e., hard drives, digital memory medium) and transmission media used to exchange information in electronic storage media (i.e., internet, extranet, and other networks). PHI transmitted via facsimile and telephone is not considered to be transmissions via electronic media.
- 2.11 **Election** means the choice of Optional Benefits and means of payment made by the Participant as described in Article V.
- 2.12 **Election Period** means the open enrollment period of time identified by the Plan Administrator prior to the start of a Plan Year during which a Participant may change his or her Election. For a Participant who enters the Plan other than at the start of a Plan Year, Election Period means the period of time identified by the Plan Administrator prior to the date on which the Eligible Employee begins participation during which an Eligible Employee may make an Election or change a deemed Election.

- 2.13 **Eligible Employee** means each Employee who has met the eligibility requirements of Section 3.1.
- 2.14 **Employee** means any person employed by the Employer on or after the Effective Date, except that it shall not include:
  - (a) any self-employed individual as described in Section 401(c) of the Code;
  - (b) any employee included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this Plan;
  - (c) any employee who is a nonresident alien and receives no earned income from the Employer from sources within the United States; or
  - (d) any employee who is a leased employee as defined in Section 414(n)(2) of the Code.

All employees who are treated as employed by a single employer under subsections (b), (c) or (m) of Section 414 of the Code are treated as employed by a single employer for purposes of this Plan. Employee also includes any elected official of the Employer employed by the Employer on or after the Effective Date.

- 2.15 **Employer** means the City of Minneapolis and the Independent Boards and Agencies who have adopted and not terminated participation in the Plan.
- 2.16 **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 125(e)(2) of the Code.
- 2.17 **Highly Compensated Participant** means a Participant who is highly compensated as defined in Section 125(e)(1) of the Code.
- 2.18 **HIPAA** means Health Insurance Portability and Accountability Act of 1996, and regulations thereunder, as amended from time to time.
- 2.19 **Independent Boards and Agencies** means the Minneapolis Employee Retirement Fund, the Municipal Building Commission, the Minneapolis Park and Recreation Board, the Minneapolis Library Board, the Minneapolis Board of Estimate and Taxation, the Minneapolis Neighborhood Revitalization and Policy Board, the Minneapolis Youth Coordinating Board and the Minneapolis Public Housing Authority.
- 2.20 **Insurer** means any insurance company that has issued a policy through which benefits are made available under this Plan.
- 2.21 **Optional Benefits** means the benefits made available through this Plan as follows:
  - (a) City of Minneapolis Medical Plan;
  - (b) City of Minneapolis Dental Plan;
  - (c) City of Minneapolis Group Term Life Plan;
  - (d) City of Minneapolis Medical Expense Reimbursement Plan; and
  - (e) City of Minneapolis Dependent Care Expense Reimbursement Plan.

- 2.22 **PHI** means health information that:
  - (a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse;
  - (b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
  - (c) either identifies the individual or reasonably could be used to identify the individual.

PHI includes ePHI.

- 2.23 **Participant** means an Eligible Employee who participates in the Plan in accordance with Article III and has not ceased to be a Participant under Section 3.4.
- 2.24 **Plan** means the City of Minneapolis Minneflex Plan, as it may be amended or restated from time to time.
- 2.25 **Plan Administrator** means the entity determined under Section 6.1.
- 2.26 **Plan Year** means the twelve-month period commencing on the first day of January and ending on the last day of December.
- 2.27 **Privacy Rules** means the *Standards and Privacy of Individually Identifiable Health Information* at 45 C.F.R. Part 160 and Part 164 at subparts A and E.
- 2.28 **Security Rules** means the *Security Standards and Implementation Specifications* at 45 C.F.R. Part 160 and Part 164, subpart C.
- 2.29 **Spouse** means an individual who is legally married to a Participant and who is treated as a "spouse" under the Code.

### ARTICLE III. ELIGIBILITY AND PARTICIPATION

- 3.1 **Eligibility Requirements**. Eligibility, waiting periods, effective dates of participation, and employee contribution requirements will be determined by the Employer based on applicable policy or collective bargaining agreement.
- 3.2 **Notification of Participants**. The Plan Administrator shall provide each Eligible Employee written notice of the Employee's eligibility to participate in the Plan in sufficient time to enable such Eligible Employee to submit an application for participation in the Plan. The amount of time that is "sufficient" shall be determined by the Plan Administrator.
- 3.3 **Application for Participation.** To become a Participant, an Eligible Employee shall execute and deliver to the Plan Administrator a written application signed by the Eligible Employee in which the Eligible Employee applies to participate in the Plan, designates the required portion of Compensation for the pre-tax and after-tax (if any) contributions, makes a benefit Election, and supplies any other pertinent information that the Plan Administrator may reasonably require. By signing such application or agreement, the Eligible Employee shall be deemed for all purposes to have agreed to participate and to conform to the requirements of the Plan. Alternatively, or in addition to, the Plan Administrator may require or permit application of same scope by electronic means.
- 3.4 **Termination of Participation**. A Participant automatically ceases to be a Participant at midnight of the earliest of the following dates:
  - (a) the death of the Participant;
  - (b) the date of termination of the Participant's employment with the Employer;
  - (c) the date of the Participant's failure to meet the eligibility requirements of Section 3.1, as may be amended from time to time; or
  - (d) the date of termination of the Plan in accordance with Article VII.

In the event the Plan does not learn that a Participant has automatically ceased to be a Participant until a date after the date participation ceased, participation will be terminated retroactively and the Plan shall be entitled to recover any benefits paid after the date participation is terminated. Termination of participation in this Plan shall not prevent a former Participant from continuation coverage, conversion coverage or benefits under the respective Optional Benefit plans if and to the extent provided by such plans.

3.5 **Conditions of Participation**. As a condition of participation and receipt of benefits under this Plan, the Participant agrees to:

- (a) observe all Plan rules and regulations;
- (b) consent to inquiries by the Plan Administrator with respect to any provider of services involved in a claim under this Plan; and
- submit to the Plan Administrator all notifications, reports, bills, and other information required by the Plan or which the Plan Administrator may reasonably require.

Failure to do so relieves the Plan, Plan Administrator, Employer, and Claims Administrator from any and all obligations under this Plan.

3.6 **Participation in Optional Benefit Plans**. In order to elect a specific Optional Benefit provided under this Plan, a Participant must elect that Optional Benefit on such forms as the Plan Administrator may require (unless the benefit is provided to all Participants) and, if the cost of Optional Benefit is not fully paid by the Employer, shall be required to share the cost of the Optional Benefit as provided in Article IV. Further, the Participant must meet any eligibility, participation, etc., requirements applicable to that Optional Benefit in accordance with the terms of the Plan through which the Optional Benefit is provided.

### ARTICLE IV. CONTRIBUTIONS

- 4.1 **Salary Reduction Contributions**. The Participant's Compensation will be reduced and an amount equal to the reduction shall be allocated by the Employer to the Optional Benefits designated by the Participant. For contributions to the City of Minneapolis Medical Expense Reimbursement Plan and the City of Minneapolis Dependent Care Expense Reimbursement Plan, a Participant's Compensation shall be reduced per pay period by pro-rata amounts of the Participant's total salary reduction Election. For contributions to the City of Minneapolis Medical Plan, the City of Minneapolis Dental Plan, and the City of Minneapolis Group Term Life Plan, a Participant's Compensation shall be reduced monthly on the second pay period of each month by pro-rata amounts of the Participant's total salary reduction Election. Salary reduction is done on a pre-tax basis before any withholdings have been made.
- 4.2 **Salary Deduction Contributions**. The Employer may require that amounts for which the Participant is responsible, but which cannot be paid with pre-tax dollars through salary reduction described above, be funded with after-tax dollars pursuant to a salary deduction agreement. Such salary deductions shall be made on a periodic basis and relate to a Participant's Compensation after taxes and withholdings have been made.
- 4.3 **Maximum**. Under no circumstances may a Participant's total salary reduction exceed the sum of (a) the cost of benefits provided through insurance or insurance types of benefits plus (b) the maximum Election amounts permitted under reimbursement plans.
- **No Trust**. Nothing in this Plan is intended to require the establishment of a trust. The benefits paid under this Plan attributable to Participant contributions including, but not limited to, salary reductions amounts are paid from the Employer's general assets.

### ARTICLE V. ELECTION OF AVAILABLE BENEFITS

- 5.1 **Initial Elections**. An Election must have been made (1) prior to the date on which the Eligible Employee becomes a Participant, and (2) within the applicable Election Period. If an Election form is not received by the Plan Administrator, or its designee, prior to the expiration of the Election Period, the following shall apply:
  - (a) For the City of Minneapolis Medical Plan and City of Minneapolis Dental Plan an Eligible Employee enrolled in one or both of such plans is deemed to have elected to participate in this Plan for the purpose of paying the Eligible Employee's share of the cost of such benefits through salary reduction unless (i) the Eligible Employee specifically elects not to participate in this Plan and notifies the Plan Administrator in writing on or before the start of the Plan Year, or (ii) such deemed Election is otherwise prohibited by law.
  - (b) **For all other Optional Benefits** an Eligible Employee will be deemed to have elected to not participate in those benefits or pay for those benefits through salary reduction under this Plan.
- 5.2 **Subsequent Elections**. During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to change his or her Election. Such changes include the following:
  - (1) an Eligible Employee who is not participating may elect to begin participating by electing Optional Benefits during the Election Period;
  - (2) a Participant may terminate participation in the Plan; or
  - (3) a Participant may elect different Optional Benefits or different levels of Optional Benefits.

If a Participant does not make an Election during the annual Election Period described in this section, the following shall apply:

- (a) For the City of Minneapolis Medical Plan, the City of Minneapolis Dental Plan, and the City of Minneapolis Group Term Life Plan unless prohibited by law, a Participant enrolled in one or both of such plans is deemed to have elected to continue participating in this Plan for the purpose of paying the Participant's share of the cost of such benefits through salary reduction for the upcoming Plan Year.
- (b) **For all other Optional Benefits** a Participant will be deemed to have elected to not continue participating in those benefits or paying for those benefits through salary reduction under this Plan for the upcoming Plan Year.
- 5.3 **Elections Irrevocable**. Once an Election becomes effective, such Election shall be irrevocable for the Plan Year or the remainder of the Plan Year except under the following circumstances:
  - (a) Change in Status. A Participant may change or terminate his or her actual or deemed Election under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status that affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's Dependent (referred to as the general consistency requirement). The Plan Administrator

(in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her Election based on that change.

- (1) Loss of Dependent Eligibility. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance, or insurance type, coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant, the Participant's Spouse (but not ex-Spouse) or the Participant's Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's Plan, the Participant may increase the Election for that Optional Benefit to pay for such coverage provided the Participant is still eligible under the Plan and still receiving Compensation.
- (2) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's Dependent gains eligibility for coverage under another employer's cafeteria plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage only if that coverage becomes effective or is increased under the other employer's plan.
- (3) Dependent Care Expense Reimbursement Plan. With respect to the Dependent Care Expense Reimbursement Plan, a Participant may change or terminate his or her Election only if (i) such a change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (ii) the Election change is on account of and corresponds with a Change in Status that affects eligibility of dependent care expenses for the tax exclusion available under Code § 129 of the Code.
- (4) Group Term Life Insurance and Disability Income Coverage. For a Change of Status involving a Participant's legal marital status or the employment status of a Participant's Spouse or Dependent (disregarding the requirement that the event cause a loss or gain of eligibility), a Participant may elect either to increase or to decrease group term life insurance or disability income coverage offered under the Plan.
- (b) HIPAA Special Enrollment Rights. If a Participant's Spouse or a Participant's Dependent is entitled to special enrollment rights under a group health plan, as required by Code § 9801(f), medical coverage was declined under the group health plan because of outside medical coverage, and eligibility for the outside medical coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, then a Participant may revoke a prior Election for health or accident coverage and make a new Election (including salary reduction Election), provided that the Election corresponds with the exercise of such special enrollment right. For purposes of this provision (1) an Election to add previously

eligible Dependents as a result of the acquisition of a new Spouse or Dependent child, subject to the provisions of the underlying group health plan, shall be considered consistent with the special enrollment right (a/k/a the Tag-along Rule); and (2) a HIPAA special enrollment Election attributable to the birth or adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactive (up to thirty (30) days).

- (c) Certain Judgments, Decrees and Orders. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a medical child support order) requires accident or health coverage for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may: (1) change his or her Election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage and subject to the provisions of the underlying group health plan); or (2) change his or her Election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan.
- (d) Medicare and Medicaid. If a Participant, a Participant's Spouse, or a Participant's Dependent who is enrolled in a health or accident benefit under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the health or accident coverage.

#### (e) Change in Cost.

- (1) Automatic Increase or Decrease for Insignificant Cost Changes. If the cost of a Optional Benefit (other than the Medical Expense Reimbursement Plan) increases or decreases during a Plan Year by an insignificant amount, then the pre-tax contributions or after-tax contributions (as applicable) under each affected Participant Election shall be prospectively increased or decreased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in Participant contributions in accordance with such cost changes. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).
- (2) Significant Cost Increases. If the Plan Administrator determines that the cost of a Optional Benefit (other than the Medical Expense Reimbursement Plan) significantly increases during a Plan Year, the Participant may either (a) make a corresponding prospective increase in his or her contributions, or (b) simply revoke his or her Election, and in lieu thereof, receive coverage under another Plan option which provides similar coverage. If no similar coverage is available, the Participant may revoke his or her Election. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

- (f) Change in Coverage.
  - (1) Significant Curtailment. If the Plan Administrator determines that a Optional Benefit (other than the Medical Expense Reimbursement Plan) under this Plan is significantly curtailed or ceases during a Plan Year, the Participant may revoke his or her Election under the Plan. To the extent there is similar coverage, the Participant may prospectively elect such coverage. If no similar coverage is available, the Participant may simply revoke his or her Election. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant", and whether a substitute Optional Benefit constitutes "similar coverage" based upon all the surrounding facts and circumstances.
  - (2) Addition or Elimination of a Benefit Providing Similar Coverage. If during a Plan Year, the Plan adds or eliminates a Optional Benefit (other than the Medical Expense Reimbursement Plan), an affected Participant may elect a newly-added option or elect another Optional Benefit (where a Plan option has been eliminated), and may do so prospectively on a pre-tax basis by making corresponding Election changes with respect to coverage under another Optional Benefit that provides similar coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a substitute Optional Benefit constitutes "similar coverage" based upon all the surrounding facts and circumstances.
  - (3) Change in Coverage of Spouse or Dependent Under Their Employer's Plan. A Participant may make a prospective Election change (other than under the Medical Expense Reimbursement Plan) that is on account of and corresponds with a change made under the plan of the Spouse's, former Spouse's, or Dependent's employer, so long as (a) the cafeteria plan or qualified benefits plan of the Spouse's, former Spouse's, or Dependent's employer permits its participants to make an Election change that would be permitted under the proposed or final IRS regulations; or (b) the Plan permits Participants to make an Election for a Plan Year period of coverage which is different from the plan year period of coverage under the cafeteria plan or qualified benefits plan of the Spouse's, former Spouse's or Dependent's employer. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the Spouse's, former Spouse's, or Dependent's employer.
  - (4) Loss of Governmental or Educational Coverage. A Participant may prospectively change his or her Election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable benefit package option(s).

(g) Other. The Plan Administrator shall have the discretion to allow a change to or termination of an Election to the extent such change or termination is the result of any other situation informally recognized by the Internal Revenue Service as providing an exception to the general rule that Elections are irrevocable (e.g., corrections of mistakes, changes to meet nondiscrimination requirements).

A Participant entitled to make a new Election under this Section must do so within thirty (30) days of the event. An Employee who is eligible to elect benefits but declined to do so during the initial Election period, or during a subsequent Election period, may file a new Election within thirty (30) days of the occurrence of an event described above, but only if the new Election is made on account of and corresponds with the event. Subject to the provisions of the underlying group health plan, Elections made to add medical coverage for a newborn or newly adopted Dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to thirty (30) days. All other new Elections shall be effective prospectively immediately following the date the Participant files the new Election with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the Election is made unless a subsequent event (described above) allows a further Election change.

For purposes of Section 5.3, to the extent the term "Dependent" is defined differently under a contract or policy with respect to an Optional Benefit, the definition contained in the contract or policy shall control for purposes of Elections related to such Optional Benefit.

- Rehire and Eligibility Loss. Termination of employment shall automatically revoke any Election. Except as otherwise limited by applicable Optional Benefits, former Participants who are rehired:
  - (a) After thirty (30) days following a termination of employment, shall have two "periods of coverage;" that period prior to the termination of employment and that period following the re-employment of the terminated Employee. Expenses incurred prior to the termination of employment shall be subject to the Election in effect upon termination; while the Employee shall have an opportunity to make a new Election and expenses incurred after re-employment shall be subject to the Election made upon re-employment.
  - (b) Within thirty (30) days following a termination of employment, shall have the Election in effect prior to the termination of employment reinstated upon re-employment.
- Benefit Descriptions. While an Election to receive one or more of the Optional Benefits may be made under this Plan, the benefits themselves may be provided in accordance with Plan documents or contracts which describe the types and amounts of benefits available, the requirements for participation, procedures for submitting claims, and the other terms and conditions of coverage. Such underlying Plan documents or contracts, if any, are incorporated into this Plan by reference and are identified in Exhibit A.
- Forfeiture. Any amounts, whether obtained through salary reduction, salary deduction, or otherwise, under this Plan which cannot be distributed by the Plan Administrator to cover the cost of Optional Benefits for the applicable Plan Year, shall be forfeited by the Participant. The Plan Administrator may use such forfeited amounts to defray the reasonable administrative costs of the Plan. To the extent forfeited amounts remain, the Plan Administrator shall arrange for the provision of a benefit for a broad cross section of Participants of the same type as the benefit which resulted in the forfeitures. Under no circumstances shall the Plan Administrator establish an outside formal or informal arrangement under which the forfeited amounts will be "currently available" (as defined in Internal Revenue Service proposed or final regulations) to the Participant

who experienced the forfeiture. This forfeiture requirement shall be applied separately for each Optional Benefit.

5.7 **Limitations on Benefits**. Benefits shall be limited in a manner which will prevent the Plan from discriminating in favor of Highly Compensated Individuals as to eligibility to participate and Highly Compensated Participants as to contributions and benefits. As provided in Section 6.13, the Plan Administrator shall determine the manner of adjusting eligibility, benefits, and contributions, if necessary, and may do so with or without the consent of such Participants.

### ARTICLE VI. ADMINISTRATION

#### 6.1 **Plan Administrator.**

- (a) The Plan Administrator shall be responsible for the general supervision of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan.
- (b) The City shall be the Plan Administrator unless the City's managing body designates a person or persons other than the City to be the Plan Administrator. The City shall also be the Plan Administrator if the person or persons so designated cease to be the Plan Administrator.
- (c) The Plan Administrator may designate an individual or entity to act on its behalf with respect to certain powers, duties, responsibilities, etc. with respect to the operation and administration of this Plan. Where benefits under this Plan are provided through an insurance company, Health Maintenance Organization ("HMO"), or Dental Maintenance Organization ("DMO"), that insurance company, HMO or DMO shall be the Claims Administrator with respect to those benefits. In all other situations, the Plan Administrator shall be the Claims Administrator unless the Plan Administrator contracts with another entity to act on its behalf.
- 6.2 **Agent for Service of Legal Process**. The agent for service of legal process for the Plan is the Minneapolis City Clerk.
- 6.3 Allocation of Responsibility for Administration. The Plan Administrator shall have the sole responsibility for the administration of this Plan as is specifically described in this Plan. The designated representatives of the Plan Administrator shall have only those specific powers, duties, responsibilities, and obligations as are specifically given to them under this Plan. The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. It is intended under this Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Plan Administrator (including any designee) nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.
- Rules and Decisions. Except as otherwise specifically provided in the Plan, the Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or legal counsel.
- 6.5 **Procedures**. The Plan Administrator may act at a meeting or in writing. The Plan Administrator may adopt by-laws and regulations as it deems desirable for the conduct of the Plan's affairs and as are consistent with the terms of the Plan.
- 6.6 **Records and Reports**. The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

6.7 **Notice of Claim.** In the event a Participant has a claim for any benefits under this Plan, the Participant shall file a claim with the Claims Administrator on forms provided for such purpose. Upon request, the Claims Administrator shall provide the Participant or Participant's designated representative with any and all necessary forms. Prior to making any payment of benefits under this Plan, the Claims Administrator may require the Participant to provide such information to complete such appropriate documents or forms as necessary for the proper administration of this Plan. The Claims Administrator may rely upon all such information furnished to it, including Participant's mailing address.

#### 6.8 Claims Review Procedure.

- (a) **Third Party Benefits.** The claims requirements and appeal procedures regarding benefits available from third parties shall be handled in accordance with the governing documents for those benefits.
- (b) Other Benefits. For benefits other than those described in (a), the Plan Administrator, or the Plan Administrator's designee, shall notify the claimant within thirty (30) days after a claim for benefits is filed, the claim will either have been paid or the Plan Administrator will notify the claimant that it has been denied. If the Plan Administrator denies the claim, the claimant will be provided with the following information in writing: (i) the specific reasons for the denial; (ii) a description of any additional material or information necessary for the claimant to complete the claim; and (iii) an explanation of why such material or information is necessary.
- 6.9 **Authorization of Benefit Payments**. The Plan Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's assets, pursuant to the provisions of the Plan, and warrants that all such directions are in accordance with the Plan.
- 6.10 **Facility of Payment.** Whenever, in the Plan Administrator's opinion, a person entitled to receive any payment of a benefit or installment under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage their financial affairs, the Plan Administrator may request the Employer to make payments to such person, or the Plan Administrator may request the Employer to apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment of a benefit, or installment, in accordance with the provisions of this Section, shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.
- 6.11 **Other Powers and Duties of the Administrator**. The Plan Administrator shall also have such other duties and powers as may be necessary to discharge its duties under the Plan including, but not limited to, the following:

- (a) discretion to construe and interpret the Plan in a non-discriminatory manner, to decide all questions of eligibility, except to the extent the eligibility determinations are governed by an insurance policy, and to determine all questions arising in the administration and application of the Plan;
- (b) to receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;
- (c) to furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and
- (d) to appoint individuals to assist in the administration of the Plan and any other agents he or she deems advisable, including legal and actuarial counsel. The Plan Administrator shall not have the power to add to, subtract from, or modify any of the terms of the Plan, to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under this Plan.
- 6.12 **Indemnification.** To the maximum extent allowed by, and in accordance with, applicable law, the Employer shall indemnify and hold harmless any Employee that is deemed to be a fiduciary against any and all losses, claims, damages, expense (including court costs and attorneys' fees), and liability arising from the Employee's duties and responsibilities in connection with the Plan, unless the same is determined to be intentional or willful.
- 6.13 **Changes by the Administrator**. If the Plan Administrator determines before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitation. Such action may include, without limitation, a modification of Elections by Highly Compensated Participants with or without consent of such Employees and/or a re-characterization within the Plan Year of benefits provided under the Plan as taxable income with or without consent of such Employees.

### ARTICLE VII. PLAN AMENDMENT AND TERMINATION

- 7.1 **Amendments**. The City reserves the right to make, from time to time, any amendment or amendments to this Plan, and the City expressly may make any amendment it determines necessary or desirable, with or without retroactive effect, to comply with the law. Such amendments shall not affect any right to benefits that accrued prior to such amendments. Such amendment shall be made in writing.
- 7.2 **Right to Terminate**. Although the City expects the Plan to be maintained for an indefinite time, the City reserves the right to terminate the Plan or any portion of the Plan at any time. In addition, any Employer has the right to terminate its participation in the Plan or any portion of the Plan at any time. Such termination shall not affect any right to benefits that accrued prior to such termination. Such action shall be taken in writing.

### ARTICLE VIII. GENERAL PROVISIONS

- 8.1 **Plan Not a Contract of Employment**. The Plan is not an employment agreement and does not assure the continued employment of any Employee or Participant for any period of time. Nothing contained in the Plan shall interfere with the Employer's right to discharge an Employee or Participant at any time, regardless of the effect such discharge may have upon the individual as a Participant in this Plan.
- 8.2 **No Right to Employer's Assets**. No Employee, Participant or beneficiary thereof 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 this Plan, and then only to the extent of the benefits payable under the Plan to such Employee, Participant or beneficiary thereof. In addition, the Claims Administrator shall not be liable in any manner for such payments.
- 8.3 **Non-Alienation of Benefits**. Benefits payable under this Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Employer, Plan Administrator and/or Claims Administrator shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.
- 8.4 **Action by Employer**. Whenever an Employer, under the terms of this Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by the managing body of the Employer or such representatives of the Employer as the managing body may designate.
- 8.5 **No Guarantee of Tax Consequences**. Notwithstanding any provision in this Plan to the contrary, neither this Plan nor the Employer make any commitment or guarantee that any amounts paid to or on behalf of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.
- Indemnification of Employer by Participants. If any Participant receives one or more payments or reimbursements under this Plan that are not for eligible expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.
- 8.7 **Benefits Provided Through Third Parties**. In the case of any Optional Benefit provided through a third party (e.g., 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 this Plan and the contract or policy, the terms of the contract or policy shall control, unless prohibited by applicable law. The Employer does not guarantee benefits payable under any

- insurance contract or health maintenance organization policy incorporated by reference into the Plan. Any benefits payable thereunder shall be the exclusive responsibility of the insurer or health maintenance organization that is obligated under the contract or policy.
- 8.8 **Mistakes and Errors**. It is recognized that in the administration of the Plan, certain administrative and accounting errors may be made or situations may arise by reason of factual errors in information supplied to the Employer or the Plan Administrator. The Employer and/or the Plan Administrator shall have the power to take such equitable steps as may be necessary to correct the mathematical, accounting or factual errors, as they, in their sole discretion, determine(s) to be appropriate.
- 8.9 **Limitation on Liability**. The Employer does not guarantee benefits payable under any insurance policy or other similar contract described or referred to herein, and any benefits thereunder shall be the exclusive responsibility of the Insurer or other entity that is required to provide such benefits under such policy or contract.
- 8.10 **Governing Law**. This Plan shall be construed and enforced according to the laws of Minnesota except to the extent preempted by federal law.
- 8.11 **Family and Medical Leave Act of 1993**. Notwithstanding any provision of this Plan to contrary, this Plan shall be operated and maintained in a manner consistent with the Family and Medical Leave Act of 1993 ("FMLA") and the Employer's FMLA policy required thereunder.
- 8.12 Uniformed Services Employment and Reemployment Rights Act of 1994. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"), and the Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA.

### ARTICLE IX. CITY OF MINNEAPOLIS MEDICAL PLAN

- 9.1 **Separate Written Plan**. For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan, the City of Minneapolis Medical Plan, providing for the pre-tax payment of Insurance Premiums for Health Benefits to Participants. To the extent necessary, other provisions of the Plan are incorporated by reference.
- 9.2 **Purpose**. The Employer provides Health Benefits through one or more "plans" within the meaning of Sections 105 and 106 of the Code. The purpose of this Article is to provide for the pre-tax payment of Insurance Premiums for Health Benefits to Participants. The HMO and/or Insurance Contracts and/or other health benefit agreements through which the Health Benefits are provided are identified in Exhibit A.

#### 9.3 **Definitions**.

- (a) **Health Benefits** means the medical coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual Insurance Contracts.
- (b) **HMO** means a health maintenance organization authorized to do business in the State of Minnesota with which an agreement has been entered for the purpose of providing benefits under the Plan.
- (c) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5)(c) of the Code.
- (d) **Insurance Contract** means any insurance contract secured from an insurance company authorized to do business in the State of Minnesota, which has been obtained for the purpose of providing benefits under this Medical Plan; or a self-insured plan administered by a third party.
- (e) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for group coverage. Insurance Premiums includes amounts for insurance types of benefits, including but not limited to Insurance Contracts, HMO coverage and self-insured programs for which "premium equivalents" are charged.
- (f) **Medical Plan** means this Article of the City of Minneapolis Minneflex Plan which constitutes a separate written plan as described in Section 9.1 above.
- 9.4 **Terms, Conditions and Limitations**. The Employer shall secure the necessary Insurance Contracts, HMO agreements, or other health benefit agreements from third party providers regulated by the State in which they operate with respect to the provision of Health Benefits, and/or establish the necessary self-insured program. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts, HMO agreements, other health benefit agreements, and/or self-insured plan documents. Such Insurance Contracts, agreements, and plan documents are expressly incorporated into and made part of this Plan.

- Payments. The Plan Administrator shall make Insurance Premium payments for the Health Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. The Plan Administrator shall also make such payments on behalf of the Participant's Spouse and dependents (as determined under the appropriate Insurance Contract, HMO/DMO agreement, other health benefit agreement, or self-insured plan documents, provided the dependent is a "dependent" under Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), if the Participant has elected to have the cost of their coverage paid under this portion of the Plan. Such payments shall be made from contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant.
- 9.6 **Nondiscrimination**. To the extent this portion of the Plan is subject to Section 105(h) of the Code, it shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result. If this portion of the Plan fails any applicable nondiscrimination requirements, Highly Compensated Individuals shall have taxable income imputed to the extent required by law.
- 9.7 **Medical Child Support Orders**. Notwithstanding any provision of this Medical Plan to the contrary, this Medical Plan shall recognize child support orders regarding coverage under this Plan to the extent required by applicable law. Participants involved in a divorce or child custody matter should be directed to have their legal counsel contact the Plan Administrator.
- 9.8 **Continuation of Coverage**. Continued coverage shall be provided if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and as reflected in the Public Health Services Act ("PHSA"), as amended. To the extent not contained in Article XVI, the Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage. There shall also be compliance with applicable state laws concerning continuation of health insurance coverage to the extent not preempted by federal law.

### ARTICLE X. CITY OF MINNEAPOLIS DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

- 10.1 **Separate Written Plan**. For purposes of Section 129 of the Code, this Article shall constitute a separate written plan providing reimbursement of Dependent Care Expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.
- 10.2 **Purpose**. The purpose of this City of Minneapolis Dependent Care Expense Reimbursement Plan ("DC Plan") is to provide Participants with the option of being reimbursed for eligible Dependent Care Expenses. The DC Plan is intended to qualify as a dependent care assistance program under Section 129 of the Code so that payments received under this portion of the Plan are excludable from the gross income of the Participant under Section 129(a) of the Code.

#### 10.3 **Definitions.**

- (a) **Dependent Care Account ("DC Account")** means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.
- (b) **Dependent Care Center** shall have the meaning given such term in Sections 21(b)(2)(C) and 21(b)(2)(D) of the Code: a facility that (i) complies with all applicable laws and regulations of the state and town, city or village in which it is located; (ii) provides care for more than six individuals (other than individuals who reside at the facility); and (iii) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).
- (c) Dependent Care Expenses means amounts paid by the Participant for services that if paid for by a Participant would be considered employment-related expenses under Section 21(b)(2) of the Code and under applicable proposed or final regulations issued thereunder. Employment-related expenses for purposes of this Plan include expenses incurred to enable a Participant to be Gainfully Employed during any period for which there are one or more Qualifying Individuals with respect to the Participant for (1) household services and (2) care of a Qualifying Individual. However, employmentrelated expenses which are incurred for services outside the Participant's household shall be considered Dependent Care Expenses only if incurred for the care of a Qualifying Individual described in Section 10.3(h)(1) below or a Qualifying Individual not described in Section 10.3(h)(1) below who regularly spends at least eight (8) hours each day in the Participant's household. Dependent Care Expenses do not include expenses which are incurred for services provided by a Dependent Care Center if such center does not comply with all applicable laws and regulations of the applicable State or other unit of local government which regulates the center. In addition, Dependent Care Expenses shall not include any amounts paid to an individual (i) who is a child of such Participant (within the meaning of Section 152(f)(1) of the Code) who is under the age of nineteen (19) at the close of such taxable year, or (ii) with respect to whom, for such taxable year, a deduction is allowable under Section 151(c) of the Code (relating to personal exemptions for Dependents) to such Participant or the Spouse of such Participant.
- (d) **Earned Income** shall have the meaning given such term in Section 32(c)(2) of the Code (which refers to wages, salaries, tips and other Employee compensation as well as net earnings from self-employment), but shall not include any amounts reimbursed by the Employer under this portion of the Plan. Further, if a Participant's Spouse is a Student or incapable of caring for himself or herself, the provisions of Section 21(d)(2) of the Code shall apply in determining the Earned Income of that Spouse. Generally, this Section

provides that a Spouse of a Participant shall be deemed to have Earned Income of not less than \$250 per month if there is one Qualifying Individual with respect to the Participant or \$500 per month if there are two or more Qualifying Individuals with respect to the Participant.

- (e) **Gainfully Employed** means the earning of income for services performed or the period of active search for gainful employment. Nominal reimbursement for volunteer work is not considered gainful employment.
- (f) **Highly Compensated Employees** means Employees who are highly compensated as defined in Section 414(g) of the Code.
- (g) **Non-Highly Compensated Participants** means Employees who are not Highly Compensated Employees.
- (h) Qualifying Individual means any individual who is:
  - (i) A dependent (as defined in Section 152(a)(1) of the Code) of the Participant under the age of 13; or
  - (ii) A Spouse or a dependent (as defined in Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) of the Participant who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than one-half of the year.

Unless two people are married and file a joint tax return, only one person may request reimbursement of expenses incurred with respect to a particular child, even where the child satisfies the definition of "child" as to more than one person. Special rules apply to determine which person may receive the reimbursements where more than one person wants to receive reimbursement for expenses incurred with respect to a particular child.

(i) **Special Tie-breaker Rules.** In general, the parent who has custody for the longest period during the calendar year (i.e., the "custodial" parent) is entitled to receive reimbursement for dependent care expenses. This is true even though the non-custodial parent may be allowed to receive the child tax credit and the dependency exemption for the child on their federal income tax return. However, if the custodial parent does not claim the child as a qualifying child for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the non-custodial parent may receive reimbursement for dependent care expenses under a dependent care expense reimbursement program.

If one person is the child's parent and the other is not, the child is the qualifying individual of the parent and the parent may receive reimbursement for the child's dependent care expenses. If neither person is the child's parent, the person with the highest adjusted gross income for the year in question may receive reimbursement for dependent care expenses. However, in both cases, if the person otherwise entitled to claim the child as a qualifying individual does not claim the child as a qualifying child for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the other person may do so and receive reimbursement for dependent care expenses under the DC Plan.

- It is assumed that all participants in the DC Plan will be entitled to treat the child as a qualifying individual for purposes of reimbursement under the DC Plan.
- (j) **Student** shall have the meaning provided in Section 21(e)(7) of the Code which means an individual who during each of five (5) calendar months during the taxable year is a full time student at an educational organization which normally maintains a regular facility and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on as provided in Sections 21(e)(8) and 170(b)(1)(A)(ii) of the Code.
- Dependent Care Account. The DC Account will be credited as of each date Compensation is paid to the Participant with a pro-rated portion of the Participant's Election for the Plan Year. A Participant's DC Account will be decreased from time to time in the amount of payments made to the Participant for eligible Dependent Care Expenses incurred during the Plan Year.
- 10.5 **Claims for Reimbursement**. A Participant who has made an Election for a Plan Year may apply to the Claims Administrator for reimbursement of eligible Dependent Care Expenses incurred during such Plan Year by submitting a claim form provided by the Claims Administrator setting forth at least the following:
  - (a) the amount, date and nature of the expense,
  - (b) the name of the person or entity to which the expense was paid,
  - (c) the Participant's statement that the expense has not been reimbursed or is not reimbursable from any other source, and
  - (d) such other information as the Claims Administrator may require.

Such claim form shall be accompanied by bills, invoices, receipts, or other statements from an independent third party stating the eligible Dependent Care Expense has been incurred and the amount of the expense. The Claims Administrator may, to the extent provided by law, rely on information provided by Participants.

- 10.6 **Incurred Expenses**. To be reimbursable, an eligible Dependent Care Expense must have been incurred after participation in this portion of the Plan began and during the Plan Year for which reimbursement is claimed. An expense is "incurred" when the Participant is provided with the care which gives rise to the eligible Dependent Care Expense, not when the service is billed or paid. Reimbursement shall not be made for future or projected expenses.
- 10.7 **Reimbursement of Expense**. The Participant shall be reimbursed at least once per month. Reimbursements shall be made from the Participant's DC Account for eligible Dependent Care Expenses incurred during the applicable Plan Year for which the Participant submits the documentation required under Section 10.5. In no case shall a payment be made which exceeds the balance in the Participant's DC Account at the time reimbursement is requested. If a claim for reimbursement exceeds the balance in the Participant's DC Account, the excess part of the claim will be carried over into following pay periods, to be paid as the Participant's balance becomes adequate. However, under no circumstances will any balance remaining in a Participant's DC Account at the end of the Plan Year be carried over to the next Plan Year.
- 10.8 **Maximum Reimbursement**. The maximum reimbursement that a Participant may receive in a tax year under this portion of the Plan shall be the lesser of:

- (a) the Participant's Earned Income for the tax year,
- (b) the actual or deemed Earned Income of the Participant's Spouse for the tax year, or
- (c) \$5,000, or in the case of a Participant who is married and filing a separate income tax return from his or her Spouse, \$2,500.

This maximum includes the DC Account forfeitures and the Participant's salary reduction. If a Participant is married and the spouse of the Participant also participates in a dependent care program under Section 129 of the Code, the combined reimbursements may not exceed the limits described above for the tax year. It shall be the Participant's responsibility to monitor the combined reimbursements.

- 10.9 **Reimbursement Upon Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan during a Plan Year, no further allocations will be credited to the DC Account. However, reimbursements shall continue for eligible Dependent Care Expenses incurred during that Plan Year up to the balance of the DC Account at the time the Participant's participation terminated.
- 10.10 **Participant's Death**. In the event a Participant dies having incurred an eligible Dependent Care Expense which would have been reimbursable out of the Participant's DC Account had the Participant not died and a person or the Participant's estate has paid for or assumed liability for the expense, reimbursement may be made to that person or the estate for that payment or assumption. The remainder of the Participant's DC Account shall be forfeited in accordance with Section 5.6.
- 10.11 **Nondiscrimination.** This portion of the Plan shall not discriminate in favor of Highly Compensated Employees or their Dependents with respect to eligibility, contributions or benefits. The average eligible Dependent Care Expenses paid to Non-Highly Compensated Employees shall be at least fifty-five (55%) of the average eligible Dependent Care Expenses paid to Highly Compensated Employees. If benefits are provided through salary reduction agreements, Employees with annual compensation less than \$25,000 may be excluded. If the Plan Administrator determines that the Plan is or will be discriminatory, the Plan Administrator may take any action permitted by law to avoid such result. If the Plan fails any of these requirements, benefits provided under this portion of the Plan will become taxable to the extent required by law.
- 10.12 **Dependent Care Account Forfeiture**. Amounts attributed to a Participant's DC Account for any Plan Year shall be used only to reimburse the Participant for eligible Dependent Care Expenses incurred during such Plan Year. Any balance remaining in a Participant's DC Account for a Plan Year shall be forfeited on April 16<sup>th</sup> following the end of such Plan Year in accordance with Section 5.6. Any claims incurred during the prior Plan Year not submitted by April 15<sup>th</sup> following the end of such Plan Year shall not be eligible for reimbursement. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.
- 10.13 **Dependent Care Limitations.** Reimbursement or payment of eligible Dependent Care Expenses shall be made by the Employer only in the event and to the extent that such reimbursement or payment is: (i) not provided for under any insurance policy, whether the premium on such policy is paid by the Employer or an individual, and (ii) not provided for or reimbursable under any other Plan or policy.

10.14 **Reporting and Disclosure**. Each Participant must be furnished with a written statement showing the amounts paid under this portion of the Plan by an Employer on behalf of the Participant for a calendar year. The statement must be furnished before January 31st of the following year. For calendar years beginning after December 31, 1988, the law requires that this information be placed on Internal Revenue Service Form W-2 for the applicable year.

## ARTICLE XI. CITY OF MINNEAPOLIS MEDICAL EXPENSE REIMBURSEMENT PLAN

- 11.1 **Separate Written Plan**. For purposes of Section 105 of the Code, this Article shall constitute a separate written plan, the City of Minneapolis Medical Expense Reimbursement Plan ("ME Plan"), providing for the reimbursement of Medical Expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.
- 11.2 **Purpose**. The purpose of this Article is to provide Participants with the option of being reimbursed for eligible Medical Expenses. This Article is intended to qualify as a medical reimbursement plan under Section 105(h) of the Code so that payments received under this portion of the Plan are excludable from the gross income of the Participant under Section 105(b) of the Code.

#### 11.3 **Definitions**.

- (a) **Medical Expense** means an expense incurred during the applicable Plan Year by a Participant, Spouse, or Dependent for medical care as defined in Section 213 of the Code, excluding premiums for health coverage, health reimbursement arrangements ("HRAs"), medical savings accounts ("MSAs"), and long-term care coverage. Medical care generally refers to the diagnosis, cure, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. Also included, are transportation expenses for and essential to medical care and over-the-counter (OTC) medications.
- (b) **Medical Expense Account ("ME Account")** means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.
- (c) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5)(c) of the Code.
- 11.4 **Medical Expense Account**. The ME Account will be credited with the amount elected by the Participant at the beginning of the Plan Year. A Participant's ME Account will be decreased from time to time in the amount of payments made to the Participant for eligible Medical Expenses incurred during the Plan Year.
- 11.5 **Claims for Reimbursement**. A Participant who has made an Election for a Plan Year may apply to the Claims Administrator for reimbursement of eligible Medical Expenses incurred during such Plan Year by submitting a claim form provided by the Claims Administrator setting forth at least the following:
  - (a) the amount, date and nature of the expense,
  - (b) the name of the person or entity to which the expense was paid,
  - (c) the Participant's statement that the expense has not been reimbursed or is not reimbursable from any other source, and
  - (d) such other information as the Claims Administrator may require.

Such claim form shall be accompanied by bills, invoices, receipts, or other statements from an independent third party stating the eligible Medical Expense has been incurred and the amount of

- the expense. The Claims Administrator may, to the extent provided by law, rely on information provided by Participants.
- 11.6 **Incurred Expenses**. To be reimbursable, an eligible Medical Expense must have been incurred after participation in this portion of the Plan began and during the Plan Year for which reimbursement is claimed. An expense is "incurred" when the Participant is provided with the care which gives rise to the eligible Medical Expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses.
- 11.7 **Reimbursement of Expense**. The Participant shall be reimbursed at least once per month. Reimbursements shall be made from the Participant's ME Account for eligible Medical Expenses incurred during the applicable Plan Year for which the Participant submits the documentation required under Section 11.5. An amount up to the sum of the Participant's Election and reduced as of any particular time for prior reimbursements for the same Plan Year, shall be available for reimbursement at all times during the Plan Year.
- 11.8 **Maximum Reimbursement.** The maximum reimbursement a Participant may receive for a Plan Year under this portion of the Plan shall be \$20,000. The maximum reimbursement amount applies to the Participant, Spouse, and Dependent children on an aggregate basis, not an individual basis.
- 11.9 **Reimbursement Upon Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan, coverage shall cease (which means that reimbursements shall cease) unless benefits under the Plan are continued as provided in Section 11.14. If coverage ceases, reimbursements for eligible Medical Expenses incurred before participation stopped will continue to be made in accordance with Section 11.7.
- 11.10 **Participant's Death**. In the event a Participant dies having incurred an eligible Medical Expense which would have been reimbursable out of the Participant's ME Account had the Participant not died and a person or the Participant's estate has paid for or assumed liability for the expense, reimbursement may be made to that person or the estate for that payment or assumption. The remainder of the Participant's ME Account shall be forfeited in accordance with Section 5.6.
- 11.11 **Nondiscrimination**. This portion of the Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such result. If the Plan fails any applicable nondiscrimination requirements, Highly Compensated Individuals shall have taxable income imputed to the extent required by law.
- 11.12 **ME Account Forfeitures**. Amounts attributed to a Participant's ME Account for any Plan Year shall be used only to reimburse the Participant for eligible Medical Expenses incurred during the Plan Year. Any balance remaining in a Participant's ME Account for a Plan Year shall be forfeited on April 16<sup>th</sup> following the end of such Plan Year in accordance with Section 5.6. Any claims incurred during the prior Plan Year not submitted by April 15<sup>th</sup> following the end of such Plan Year shall not be eligible for reimbursement. The Plan Administrator may extend this period in the event the Participant cannot obtain proper documentation until after the expiration of the period. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year, or used by the Participant for any other purpose.
- 11.13 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under this Plan to the extent

required by applicable law. Participants involved in a divorce or child custody matter should be directed to have their legal counsel contact the Plan Administrator.

11.14 **Continuation of Coverage**. Continued coverage shall be provided if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and as reflected in the Public Health Services Act ("PHSA"), as amended. To the extent not contained in Article XVI, the Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage.

#### 11.15 Further Limitations on Benefits.

- (a) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any worker's compensation law or other employer, union, association or governmental sponsored group insurance plan.
- (b) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are received by the Participant, the Participant's Spouse or the Participant's Dependent under any health and accident insurance policy or program, whether or not premiums are paid by the Employer or the Participant, the Participant's Spouse or the Participant's Dependent child.
- (c) Amounts reimbursed under a dependent care assistance program described in Section 129 of the Code shall not be reimbursed under this Plan.
- (d) A Participant in the Plan may not participate under this Article and contribute to a health savings account ("HSA") within the meaning of Section 223 of the Code.

### ARTICLE XII. CITY OF MINNEAPOLIS DENTAL PLAN

- **Separate Written Plan**. For purposes of Section 105 and 106 of the Code, this Article shall constitute a separate written plan, the City of Minneapolis Dental Plan, providing for the pre tax payment of Insurance Premiums for Group Dental Benefits to Participants. To the extent necessary, other provisions of the Plan are incorporated by reference.
- 12.2 **Purpose**. The Employer provides Group Dental Benefits through one or more "plans" within the meaning of Sections 105 and 106 of the Code. The purpose of this Article is to provide for the pre tax payment of Insurance Premiums for Group Dental Benefits to Participants. The DMO and/or Insurance Contracts and/or other health benefit agreements through which the Group Dental Benefits are provided are identified in Exhibit A.

#### 12.3 **Definitions.**

- (a) **DMO** means a dental maintenance organization authorized to do business in the state in which an agreement has been entered for the purpose of providing benefits under this portion of the Plan.
- (b) **Dental Plan** means this Article of the City of Minneapolis Minneflex Plan which constitutes a separate written plan as described in Section 12.1 above.
- (c) **Group Dental Benefits** means the dental coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual Insurance Contracts.
- (d) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.
- (e) **Insurance Contract** means any insurance contract secured from an insurance company authorized to do business in the State of Minnesota which has been obtained for the purpose of providing benefits under this portion of the Plan; or a self-insured plan administered by a third party.
- (f) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for group coverage. Insurance Premiums includes amounts for insurance types of benefits, including but not limited to Insurance Contracts, DMO coverage and self-insured programs for which "premium equivalents" are charged.
- Terms, Conditions and Limitations. The Employer shall secure the necessary Insurance Contracts, DMO agreements, other health benefit agreements from third party providers with respect to the provision of Group Dental Benefits and/or establish the necessary self-insured program. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts, DMO agreements, other health benefit agreements, and/or self-insured plan documents described in Exhibit A. Such contracts, agreements, and plan documents are expressly incorporated into and made part of this Plan.
- Payments. The Plan Administrator shall make Insurance Premium payments for the Group Dental Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. The Plan Administrator shall also make such payments on behalf of the Participant's Spouse and dependents (as determined under the appropriate Insurance Contract, HMO/DMO agreement, other health benefit agreement, or self-insured plan document, provided the dependent is a

"dependent" under Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), if the Participant has elected the cost of their coverage paid pretax under this portion of the Plan. Such payments shall be made from contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant.

- 12.6 **Nondiscrimination**. To the extent this portion of the Plan, is subject to Section 105(h) of the Code, it shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result. If this portion of the Plan fails any applicable nondiscrimination requirements, Highly Compensated Individuals shall have taxable income imputed to the extent required by law.
- 12.7 **Medical Child Support Orders**. Notwithstanding any provision of this Dental Plan to the contrary, this Dental Plan shall recognize child support orders regarding coverage under this Dental Plan to the extent required by applicable law. Participants involved in a divorce or child custody matter should be directed to have their legal counsel contact the Plan Administrator.
- 12.8 **Continuation of Coverage**. Continued coverage shall be provided if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and as reflected in the Public Health Services Act ("PHSA"), as amended. To the extent not contained in Article XVI, the Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage. There shall also be compliance with state laws concerning continuation of dental insurance coverage to the extent not preempted by federal law.

### ARTICLE XIII. CITY OF MINNEAPOLIS GROUP TERM LIFE PLAN

- 13.1 **Separate Written Plan**. For purposes of Section 79 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of Insurance Premium expenses. To the extent necessary, other provisions of the Plan or program are incorporated by reference in this document.
- Purpose. The purpose of this Article is to provide for the pre-tax payment of Insurance Premiums for Group Term Life Benefits to Participants. This Article does not permit pre-tax payment of Insurance Premiums for Spouse and/or Dependent coverage.

#### 13.3 **Definitions**.

- (a) **Group Term Life Benefits** means the group term life insurance coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual Insurance Contracts.
- (b) **Insurance Contract** means any insurance contract secured from an insurance company authorized to do business in the state in which such contract is issued that has been obtained for the purpose of providing benefits under this portion of the Plan.
- (c) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for group coverage.
- Terms, Conditions and Limitations. The Employer shall secure the necessary Insurance Contracts from third party providers with respect to the provision of Group Term Life Benefits. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this Plan. The terms, conditions and limitations of the Group Term Life Benefits offered shall be specifically described in the policy or contract identified in Exhibit A.
- Payments. The Plan Administrator shall make Insurance Premium payments for the Group Term Life Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant.
- 13.6 **Nondiscrimination**. The group term life coverage shall comply with the applicable nondiscrimination requirements under Section 79(d) of the Code. If the Plan Administrator determines that the Plan is or may be discriminatory, the Plan Administrator may take any action permitted by law to avoid such result.
- 13.7 **Limitation on Group Term Life Benefits**. The cost of group term life insurance on the Participant's life paid by the Employer shall not be included in the Participant's gross income to the extent the face amount of the Insurance Contract(s) does not exceed \$50,000. If the face amount of the Insurance Contract(s) paid by the Employer exceeds \$50,000, the cost of the coverage in excess of \$50,000 shall be imputed to the Participant as income in accordance with Section 79 of the Code. For purposes of this limitation, coverage paid by the Participant on a pre-tax basis is considered "paid by the Employer." In addition, any coverage on the life of the Spouse or Dependent of the Participant shall be paid with after-tax dollars.

13.8 **Continuation/Conversion of Coverage**. There shall be compliance with applicable state law regarding continuation of coverage and conversion of coverage to the extent such state law is not preempted by federal law. In addition, any continuation and conversion rights provided under the terms of the Insurance Contract(s) through which benefits are provided shall be available to the extent they are not prohibited or preempted by federal law.

### ARTICLE XIV. HIPAA PRIVACY PROVISIONS

The Privacy Rules under the HIPAA apply to certain Optional Benefits that constitute "covered entities" within the meaning of HIPAA (e.g., employer sponsored group health plans), unless such Optional Benefits are self-insured and have less than fifty (50) Participants and the Employer is the Claims Administrator for such Optional Benefit.

- 14.1 **Use and Disclosure of PHI**. The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.
  - (a) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
    - (1) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
    - (2) Coordination of benefits;
    - (3) Adjudication of health benefits claims (including appeals and other payment disputes);
    - (4) Subrogation of health benefit claims;
    - (5) Establishing employee contributions;
    - (6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
    - (7) Billing, collection activities and related health care data processing;
    - (8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
    - (9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
    - (10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;
    - (11) Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
    - Oisclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health plan); and

- (13) Reimbursement to the Plan.
- (b) Health care operations include, but are not limited to, the following activities:
  - (1) Quality assessment;
  - (2) Population-based activities relating to improving health or reduction 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;
  - (3) Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
  - (4) Underwriting, premium rating and other activities relating 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);
  - (5) Conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;
  - (6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
  - (7) Business management and general administration activities of the Plan, including, but not limited to:
    - a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
    - b. Customer service, including data analyses for policyholders;
  - (8) Resolution of internal grievances; and
  - (9) 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 under HIPAA or following completion of the sale or transfer, will become a covered entity.
- 14.2 **Employer's Obligations.** Under HIPAA, the Plan may not disclose PHI to the Employer unless the Employer agrees to certain conditions. The Employer agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Employer. The Employer will:
  - (a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
  - (b) Ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

- (c) Not use or disclose PHI for employment related actions and decision unless authorized by an individual;
- (d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;
- (e) Report to the Plan any PHI use or disclosure, that is inconsistent with the uses or disclosures provided for, of which it becomes aware;
- (f) Make available to an individual for inspection and copying PHI about the individual as allowed by and in accordance with HIPAA;
- (g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- (h) Make available the information required to provide an accounting of disclosures;
- (i) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- (j) If feasible, return or destroy all PHI received for the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).
- 14.3 Adequate separation between the Plan and the Employer must be maintained. In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
  - (1) The benefits manager; and
  - (2) Staff designated by the benefits manager.

For this purpose, "benefits manager" is a designation made by the Employer.

- 14.4 **Limitation of PHI Access and Disclosure**. The persons described in Section 14.3 above may only have access to and use and disclose PHI for Plan administration functions that the Employer performs for the Plan.
- Noncompliance Issues. If a person described in Section 14.3 above does not comply with this Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including, but not limited to, disciplinary sanctions.

### ARTICLE XV. HIPAA SECURITY PROVISIONS

The Security Rules under the HIPAA apply to certain Optional Benefits that constitute "covered entities" within the meaning of HIPAA (e.g., employer sponsored group health plans), unless such Optional Benefits are self-insured and have less than fifty (50) Participants and the Employer is the Claims Administrator for such Optional Benefit.

- 15.1 **Definitions**. For the purposes of this Article XV the following terms shall have the meanings set forth in this Section 15.1.
  - (a) **Summary Health Information** means "summary health information" as defined in 45 C.F.R. Section 164.504, which generally defines "summary health information" to include information, which may be PHI, that summarizes claims history, claims expenses, or the type of claims experienced by individuals receiving benefits under the Plan from which certain identifiers have been deleted.
  - (b) **Security Incident** means "security incident" as defined in 45 C.F.R. Section 164.304, which generally defines "security incident" to include attempted or successful unauthorized access, use, disclosure, modification, or destruction of ePHI.
- 15.2 **Employer's Obligations**. If the Employer creates, receives, maintains, or transmits ePHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer will:
  - (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI;
  - (b) Ensure that any agents, including subcontractors, who create, receive, maintain, or transmit ePHI on behalf of the Plan implement reasonable and appropriate security measures to protect the ePHI;
  - (c) Report to the Plan any Security Incident of which it becomes aware; and
  - (d) Implement reasonable and appropriate security measures to ensure that only those persons identified in Section 14.3 have access to ePHI and that such access is limited to the purposes identified in Section 14.4.

### ARTICLE XVI. CONTINUATION COVERAGE

- 18.3 **COBRA Notification Procedures**. The City of Minneapolis Medical Plan, City of Minneapolis Dental Plan, and City of Minneapolis Medical Expense Reimbursement Plan (hereinafter referred to as the "Health Plans") require the notifications described below with respect to continuation coverage under COBRA:
  - (a) **Notice of qualifying event.** Under the law, a Covered Individual (or a representative acting on behalf of the Covered Individual) has the responsibility to inform the Health Plans of a divorce, legal separation, or a child losing Dependent status under the Health Plans (the "qualifying event") within sixty (60) days of the latest of: (i) the date of the qualifying event; (ii) the date coverage would be lost because of the qualifying event; or (iii) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. The notification must be provided in writing and be mailed to the Health Plans. Oral notification, including notification by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:
    - (1) state the name of the Health Plans;
    - (2) state the name and address of the employee or former employee who is or was covered under the Health Plans;
    - state the name(s) and address(es) of all Covered Individuals who lost coverage due to the qualifying event;
    - (4) include a detailed description of the event;
    - (5) identify the effective date of the event; and
    - (6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Health Plans are able to determine the plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

- (b) **Notice of second qualifying event.** A Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Health Plans of the death of the employee, divorce or separation from the employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Health Plans, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Health Plans. Oral notification, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:
  - (1) state the name of the Health Plans;

- state the name and address of the employee or former employee who is or was covered under the Health Plans;
- state the name(s) and address(es) of all Covered Individuals who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
- (4) identify the nature and date of the initial qualifying event that entitled the Covered Individuals to COBRA coverage;
- (5) include a detailed description of the event;
- (6) identify the effective date of the event; and
- (7) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Health Plans are able to determine the plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

- (c) **Notice of disability.** A Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Health Plans when a Covered Individual has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (i) the date of the disability determination; (ii) the date of the qualifying event; (iii) the date coverage would be lost because of the qualifying event; or (iv) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. Notwithstanding the foregoing, notification must be provided before the end of the first eighteen (18) months of continuation coverage. The notification must be provided in writing and be mailed to the Health Plans. Oral notification, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:
  - (1) state the name of the Health Plans:
  - state the name and address of the employee or former employee who is or was covered under the Health Plans;
  - state the name(s) and address(es) of all Covered Individuals who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
  - (4) identify the nature and date of the initial qualifying event that entitled the qualified beneficiaries to COBRA coverage;
  - (5) state the name of the disabled Covered Individual;
  - (6) identify the date upon which the disabled Covered Individual became disabled;
  - (7) identify the date upon which the Social Security Administration made its determination of disability; and
  - (8) include a copy of the determination of the Social Security Administration.

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Health Plans are able to determine the plan to which it applies, the identity

of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Health Plans of that determination within thirty (30) days of the later of: (i) the date of such determination; or (ii) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. The notification must be in writing and be mailed to the Health Plans. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If the notification is not provided within the required time, the Health Plans reserve the right to seek reimbursement of any benefits provided by the Health Plans between the date coverage terminates and the date the notification is provided.

(d) Notice of Coverage Under Another Group Health Plan or Medicare. A Covered Individual must notify the Health Plans immediately if any Covered Individuals receiving continuation coverage actually become covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a Covered Individual on continuation coverage receives any benefits under the Health Plans after coverage is to cease under the foregoing rule, the Health Plans reserve the right to seek reimbursement from such Covered Individual.

Dated:	CITY OF MINNEAPOLIS
	By:
	Its:
	By:
	lts·

Effective Date.

IN WITNESS WHEREOF, the City has adopted and executed this Plan document as of the

# EXHIBIT A Insurance Carrier / Third Party Provider Information (as of January 1, 2007)

City of Minneapolis Minneflex Plan

City of Minneapolis Medical Expense Reimbursement Plan

**City of Minneapolis Dependent Care Expense Reimbursement Plan** 

Claims Administrator: Administration Resource Corporation

Address: ARC, FSA Department

P.O. Box 728

Anoka, MN 55303-0728

**Phone Number:** 763-421-5510 **Fax Number:** 763-767-4700

City of Minneapolis Medical Plan

Carrier Name: Medica

Address: 407 Carlson Parkway, Mtka, MN 55305-5387

**Phone Number:** 952-992-2200

**Policy or Group Number:** 48391, 48392, 48393, 48394, 48417, 48418

**City of Minneapolis Dental Plan** 

Carrier Name: Delta Dental

**Address:** 7807 Creekride Circle, PO Box 330

Minneapolis, MN 55440-0330

**Phone Number:** 651-994-5300

Policy or Group Number: 0480

City of Minneapolis Group Term Life Plan

**Carrier Name:** Principal Life Insurance Company

Address: 711 High Street, Des Moines, IA 50309-9979

**Phone Number:** 800-986-3343

Policy or Group Number: H14102