

SUMMARY DESCRIPTION

of the

CITY OF MINNEAPOLIS

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

January 1, 2011

SUMMARY PLAN DESCRIPTION

This summary is intended to explain the Plan in a manner that you can easily understand. If you have any questions after reading this Summary Plan Description, please call the City of Minneapolis Benefits Office at (612) 673-2282.

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I. THE PURPOSE OF THE PLAN

The City has adopted medical plans coupled with a Healthcare Reimbursement Arrangement (HRA) and has established a Voluntary Employees' Beneficiary Association Trust (VEBA) to fund Benefits under this Plan. Plan Benefits are available to reimburse Members for Eligible Health Expenses.

This description is not meant to interpret, extend, or change the provisions of this Plan in any way. The provisions of this Plan may only be accurately determined by reading the actual Plan document. A copy of the Plan document is on file at the City of Minneapolis Benefits Office, Room 100, 250 South 4th Street, Minneapolis, Minnesota, 55415, and may be read by you or your legal representatives at any reasonable time. If you have questions regarding this Plan or this Summary Plan Description, you should contact the Benefits Department. **In the event of any discrepancy between this description and the actual provisions of the Plan, the Plan provisions will govern.**

II. DEFINITIONS

Following are definitions that will help you better understand this summary of this Plan:

Abandoned means that the Plan has not been able to make contact with the member for a 36 month period at the members last known address.

Account Balance means the amount in the Member Account.

Benefits means any amounts paid to a Member as reimbursement for Eligible Health Expenses incurred by the Member or the Member's Eligible Dependents.

Child means the Employee's biological child, step child, adopted child (including a child placed for adoption) and foster child provided such child as of the end of the applicable calendar year has not attained the age of 27.

Claims Administrator means the individual or entity retained by the City from time to time to administer all or a portion of this Plan. In the absence of an individual or entity retained to administer all or a portion of this Plan, Claims Administrator means the City of Minneapolis, Human Resources Department.

Code means the Internal Revenue Code of 1986, as amended from time to time.

Contributions means Employer amounts deposited in the Trust pursuant to the terms of the Plan.

Eligible Dependent means the Employee's Spouse, the Employee's Child and any other person who qualifies is a dependent of the Employee for purposes of Sections 105 and 106 of the Code, as clarified in Revenue Procedure 2008-48.

Eligible Employee means any Employee who (1) is covered by a collective bargaining agreement providing for coverage in this Plan and has elected coverage under a City of Minneapolis medical plan including a health reimbursement arrangement component or (2) is entitled to coverage in this Plan by Employer's personnel policies or directives and has elected coverage under the City of Minneapolis Medical Plan.

Eligible Health Expense means those expenses incurred by a Member or a Member's Eligible Dependent that are not covered by other insurance available to the Member and

the Member's Eligible Dependents and are reimbursable expenses as defined by Code Section 213(d). Also included as eligible health expenses are transportation expenses for and essential to medical care, insulin, over-the-counter medicines or drugs provided the over-the-counter medicines or drugs are prescribed (determined without regard to whether such medicines or drugs are available without prescription) and medical equipment and supplies meeting the definition of medical care in Code Section 213(d)(1). For this purpose, an expense is "incurred" at the time the medical care or service which gave rise to the expense is furnished.

Employee means any person hired and paid under the salary authority of the City Council or Independent Boards or Agencies who adopted this Plan, including any such person covered by a collective bargaining unit agreement providing for participation in this Plan, but does not include an independent contractor, a leased employee within the meaning of Code section 414(n), or a person hired by the City Council or an Independent Board or Agency under a personal services contract.

Employer means the City of Minneapolis, or any of the City's Independent Boards or Agencies that have adopted and not terminated this Plan. (A list of participating Independent Boards and Agencies is on file with the Benefits Department.)

Former Employee means an employee who has severed employment with the Employer.

Medical Expense Account means the component of the City of Minneapolis Minneflex Plan through which an Employee and the Employee's Eligible Dependents may have health care expenses reimbursed with pre-tax dollars.

Member means a current Employee or a Former Employee for whom Employer deposits have been received by the Trust and whose Member Account has a positive balance.

Member Account refers to the bookkeeping account maintained by this Plan's Claims Administrator in the name of an Employee which reflects all contributions made to the Trust in the name of the Employee, investment earnings and losses, administrative expenses, and distributions made for the payment of Eligible Health Expenses.

Plan means the City of Minneapolis Healthcare Reimbursement Arrangement Plan, as it may be amended from time to time.

Plan Year is the twelve month period ending each year on the last day of December.

Severance means a Member's voluntary or involuntary termination of employment with the Employer.

Spouse means an individual who is legally married to an Employee (and who is treated as a spouse under the Code), but shall not include an individual separated from the Employee under a legal separation decree.

Tax Dependent means for federal taxation purposes an individual who qualifies as a "dependent" of the Employee for purposes of Sections 105 and 106 of the Code, as clarified in Revenue Procedure 2008-48. For state purposes, Tax Dependent means an individual who qualifies as a "dependent" of the Employee as defined in the Internal Revenue Code incorporated into Minnesota Statutes, section 290.01, Subd.19.

III. ELIGIBILITY AND PARTICIPATION

This Plan is maintained pursuant to collective bargaining agreements and Employer personnel policies and directives. Copies of the collective bargaining agreements are available from the City of Minneapolis Human Resources Department.

You are eligible to participate in the Plan on the date that you are covered under a City of Minneapolis medical plan that includes an HRA component.

To participate in the Plan and receive reimbursement Benefits under this Plan, you must:

1. Enroll in the City of Minneapolis Medical Plan;
2. Observe all Plan rules and regulations;
3. Agree to inquiries by the Claims Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by this Plan; and
4. Submit to the Claims Administrator all reports, bills, and other information that the Claims Administrator may reasonably require.

IV. PLAN BENEFITS

The City of Minneapolis has established this Plan to provide tax-free accounts for Members to pay for medical, dental, vision and tax qualified long-term care expenses that are not paid by other insurance plan(s).

This Plan is funded by Employer Contributions that are credited to your Member Account. Member contributions are not permitted. Contribution amounts may vary based on the medical plan option you elect, whether you choose single or family medical coverage and whether or not you participate in certain Employer sponsored wellness initiatives. You can use this Plan to be reimbursed for Eligible Health Expenses that are incurred by you and your Eligible Dependents on or after your participation date.

Benefits are available to Employees on leaves of absence and to Former Employees for the out-of-pocket portion of Medicare premiums, COBRA premiums or any other health insurance contract or plan. Benefits for such expenses are not available to Employees.

Benefits are **not** available to reimburse expenses that are reimbursable by your Medical Expense Account until after the Medical Expense Account has paid expenses totaling the dollar amount your Medical Expense Account election for the Plan Year.

V. **BENEFIT REIMBURSEMENT RULES**

1. **What Expenses Can be Reimbursed under the Plan?**

The Plan will only reimburse Eligible Health Expenses that are incurred on or after the date you enroll in a medical plan with an HRA component. All claims must be submitted for reimbursement within 18 month of the dates expenses were incurred.

Example: You enroll for medical coverage effective January 1st and you automatically become a Plan Member on that date. You can receive reimbursement only for eligible expenses incurred on or after the date you are first eligible.

Eligible Health Expenses are expenses incurred by you or an Eligible Dependent that are:

- not covered by other insurance available to you or to an Eligible Dependent and
- are reimbursable expenses as defined by Code Section 213(d).

Examples of Eligible Health Expenses are medical, prescription drug, dental, vision and qualified long-term care expenses including the deductibles, co-payments, and co-insurance you pay under the City-sponsored medical and dental plans.

Under no circumstance will an expense be reimbursed under this Plan if the expense is provided, paid or payable by any other health or accident plan or insurance policy covering you or an Eligible Dependent (including Social Security, Medicare or Medicaid) or if you will be reimbursed for the expense from another source.

Benefits are **not** available to reimburse expenses that are reimbursable by the Medical Expense Account until after the Medical Expense Account has paid expenses totaling the dollar amount you elected to contribute to the Medical Expense Account for the Plan Year.

Benefits will always be limited to a maximum of the amount in your individual Member Account. If claims are mistakenly paid that exceed the amount in your Member Account, you will be responsible for reimbursing the Plan for such excess amount. To recover excess payments, the Plan may reduce future reimbursement payments to or on your behalf. The right to offset future benefit payments does not limit this Plan's right to recover overpayments in any other manner.

2. **When is an Expense “Incurred”?**

A health care expense is incurred at the time the medical care or service which gave rise to the expense is furnished. The date of billing or payment is irrelevant.

Example: Jones visits his doctor on March 15th is billed for the services subject to the deductible on April 5th, and pays the bill on April 14th. Jones incurred the expense when he visited his doctor on March 15th.

3. **Who is an Eligible Dependent under the Plan?**

An Eligible Dependent is your Spouse and any other person who is considered a “qualifying child” or “qualifying relative” under Section 152 of the Code. In general, a person will qualify as an Eligible Dependent for a Plan Year if the person lives with you for more than one-half (1/2) of the year and you provide more than one-half (1/2) of his or her support during the Plan Year and certain other tests are met.

A “qualifying child” will usually include a child with whom you maintain a parent-child relationship, and:

- who was eighteen (18) years old or younger at the end of the Plan Year; or
- who was twenty-three (23) years old or younger at the end of the Plan Year and was a full-time student at a school for at least five (5) months during the Plan Year; or
- who was permanently and totally disabled.

“Qualifying relatives” will usually include other individuals who:

- are either related to you by blood or marriage and live in your home as a member of your household during the entire Plan Year; and
- receive more than one-half (1/2) of his or her support from you; and
- is not your “qualifying child” or the “qualifying child” of any other taxpayer.

If the relationship between individuals is in violation of local or state law, the individual will not be considered a “qualifying relative.”

A temporary absence from your home will not disqualify an individual from being an Eligible Dependent unless there is reason to believe the individual will not return to your home. *Example:* If a student lives in a condo purchased by his or her parents, it is not reasonable to believe the student will return to the parents’ home. Therefore, the student is not an Eligible Dependent.

The instructions on your federal income tax return discuss in some detail who qualified as your Eligible Dependent.

4. How Do I Claim Plan Benefits?

You must deliver a completed claim form to the Claims Administrator. You may obtain a claim form from the Claims Administrator by calling (866) 204-8154 or by visiting their website at www.ohfsbenefitaccess.com/invest.

The claim form includes information such as:

- the name of the person on whose behalf Eligible Health Expenses have been incurred;
- the nature of the expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such expenses have not otherwise been paid through insurance or reimbursed from any other source. Other information regarding the claim may be reasonably requested by the Claims Administrator.

You must attach a copy of your bill or receipt or other satisfactory third party documentation of the amount of the expense and the date(s) the expense was incurred (a canceled check is not sufficient). You must also certify that each expense is eligible for reimbursement under this Plan, that it has not been previously reimbursed under this Plan and that it is not reimbursable from any other source (e.g., insurance). After your claim is reviewed, processed, and approved, you will receive a reimbursement. Claims with missing or illegible information will be denied, pending re-submission of legible information.

5. How Often are Claims for Reimbursement Paid?

Benefits are paid at least semi-monthly.

6. How are Reimbursements from the Plan Coordinated with Reimbursements from my Medical Expense Account?

If you elected to participate in the Minneflex Medical Expense Account, submitted health expenses will be applied to the Medical Expense Account first until that benefit is exhausted. Additional claims may then be applied to your Member Account in this Plan. Claims for reimbursement that exceed the balance remaining in your Medical Expense Account will not automatically be paid by this Plan unless you request it in the space provided on your claim form.

Example: Your remaining Medical Expense Account balance is \$100 and you submit a claim for Eligible Health Expenses totaling \$150. \$100 will be reimbursed from your Medical Expense Account, but the remaining \$50 will not be paid unless you elect to be reimbursed by this Plan.

7. How Long Do I Have to Submit a Claim for Reimbursement?

You have 18 months after an Eligible Health Expense was incurred to have a correct and complete claim *received by* the Claims Administrator.

Eligible Health Expenses that are incurred prior to the date a dependent ceases to be an Eligible Dependent may be submitted for reimbursement from available funds within 18 months of the date they were incurred.

8. How Long May I Continue to Participate in the Plan?

If you leave employment or terminate your participation in the Plan, any funds remaining in your account will be available to you for reimbursement as allowed under the terms of the Plan. If the plan has been unable to contact you for 36-month period at your last known address, any remaining funds will be forfeited and surrendered for the benefit of the Plan and will be used to pay future administrative expenses.

9. Are Survivor Benefits Provided under the Plan?

If a Member dies with a positive account balance, the Member's Eligible Dependents would be entitled to the reimbursement of Eligible Health Expenses they incurred as of and following the Member's date of death. Eligible Health Expenses incurred by the Member in the 18 months prior to death could also be reimbursed by the Plan.

10. Could My Member Account Balance Ever Be Forfeited?

A Member's Account balance is forfeited on the earlier of:

- (a) The date on which the Member Account is determined to be Abandoned; or
- (b) If continued participation in lieu of COBRA is elected, the date on which:
 - i. The Member dies without a surviving Eligible Dependent; or
 - ii. The Member's longest surviving Eligible Dependent dies.
- (c) If continuation coverage is elected under COBRA, the date on which:
 - i. The COBRA continuation period ends; or
 - ii. The required COBRA contributions are not received when due.

11. What Happens to Forfeited Amounts?

Amounts that are forfeited under circumstances outlined in (a) and (c) above are used to pay future administrative expenses. In no case may these forfeitures revert to the Employer.

Amounts that are forfeited following a Member's death will be divided evenly among members of the bargaining unit to which the deceased Member last belonged.

VI. RESTRICTIONS ON RECEIVING BENEFITS

Tax laws impose a variety of nondiscrimination requirements and benefits tests that must be met before Benefits under the Plan will be nontaxable to all employees. These are generally intended to restrict the amount of nontaxable benefits available to certain employees of the Employer who are defined as “highly compensated” under the Code. If the Employer believes that any of these requirements or limits may be violated, it may limit the amount of Benefits available to certain members so that this Plan and its Benefits will not be discriminatory.

VII. LEAVES OF ABSENCES INCLUDING FAMILY OR MEDICAL LEAVES

If you take a leave of absence that is not a Family or Medical Leave under the Family and Medical Leave Act of 1993, your participation in this Plan will continue in the same manner as your participation in the medical plan.

If you take a leave of absence that is a Family or Medical Leave under the Family and Medical Leave Act of 1993, you should contact the benefits office to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid Family or Medical Leave, you may continue to participate in the Plan.

Please contact the Benefits Office at (612) 673-2282 as soon as you know you will be taking a Family or Medical Leave.

VIII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In certain circumstances, you may be able to enroll a child of a Plan Member in accordance with a “Qualified Medical Child Support Order” (“QMCSO”). Upon receipt of a medical child support order issued by an appropriate court or governmental agency, the Employer will follow established procedures in determining whether the medical child support order is “qualified.” For more information relating to QMCSOs, please contact the Benefits Office at (612) 673-2282.

IX. HOW BENEFITS ARE TAXED

Subject to applicable nondiscrimination requirements discussed above, the Code provides that Employer Contributions and any earnings used to pay for Benefits will not be subject to federal or state income taxes or to social security taxes. Benefit payments will not be reduced by income tax or social security withholding.

If a Member submits a claim for Benefits of Eligible Health Expenses for an Eligible Dependent who is not also a Tax Dependent, the entire dollar value of the non-Tax Dependents Eligible Health Expenses shall be imputed as income to the Member.

X. PLAN EXPENSES

Employee Member accounts are not currently charged fees for claims administration or Plan administration expenses. However, the Trustee fees are paid out of the Trust and reduce its rate of return. Beginning the January 1st of the Plan Year following the year in which a Member expenses a one year break in service, the Former Employee will pay \$1.50 per month for claims administration and Plan administration expenses. Such fees are deducted from the Former Employee’s Member Account. Other necessary Plan expenses, as well as consultant and investment manager expenses are currently paid by

the Employer, although such fees and expenses may instead be charged against Members' accounts.

XI. TERMINATION OF EMPLOYMENT

If your employment terminates, Employer Contributions will cease. Any funds remaining in your Member Account will be available to you for reimbursement as allowed under the terms of this Plan. Subject to rights you may have to continue coverage, you may be able to elect to continue to make after-tax contributions. (See RIGHTS TO CONTINUATION COVERAGE.) If you stop making payments toward that coverage, the coverage will cease.

XII. AMENDING OR TERMINATING THE PLAN

City reserves the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended, your benefits accrued prior to the amendment will not be affected. Benefits for periods after the amendment will depend on the nature of the amendment. If the Plan is terminated, you will not lose your Member Account. In the event of Plan termination, the City will determine, subject to the provisions of Section 501(c) (9) of the Code, the method in which trust assets will be distributed.

XIII. RIGHTS TO CONTINUATION COVERAGE

Under a federal law that is commonly known as COBRA (Public Law 99-272, Title X), most employers sponsoring "group health plans" are required to offer the opportunity for a temporary extension of health coverage (called "continuation coverage") in certain instances where coverage under the plan would otherwise end. The Plan qualifies as "group health coverage" for purposes of COBRA. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law.

You have a right to choose this continuation coverage if you lose your group health coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

When the Employer is notified that one of these events has happened, the Employer, in turn, will notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Employer that you want continuation coverage.

Under the law, the employee or a family member has the responsibility to inform the Employer of a divorce, legal separation, or a child losing dependent status under a COBRA plan. Notice must be given to the Employer within 60 days of the happening of the event.

If you do not choose continuation coverage, your group health coverage will end as of the end of the month in which you paid your last premium.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the COBRA plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your

coverage will be modified. The law requires that you are eligible to continue coverage for no more than 18 months after termination of employment or 36 months after any other qualifying event. For an employee or family member who is disabled at the time of the employee's termination or reduction in hours or who becomes disabled during the first 60 days of COBRA coverage, the continuation coverage period is 29 months. The disability that extends the continuation coverage period must be determined by the Social Security Administration under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. Such determination must be made within the first 18 months of COBRA continuation coverage. For the 29-month continuation coverage period to apply, the covered employee or other qualified beneficiary must notify the Employer within 60 days of the determination of disability under the Social Security Act and within the first 18 months of COBRA continuation coverage.

The Employer may charge 102% of the appropriate premium not otherwise subject to the disability extension.

If a second qualifying event occurs within 18 months after a termination or reduction in hours, you have three years of continuing coverage from the date of the original qualifying event. If you or a family member have a 29-month continuation period by reason of a disability, as described above, and another qualifying event (other than bankruptcy) occurs within the 29-month continuation period, then the continuation coverage period is 36 months from the termination of employment or reduction in hours.

The law provides that your continuation coverage may be cut short for any of the following reasons:

- (1) The Employer no longer provides group health coverage to any of its employees;
- (2) The premium for coverage is not paid on time;
- (3) The normal time period for which continuation coverage must be allowed expires.

If you have any questions about the law, please contact the Benefits Office at (612) 673-2282. Also, if you change your marital status, or you change your address, please notify the City's Benefits Office.

If you take a military leave of absence, you may have a right to have your coverage continued under the Plan. Upon your return from a military leave of absence, you may have a right to reinstate your coverage without any waiting periods.

XIII. CLAIM FOR BENEFITS

In the event the Claims Administrator determines that a Request for Benefits is questionable, the Claims Administrator shall, within fifteen (15) days from the date the Claimant's (for purposes of this section, a Claimant is defined as a person claiming benefits under this Plan) request for Plan Benefits was received by the Claims Administrator, unless special circumstances require an extension of time for reviewing said Request for Benefits, provide the Claimant with written notice of its need for additional information. In the event special circumstances require an extension of time for reviewing the Claimant's Request for Benefits, the Claims Administrator shall, prior to the expiration of the initial fifteen (15) day period referred to above, provide the Claimant with written notice of the extension and of the special circumstances which require such

extension and of the date by which the Claims Administrator expects to render its decision. In no event shall such extension exceed a period of sixty (60) days from the date of the expiration of the initial period.

If the Claimant's Request for Benefits is denied, in whole or in part, by the Claims Administrator, the Claims Administrator shall notify the Claimant of such denial and shall include in such notice, set forth in a manner calculated to be understood by the Claimant, the following:

- The specific reason or reasons for the denial; and
- Specific reference to pertinent Plan provisions or IRS rules on which the denial is based; and
- A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if the Claimant wishes to submit his/her claim for review.

In the event written notice of a denial of a Request for Benefits is not provided to the Claimant in the manner set forth in this section, the request shall be deemed denied as of the date on which the Claims Administrator's time period for rendering its decision expires.

A Claimant may appeal the denial of the Request for Benefits by submitting a written Request for Review of Denial of Benefits no later than sixty (60) days from the date the Claimant received written notification of the Claim's Administrator's initial denial of the claimant's Request for Benefits or from the date the Request for Benefits was deemed denied, unless the Claims Administrator, upon the written application of the Claimant or his authorized representative, shall in its discretion agree in writing to an extension of said period.

The written Request for Review of Denial of Benefits may request either a hearing or a written reconsideration. If a hearing is requested, the Claimant and any person the Claimant chooses may present testimony or other information. The Claimant is entitled to examine all pertinent documents and to submit issues and comments in writing.

The Claims Administrator will provide the Claimant written notice of its determination and all key findings within 45 days after the Claims Administrator receives the Claimant's written request for a hearing. If a Claimant requests a written reconsideration, the Claimant may provide the Claims Administrator with any additional information the Claimant believes is necessary. The Claims Administrator will provide the Claimant written notice of its determination and all key findings within 30 days after the Claims Administrator receives the Claimant's request for a written reconsideration. The Claims Administrator decision on Request for Review of Denial of Benefits shall be furnished to the Claimant and shall:

- Be written in a manner calculated to be understood by the Claimant;
- Include specific reasons for its decision; and
- Include specific references to the pertinent Plan provisions or IRS rules on which the decision is based.

If the Claims Administrator is unable to make a determination within the time prescribed by this section due to circumstances outside its control, the Claims Administrator may take up to 14 additional days to make a determination. If the Claims Administrator takes more time than prescribed to make a determination, the Claims Administrator will inform the Claimant in advance of the reason for the extension.

The claims procedures set forth above shall be strictly adhered to by each Claimant under this Plan, and no judicial or arbitration proceedings with respect to any claim for Plan Benefits hereunder shall be commenced by any such Claimant until the proceedings set forth herein have been exhausted in full.

You (or your counsel) also have the right to review the pertinent documents. If you do not request a hearing, within the appropriate period after the Claims Administrator receives your petition, the Claims Administrator shall notify you, in writing, of its decision, stating specifically the basis of said decision and the provisions of the Plan on which the decision is based. The Claims Procedure is set forth in full in the Plan.

XV. HIPAA PRIVACY

Regulations issued under the federal Health Insurance Portability and Accountability Act (HIPAA) protect the privacy of your health information under this Plan. These regulations are generally referred to as the HIPAA Privacy Rules. Generally, these rules require this Plan to take sufficient steps to protect any medical information that might identify you individually from other sources and to allow you to have access to this information. A Notice of Privacy Practices was sent to you at the time you became eligible to participate in this Plan. This notice describes in detail how the HIPAA Privacy Rules affect you and the Employer. The notice also describes five individual rights which apply to you under the privacy rules:

- The right to inspect and copy your protected health information
- The right to request restrictions
- The right to request confidential communications
- The right to amend your protected health information
- The right to receive an accounting of certain disclosures of your protected health information

To request a copy of the Notice of Privacy Practices, please call the City of Minneapolis Benefits Office at (612) 673-2282.

XVI. GENERAL ADMINISTRATIVE INFORMATION

Name of the Plan: City of Minneapolis
Health Reimbursement Arrangement Plan

Plan Sponsor and Plan Administrator: City of Minneapolis
Room 100, 250 South Fourth Street
Minneapolis, MN 55415-1335
(612) 673-2282

Plan Sponsor Identification Number: 41-6005375

Claims Administrator: OptumHealth Financial Services
11490 NW Xeon St
Coon Rapids, MN 55303-0728
(866) 204-8154

Plan Number: 515

Plan Year: January 1 – December 31

Type of Plan: This Plan is commonly known as a Health Reimbursement Arrangement Plan. It is an employer-funded plan that provides for the tax free reimbursement of health care expenses which eligible employees might otherwise be required to pay on an after-tax basis. It is classified as an “accident or health plan” under Code Section 105.

Type of Funding: This Plan is funded through a Voluntary Employees’ Beneficiary Association (VEBA) Trust established by the Employer participates and to which the Employer contributes.

Trustee: U.S. Bank, N.A.

Type of Administration: The City of Minneapolis has overall responsibility for the administration of this Plan. However, certain administrative services are provided by OptumHealth Financial Services under a contract with the City.

Agent for Service of Legal Process: City Clerk
City of Minneapolis
350 South 5th Street
Minneapolis, MN 55415-1316
Legal process may also be served on the Trustee or the Plan Administrator.

Requests for Information: If you have any questions regarding your benefits, please contact the Benefits Department at (612) 673-2282.

Requests for Review of Denial of Benefits should be in writing and should be hand delivered or sent by certified mail to the Claims Administrator.