SUMMARY DESCRIPTION

of the

CITY OF MINNEAPOLIS

HEALTH REIMBURSEMENT ARRANGEMENT

January 1, 2017

Table of Contents **Page**

I. INTRODUCTION

The City of Minneapolis has adopted a medical plan coupled with the City of Minneapolis Healthcare Reimbursement Arrangement ("HRA" or "Plan") and has established a Voluntary Employees' Beneficiary Association Trust ("VEBA Trust") to fund benefits under this Plan. The Plan consists of two component plans: the Health Reimbursement Arrangement–Active Plan ("HRA–Active Plan") and the Health Reimbursement Arrangement–Post Employment Plan ("HRA–Post Employment Plan"). This Summary Description applies to both the HRA–Active Plan and the HRA–Post Employment Plan unless specifically stated to the contrary. Plan benefits are available to pay for certain health care expenses that are not paid by other sources.

The City of Minneapolis is the "Plan Administrator" and has overall responsibility for the administration of the Plan. The City may from time to time retain a "Claims Administrator" to administer all or a portion of this Plan. SelectAccount is the current Claims Administrator.

This summary describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. To make use of this Plan, be sure to read it carefully so that you can make informed decisions that are right for you.

If there is a conflict between the actual Plan documents and this summary, the Plan documents will govern.

If you have questions about the Plan or to obtain a copy of the Plan documents, please contact the City of Minneapolis Benefits Office at 612-673-3333 or benefits@minneapolismn.gov.

II. GENERAL PLAN INFORMATION

1. What is the purpose of the Plan?

The purpose of the Plan is to provide tax-free accounts that can be used to pay for eligible medical, dental, vision and tax qualified long-term care expenses that are not paid by other plans or government programs.

2. Who can participate in the Plan?

Only "Eligible Employees" may participate. If the policy or collective bargaining agreement governing your employment provides for coverage under this Plan, you will be eligible to participate in the Plan. Eligible Employees who actually participate in the Plan are called "Members." Members and Eligible Employees will also be referred to as "you" or "I" through this document.

The City of Minneapolis has authorized the adoption of this Plan by the Municipal Building Commission, the Minneapolis Park and Recreation Board, the Minneapolis Board of Estimate and Taxation and the Minneapolis Youth Coordinating Board. Together with the City of Minneapolis, these boards and agencies are referred to as "Employer" through this document.

An "Employee" is any person hired and paid under the salary authority of the Employer, 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 Employer under a personal services contract.

3. How do I become a Plan Member?

To participate in the Plan, you must enroll in the City of Minneapolis Medical Plan. Eligible Employees are generally eligible to participate in the City of Minneapolis Medical Plan on the first day of the month following 30 days of employment. There are certain exceptions to the general rule. You will be notified if you are covered by one of the exceptions.

As a condition of Plan membership, you must also:

- Observe all Plan rules and regulations;
- Submit to the Claims Administrator all reports, bills, and other information that the Claims Administrator may reasonably require; and
- Agree to repay any overpayments or incorrect payments you receive from the Plan.

4. How is the Plan funded?

This Plan is funded by Employer contributions to the VEBA Trust. Member contributions are not permitted. Contribution amounts vary based on whether you choose single or family medical coverage under the City of Minneapolis Medical Plan.

"Member Account" refers to the bookkeeping account maintained by this Plan's Claims Administrator in the name of a Member which reflects all contributions made to the VEBA Trust in the name of the Member, investment earnings and losses, administrative expenses, and distributions made for the payment of Plan benefits.

III. PLAN BENEFITS

1. What expenses can be reimbursed under the Plan?

You can be reimbursed only for "Eligible Health Expenses." Eligible Health Expenses are expenses incurred by you or an "Eligible Dependent" (see definition below) that:

- Are deductible as medical expenses under Internal Revenue Code Section 213(d); and
- Have not or will not be reimbursed by any other health or accident plan, insurance policy or any other source covering you or an Eligible Dependent (including Social Security, Medicare or Medicaid).

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. For Members of the HRA-Post Employment Play which covers only Members who have separated from service with the Employer, Eligible Health Expenses include the out-of-pocket portion of Medicare premiums, COBRA premiums and any other health insurance contract or plan premium incurred after the date of separation from employment.

IRS Publication 502 lists the medical and dental expenses that a person may deduct on his or her income taxes. Many, but not all, expenses that are tax deductible are also reimbursable under the Plan. If you have questions regarding Eligible Health Expenses, you should contact SelectAccount at (800) 859-2144.

Benefits are **not** available to reimburse expenses that are reimbursable by the Minneflex Medical Expense Account (the "Health Care FSA") until after the Health Care FSA has paid expenses totaling the dollar amount you elected to contribute to the Health Care FSA for the calendar year.

Benefits will always be limited to the balance in your Member Account. If claims are mistakenly paid that exceed the balance 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 you or payments

on your behalf to providers. The right to offset future benefit payments does not limit this Plan's right to recover overpayments in any other manner.

The Plan will only reimburse your Eligible Health Expenses that are incurred on or after the date you enroll in the City of Minneapolis Medical Plan.

The Plan will only reimburse Eligible Health Expenses that are incurred on or after the date an individual becomes an Eligible Dependent. (See Q3 below.) Claims may not be reimbursed for expenses incurred after the date an individual ceases to be an Eligible Dependent.

If you are a Member of the HRA-Active Plan and you submit a claim for reimbursement for expenses incurred by a dependent who is not enrolled in the City of Minneapolis Medical Plan, you will be asked to provided certain information about that individual and to certify that the individual is your Spouse or Child and is covered by another employer's group medical plan that meets the integration requirements.

All claims must be submitted for reimbursement no later than 18 months after the end of the calendar year in which the expense was incurred.

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: You visit your doctor on March 15th and are billed for the services subject to the deductible on March 31st. You pay the bill on April 14th. You incurred the expense when you visited the doctor on March 15th.

3. Who is an Eligible Dependent under the Plan?

For purposes of the HRA – Active Plan, an Eligible Dependent is your Spouse or Dependent who is currently enrolled in the City of Minneapolis Medical Plan or another group health plan. For purposes of the HRA – Post Employment Plan, an Eligible Dependent is your Spouse or Dependent.

For purposes of this Plan, a Dependent child means the biological child, step child, adopted child (including a child placed for adoption) and foster child of a Member or the Member's Spouse up to the plans limiting age of 26. A Dependent child also includes the grandchild of a Member or a Member's Spouse who is dependent upon and resides with the Member or Spouse continuously from birth.

4. How do I claim Plan Benefits?

To claim Plan Benefits, you must submit a valid Request for Benefits. You have three options to submit your Request for Benefits:

- Pay Me
- Pay My Provider
- SelectAccount Debit Card

Pay Me

With this option, you pay for the expense with your own funds and then request reimbursement from SelectAccount. Pay Me claims must either be submitted in paper by mailing a completed paper claim form to SelectAccount, or be submitted electronically by visiting the www.selectaccount.com website. A paper claim form can be obtained from SelectAccount by calling (800) 859-2144.

The claim form, electronic or paper, includes information such as:

- The name of the person on whose behalf Eligible Health Expenses have been incurred.
- The nature and amount of the expenses.
- A statement that such expenses have not otherwise been paid through another health plan or insurance policy or reimbursed from any other source.

Your claim must include a copy of an itemized bill or receipt or other documentation (such as an explanation of benefits from the insurance company) of the type and amount of the expense and the date(s) the expense was incurred (a statement or canceled check is not sufficient).

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.

Pay My Provider

You can use this option to have payment sent directly to your provider from your Plan account. Pay My Provider claims can only be submitted via your online account at www.selectaccount.com. Refer to the website for more information.

Through the SelectAccount website, you can also arrange to make recurring monthly payments to your provider or insurance company. To do so, you will need documentation from your provider that includes:

- The provider name.
- Patient name.
- Description of service.
- Payment schedule including dates of service and payment amount.

SelectAccount Debit Card

You can use your debit card to pay for eligible products and services. Money for the expense is transferred directly from your Plan account to the provider or merchant. The IRS requires that all card transactions be verified as paying for eligible expenses. To do this, SelectAccount may request that you submit a detailed receipt or other documentation that shows what Eligible Health Expense was paid using the debit card. This request for receipts will appear on your online account or through an e-mail sent to the address you set up on the SelectAccount Online Member Service Center.

5. **How are Plan benefits taxed?**

The Plan is designed to meet certain requirements of federal and state tax law. As a result, Employer contributions and any earnings used to pay for Plan benefits will not generally be treated as taxable income. Benefit payments you receive from the Plan will not be reduced by income taxes or Social Security tax withholding or reported as taxable income to you.

However, 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 Members. The Plan must comply with the non-discrimination requirements as set forth under Section 105(h) of the Internal Revenue Code. If you are deemed to be a "highly compensated employee," the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Your own circumstances will dictate whether contribution limitations on "highly compensated employees" will apply. You will be notified of these limitations if you are affected. 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 remain nontaxable.

6. **How often are claims for reimbursement paid?**

Claims for reimbursement are processed daily. Submitted claims are paid or denied within five (5) business days of receipt.

7. **How are Plan reimbursements coordinated with reimbursements from my Health Care FSA?**

If you participate in the Health Care FSA, submitted health expenses will be applied to the Health Care FSA first until that account is exhausted. Additional claims may then be applied to your Member Account in this Plan.

Unless you contact SelectAccount and instruct SelectAccount customer service to not reimburse claims from this Plan, claims for reimbursement that exceed the balance remaining in your Health Care FSA will automatically be paid by this Plan.

Example: Your remaining Health Care FSA balance is $100 and you submit a claim for Eligible Health Expenses totaling $150. $100 will be reimbursed from your Health Care FSA, the remaining $50 will be paid from your Member Account unless your instruct SelectAccount customer service to not reimburse claims submitted to this Plan.

8. **How long do I have to submit a claim for reimbursement?**
   All claims for reimbursement must be submitted no later than 18 months after the end of the calendar year in which the expense was incurred.

9. **May I continue participation in the Plan if I take a leave of absence?**
   If you take a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA"), your participation in this Plan will continue in the same manner as your participation in the City of Minneapolis Medical Plan. In general, if you take an unpaid FMLA leave, you may continue to participate in the Plan.

   If you take a military leave of absence, you may have a right to have your participation continued under the Plan.

   Please contact the City of Minneapolis Benefits Office at (612) 673-3333 or benefits@minneapolismn.gov as soon as you know you will be taking a leave of absence.

10. **How long may I continue to participate in the Plan?**
    If you leave employment or cease to participate in the City of Minneapolis Medical Plan, the funds in your Member Account will remain available to reimburse you for Eligible Health Expenses. (See Coverage in Lieu of COBRA Coverage on page X.)

    If you elect to continue coverage under COBRA, no further Benefits will be available after the COBRA continuation period ends or, if earlier, the date you stop paying premiums toward the COBRA Coverage. (See RIGHTS TO CONTINUATION COVERAGE on page 13.)

11. **May I suspend participation in this Plan?**
    You may suspend participation in the Plan for yourself and any Eligible Dependents. Your election to suspend participation is effective the first of the month following your election to suspend participation. This election will remain in effect until the first of the month following your elections to resume Plan participation.

    If you are otherwise eligible for Contributions, you will continue to receive Contributions to the Plan during your suspension period.

Eligible medical expenses incurred by you and your Eligible Dependents during the suspension period cannot be reimbursed by the Plan. Eligible dental and vision expenses incurred by you and your Eligible Dependents during the suspension period may be reimbursed by the Plan. For further information and forms please contact the City of Minneapolis Benefits Office at 612-673-3333 or benefits@minneapolismn.gov.

12. My situation is such that I do not want to continue my participation in this Plan. What can I do?

You may elect to permanently opt out of further Plan participation:

- During an open enrollment period. Your election will be effective the following January 1st and no contributions will be made to the Plan after that date, or
- Upon your separation from service with the Employer.

No further Eligible Health Expenses will be reimbursed to you or to your Eligible Dependents after your election to permanently opt out of plan participation is effective.

Any balance remaining in your Member Account will be forfeited.

13. Are survivor benefits provided under the Plan?

If you die with funds in your Member account, your Account Balance will transfer to your Spouse. If you have no Spouse, your Eligible Dependents are entitled to the reimbursement of Eligible Health Expenses they incurred before or after your date of death. Eligible Health Expenses incurred by you in the 18 months prior to death can also be reimbursed by the Plan. This is explained further in the RIGHTS TO CONTINUATION OF COVERAGE section on page 13.

14. Could my Member Account balance ever be forfeited?

A Member Account balance can be forfeited in the following circumstances:

- You die and at the time of your death you are not survived by any Eligible Dependents.
- You elect to permanently opt out of the Plan during an open enrollment period or following your separation from employment with the Employer.
- 36 months following the date on which the Plan was last able to contact you at your last known address.
- If Coverage in lieu of COBRA is elected, the date on which:
    - The Member dies without a surviving Eligible Dependent; or
    - The Member's longest surviving Eligible Dependent dies.
- If continuation coverage is elected under COBRA, the date on which:
    - The COBRA continuation period ends; or
    - The required COBRA premiums are not received when due.

15. **What happens to forfeited amounts?**
Amounts that are forfeited under circumstances outlined above are used to pay future administrative expenses. In no case may forfeited amounts revert to the Employer.

16. **How are Plan expenses paid?**
HRA–Active Plan Member Accounts are not charged for Plan administrative expenses. HRA–Post Employment Plan Member Accounts are charged a monthly fee for administrative expenses. These fees are deducted from the HRA–Post Employment Plan Member Accounts. Trustee and investment management fees are deducted from VEBA Trust earnings. Other necessary Plan expenses, including consultant expenses, are currently paid by the Employer, although such fees and expenses may be charged to Member Accounts in the future.

IV. DENIAL OF REQUEST FOR PLAN BENEFITS

1. **How much time does the Claims Administrator have to deny a Request for Benefits?**
Unless special circumstances require an extension of time for reviewing your Request for Benefits, the Claims Administrator must provide you with written notice of the denial of a Request for Benefits within fifteen (15) days from the date your Request for Benefits was received by the Claims Administrator.

In the event special circumstances require an extension of time for reviewing the your Request for Benefits, the Claims Administrator shall, prior to the expiration of the initial fifteen (15) day period, provide the you 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.

2. **What happens if my Request for Benefits is denied?**
If the your Request for Benefits is denied, in whole or in part, the Claims Administrator shall notify you of such denial and shall include in such notice, set forth in a manner calculated to be understood by you, 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
- Description of any additional material or information necessary for you 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 you wish to submit your Request for Benefits for review.

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

3. **What options do I have to contest the Claims Administrator's denial of my Request for Benefits?**
   You 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 you received written notification of the Claim's Administrator's initial denial of Request for Benefits or from the date the Request for Benefits was deemed denied, unless the Claims Administrator, upon the written application by you or an authorized representative, shall in its discretion agree in writing to an extension of said period.

   Your Request for Review of Denial of Benefits may request either a hearing or a written reconsideration.

4. **How is a hearing conducted?**
   If a hearing is requested, you and any person you choose may present testimony or other information. You are entitled to examine all pertinent documents and to submit issues and comments in writing.

5. **How is a written reconsideration conducted?**
   If you requested a written reconsideration, you may provide the Claims Administrator with any additional information you believe is necessary. You must provide the written information within 180 days of your receipt of the notice of the denial of the claim.

6. **How much time does the Claims Administrator have to decide a Request for Review of Denial of Plan Benefits?**
   If you requested a hearing, the Claims Administrator will provide you written notice of its determination and all key findings within 45 days after the hearing.

   If you requested a written reconsideration, the Claims Administrator will provide you with written notice of its determination and all key findings within 30 days of your request for a written reconsideration. The Claims Administrator decision on Request for Review of Denial of Benefits shall be furnished to you and shall:

   - Be written in a manner calculated to be understood by you;
   - 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 you in advance of the reason for the extension.

7. Do I have any options other than the written Request for Review of Denial of Plan Benefits?

The claims procedures set forth above will be strictly adhered to, and you may not commence any judicial or arbitration proceedings with respect to any Benefits until the proceedings set forth above have been exhausted in full.

V. AMENDING OR TERMINATING THE PLAN

The 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 balance.

VI. RIGHTS TO CONTINUATION COVERAGE

1. COBRA & State Law Continuation Coverage

Under a federal law that is commonly known as COBRA and Minnesota State law, employers sponsoring "group health plans" are required to offer the opportunity for a temporary extension of health coverage (referred hereafter as "COBRA Coverage") in certain instances where coverage under the plan would otherwise end. This Plan qualifies as a "group health plan" for purposes of COBRA and Minnesota state law. The following paragraphs provide a summary of your rights and obligations under COBRA Coverage as it applies to the Plan. To request a copy of the City of Minneapolis Health Reimbursement Arrangement Plan COBRA Policy and Procedures, please contact the City of Minneapolis Benefits Office at (612) 673-3333 or benefits@minneapolismn.gov.

A. What circumstances establish the right to elect COBRA Coverage?

If you are a Member, you are entitled to COBRA Coverage upon the occurrence of the following qualifying events:

- Reduction of hours of employment (including a layoff or an unpaid leave of absence); or

- End of employment for any reason (voluntary or involuntary) other than gross misconduct.

- If you are the Spouse of a Member, you are entitled to COBRA Coverage upon the occurrence of the following qualifying events:
- Your spouse-Member, dies;
- Your spouse-Member's hours of employment with Employer are reduced;
- Your spouse-Member's employment with Employer ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse-Member.

If you are a dependent child of a Member, you are entitled to COBRA Coverage upon the occurrence of the following qualifying events:

- The parent-Member dies;
- The parent-Member's hours of employment with Employer are reduced;
- The parent-Member's employment with Employer ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plans as a Dependent.

B. What obligations do I have under COBRA Coverage as it applies to the Plan?

Under the law, you, the Member, or a family member has the responsibility to inform the Employer of a Social Security Administration determination of a disability, a divorce, or a child losing dependent status under a COBRA plan. Notice must be given to the Employer within 60 days of the date of the event. Should you fail to provide timely notice to the Employer, COBRA Coverage will not be available.

When the Employer is timely notified that one of the events (described in the paragraph above) has happened, the Employer, will notify you, the Member, or, if applicable, your family member, of the right to choose COBRA Coverage. Applications for COBRA Coverage must be made within 60 days from the date the notice of your right to continue coverage is received, or in the cause of a disability determination, divorce, legal separation within 60 days of the date of the event. If you do not elect COBRA Coverage within the required time period, no COBRA Coverage will be provided.

In most instances, you must pay a premium for COBRA Coverage. The Employer may charge a 2% of administration fee in addition to the premium.

C. Do additional Contributions accrue to the Member Account during COBRA Coverage

If you choose COBRA 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 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.

If Contributions are made to similarly situated employees or family members, then additional Contributions will be made to the Member's Account during the COBRA Coverage period. You will be responsible for paying the premiums for these Contributions.

D. What Benefits are available during COBRA Coverage?

When COBRA Coverage is selected, the person who selected COBRA Coverage will receive Benefits for Eligible Health Expenses incurred by the person.

Access to the Member's Account Balance during COBRA Coverage is provided on an aggregate basis.

E. What is the duration period of COBRA Coverage?

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 a Member or family member who is disabled at the time of the Member's termination or reduction in hours or who becomes disabled during the first 60 days of COBRA Coverage, the COBRA Coverage period is 29 months. The disability that extends the COBRA Coverage period must be determined by the Social Security Administration. within the first 18 months of COBRA Coverage. For the 29- month COBRA Coverage period to apply, the Member or Member's Dependent 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 Coverage.

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 occurs within the 29-month continuation period, then the

continuation coverage period is 36 months from the termination of employment or reduction in hours.

Your continuation coverage may be cut short for any of the following reasons:

- The Employer no longer provides the Plan to any of its employees;
- The COBRA Coverage premium is not paid on time;

If you have any questions about COBRA Coverage, please contact the City of Minneapolis Benefits Office at (612) 673-3333 or benefits@minneapolismn.gov. Also, if you change your marital status, or you change your address, please notify the City's Benefits Office.

A. Alternative Continuation Coverage: Coverage in Lieu of COBRA Coverage

Coverage in Lieu of COBRA Coverage is an alternative to COBRA Coverage. Coverage in Lieu of COBRA Coverage permits spending down the Account Balance of the Member Account for Eligible Health Expenses incurred by the Member and his/her Dependents.

1. What circumstances trigger Coverage in Lieu of COBRA Coverage?

Coverage in Lieu of COBRA Coverage automatically occurs upon the occurrence of the following events, unless COBRA Coverage is elected:

- Reduction of the Member's hours of employment (including a layoff or an unpaid leave of absence); or
- End of a Member's employment for any reason (voluntary or involuntary)
- Death of a Member.

Coverage in Lieu of COBRA Coverage is not available to the Spouse of a Member upon a divorce.

Coverage in Lieu of COBRA Coverage is not available to the Child of a Member parents upon the child ceasing to be an eligible Dependent.

2. Does the Employer make additional Contributions to the Member Account during Coverage in Lieu of COBRA Coverage?

No additional Contributions will be made to the Member's Account during Coverage in Lieu of COBRA Coverage period.

3. What Benefits are available during Coverage in Lieu of COBRA Coverage?

When the Member selects Coverage in Lieu of COBRA Coverage, Eligible Health Expenses shall continue to include Eligible Health Expenses incurred by the Member, the Member's Spouse, and the Member's Eligible Dependents regardless of whether the Spouse and Eligible Dependents elect COBRA Coverage or the Coverage in Lieu of COBRA.

Access to the Member's Account Balance during Coverage in Lieu of COBRA Coverage is be provided on an aggregate basis; the same as it would if COBRA Coverage were elected.

4. What is the duration period of Coverage in Lieu?

For the Member, such access shall be provided until the earlier of: (1) the date account balance reaches zero or (2) the date of the Member's death.

For a Spouse of the Member, such access shall be provided until the earlier of: (1) the date account balance reaches zero, (2) the date of the Spouse's death, or (3) the date of the entry of a valid divorce decree.

For an Eligible Dependent other than a Spouse of the Member, such access shall be provided until the earlier of: (1) the date account balance reaches zero, (2) the date of the Eligible Dependent's death, or (3) the date the Eligible Dependent ceases to be a Eligible Dependent under the terms of the Plan.

VII. 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 permit the Plan to use your health information in a number of different ways to administer your Plan Benefits, 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 the 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 contact the City of Minneapolis Benefits Office at (612) 673-3333 or benefits@minneapolismn.gov.

VIII. ADMINISTRATIVE INFORMATION

Name of the Plan:	City of Minneapolis Health Reimbursement Arrangement
Plan Sponsor and Plan Administrator:	City of Minneapolis Room 100, 250 South Fourth Street Minneapolis, MN 55415-1335 (612) 673-3333
Plan Sponsor Identification Number:	41-6005375
Claims Administrator:	SelectAccount 1750 Yankee Doodle Rd 5140 Eagan, MN 55121 (800) 859-2144
Plan Number:	515
Plan Year:	January 1 – December 31
Type of Plan:	This Plan is commonly known as a Health Reimbursement Arrangement. It consists of two component plans: the Health Reimbursement Arrangement–Active Plan ("HRA–Active Plan") and the Health Reimbursement Arrangement-Post Employment Plan ("HRA–Post Employment Plan"). It is an employer- funded plan that provides for the tax free reimbursement of health care expenses which Plan Members 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:	The Plan is funded through a Voluntary Employees' Beneficiary Association (VEBA) Trust established by the City of Minneapolis 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 SelectAccount under a contract with the City.
Agent for Service of Legal Process:	City of Minneapolis City Clerk 350 South 5th Street. Room 304 Minneapolis, MN 55415-1316
Requests for Information:	If you have any questions regarding your benefits, please contact City of Minneapolis Benefits Office at (612) 673-3333 or benefits@minneapolismn.gov.