Minnesota State Colleges and Universities

Health Reimbursement Arrangement (HRA) Plan

Plan Document

[as restated, including Amendments Nos. 1, 2, 3, 4, 5, 6 & 7]

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Minnesota State Colleges and Universities
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As Adopted Effective January 1, 2005

ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

The State of Minnesota (the "State") on behalf of the Minnesota State Colleges and Universities (the "Employer") hereby establishes the Minnesota State Colleges and Universities Health Reimbursement Arrangement (HRA) Plan (the "Plan") effective January 1, 2005 (the "Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is intended to permit an Eligible Employee to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the HRA Account.

1.2 Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code § 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b).

ARTICLE II. DEFINITIONS

2.1 Definitions

"Administrator" means the State of Minnesota, Minnesota Management and Budget (MMB). The contact person is the Employee Insurance Division Manager, who has the full authority to act on behalf of the Administrator.

"Benefits" means the reimbursement benefits for Medical Care Expenses described under Article VII.

"Code" means the Internal Revenue Code of 1986, as amended.

"Compensation" means the wages or salary paid to an Employee by the Employer.

"Covered Individual" means, for purposes of Article VIII, a Participant, Spouse or Dependent.

"Dependent" means (a) any individual who is a Participant's child as defined in Code § 152(f)(1) and who has not attained age 26, and (b) any tax dependent of a Participant as defined in Code § 105(b), provided, however, that any child to whom Code § 152(e) (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) applies, is treated as a dependent of both parents. Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Dependent" includes the child or children of an eligible employee up to age twenty-six (26), which includes the employee's: (a) biological child, (b) child legally adopted by or placed for adoption with the employee, (c) foster child, and (d) step-child. To be considered a "dependent," a foster child (including a child who is a ward of the employee or spouse, or for whom the employee or spouse is a legal guardian) is a child for whom the employee has submitted a completed Foster Child Certification form. For a step-child to be considered a dependent child, the employee must be legally married to the child's parent. A disabled child is an eligible dependent if he or she, regardless of age or marital status, is incapable of self-sustaining employment by reason of developmental disability, or mental illness or disorder, or physical disability, and is chiefly dependent on the employee for principal support and maintenance.

Adult children who have access to their own or their spouse's employer based group health coverage are not eligible dependents.

"Claims Processing Administrator" ("CPA") means Eide Bailly LLP.

"Effective Date" of this Plan has the meaning described in Section 1.1.

"Electronic Protected Health Information" has the meaning described in 45 C.F.R. §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"Employee" means an individual who is a) employed in the State University Instructional Bargaining Unit as defined in Minn. Stat. §179A.10 and who is eligible for the Minnesota Advantage Health Plan; or b) as of January 1, 2007, employed as an administrator pursuant to the Personnel Plan for MnSCU Administrators and who is eligible for the Minnesota Advantage Health Plan; or c) an individual on USERRA qualifying leave from a position satisfying clause a) or b) of this paragraph. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits in accordance with Section 3.2.

"Employer" means Minnesota State Colleges and Universities.

"Enrollment Form" means the form provided by the Administrator for the purpose of allowing an eligible Employee to participate in this Plan.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Genetic Information" means information about the genetic tests of an individual or his or her family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

"Health FSA" means a health flexible spending arrangement as defined in Prop. Treas. Reg. § 1.125-2, Q/A-7(a).

"Health Insurance Plan" means the plan(s) that the State maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance arrangement(s).

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**HRA**" means a General-Purpose health reimbursement arrangement defined in IRS Notice 2002-45 and a Limited-Purpose Health HRA as defined in IRS Revenue Ruling 2004-45.

"HRA Account" means the HRA Account described in Section 7.4.

"HSA" means a health savings account as defined in IRS Code Section §223(d).

"Medical Care Expenses" has the meaning defined in Section 7.2.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

"Period of Coverage" means the Plan Year.

"Plan" means the Minnesota State Colleges and Universities HRA Plan as set forth herein and as amended from time to time.

"Plan Year" means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31).

"Protected Health Information" shall have the meaning described in 45 C.F.R. § 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

"**Public Health Services Act (PHSA)**" is a United States federal law enacted in 1946.

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

"SPD" means the separate summary plan description describing the terms of this Plan.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if on January 1 of the current Plan Year, or such other date as determined by the Employer, the individual meets each of the following conditions:

(a) holds an existing HRA account that carried a balance of less than $700 at the close of business on December 31 of the preceding Plan Year or does not hold an existing HRA account; and

(b) meets the definition of an Employee in this Plan; and

(c) satisfies one of the following criteria:

- is eligible for and receiving full or partial employer paid health insurance under the applicable collective bargaining agreement or compensation plan on the first business day of the Plan Year; or
- on the first day of the Plan Year is on USERRA or FMLA qualifying leave from a position that has not self-terminated and which at the time the USERRA or FMLA qualifying leave commenced was eligible for and receiving full or partial employer paid health insurance under the applicable collective bargaining agreement or compensation plan.

The Employer will determine each Employee's eligibility to participate in the Plan on an annual basis. Once the Employer has determined that an Employee has met the Plan's eligibility requirements, the Employee's coverage will be effective as of the first day of the Plan Year.

If the Employer's annual determination of eligibility occurs after January 1st, coverage will be effective retroactive to the first day of the Plan Year.

An Employee otherwise eligible to participate in the Plan may elect not to participate in the Plan by providing written notice to the Director of Human Resources at the college, university or system office where the Employee is employed as follows:

(a) within 30 days of termination of employment;

(b) within 30 days of cessation of eligibility for a full or partial employer paid health insurance; between November 1 and December 15 of a Plan Year, to be effective for the succeeding Plan Year.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the date on which the Employee's HRA Account balance becomes zero
- the termination of this Plan; or
- the later of the following dates:
  - the last day of the month in which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee; or
  - the last day of the month in which the Employee's eligibility for and receipt of full or partial employer paid health insurance under the applicable collective bargaining agreement or compensation plan ceases;

provided that eligibility may continue beyond such dates for purposes of PHSA coverage or an alternative plan, as may be permitted by the Administrator on a uniform and consistent basis under Section 7.7.

Except as otherwise provided in Section 3.1 of this Article, an Eligible Employee shall cease to be a Participant on the last day of the month in which the Employee provides written notice, as provided in Section 3.1, of the Employee's election not to participate in the Plan.

Termination of participation under the provisions of this section does not require an election to not participate in the Plan as described in Section 3.1.

A Participant shall not cease to be a Participant due to the commencement of a USERRA or FMLA qualifying leave during the Plan Year. A Participant whose eligibility is based on a USERRA or FMLA qualifying leave shall cease to be a Participant upon the earlier of:

- the termination of the USERRA or FMLA qualifying leave, unless the individual has contemporaneously returned to a qualifying employment status; or
- the termination of the period of employment if the position from which the USERRA or FMLA qualifying leave was taken had a specified end date.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then is rehired, the individual will be considered a new Employee, if after re-hire the individual meets the definition of "Employee" as set forth in this Plan.

3.4 FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Employee.

3.5 Non-FMLA and Non-USERRA Leaves of Absence

If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA during which the Participant does not remain eligible for and receive full or partial employer paid health insurance under the applicable collective bargaining agreement or compensation plan, the Participant will be treated as having terminated participation, as described above under Section 3.2.

ARTICLE IV. METHOD AND TIMING OF ENROLLMENT

4.1 Effective date of Participation

For the first year of the Plan, an Employee who first becomes eligible to participate in this Plan will commence participation on the first day of the Plan Year in which the eligibility requirements have been satisfied. Once enrolled, the Employee's participation will continue until the later of the following events:

- Employee's participation ceases pursuant to Section 3.2; or
- the Employee fails to satisfy the criteria to participate set forth in Section 3.1 at the commencement of a Plan Year.

An employee may reestablish eligibility to participate in the Plan under Section 3.1.

4.2 HIPPA Special Enrollment Rights

Notwithstanding any other provision of the Plan to the contrary, effective April 1, 2009, the Eligible Employee may enroll in the Plan as required by HIPAA under either of the following circumstances:

- The Eligible Employee's or Dependent's coverage under a Medicaid plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage and the Eligible Employee requests coverage under the Plan not later than 60 days after the date of termination of such coverage.
- The Eligible Employee or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the Plan and the Participant requests coverage under the Plan not later than 60 days after the date the Eligible Employee or Dependent is determined to be eligible for such assistance.

An election change under this provision must be requested within 60 days after the termination of Medicaid or state child health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

ARTICLE V. BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

When an Eligible Employee becomes a Participant in accordance with Articles III and IV, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in Article VII. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* The Employer funds the full amount of the HRA Accounts.
(b) *Participant Contributions.* There are no Participant contributions for Benefits under the Plan.
(c) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the Plan.
(d) *Administrative Expenses.* Administrative expenses will be paid by the Employer.

5.3 Funding This Plan

All of the amounts payable under this Plan (other than the administrative expenses outlined in Section 5.2(d)) shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

ARTICLE VI. [RESERVED]

ARTICLE VII. HEALTH REIMBURSEMENT BENEFITS

7.1 Benefits

The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's HRA Account, as set forth and adjusted under Section 7.3.

7.2 Eligible Medical Care Expenses

Under the Plan, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage.

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred at a time when an individual is not a Participant are not eligible except as provided in Section 3.1 or Section 7.7.
(b) *Medical Care Expenses Generally.*
    1) "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs) and health insurance premiums for long term care insurance, individual health and dental insurance policies, and Medicare Part B, but shall not include expenses that are described

in subsection (c). Reimbursements for Medical Care Expenses incurred by a Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account as provided in Section 7.4.

2) *Limited-Purpose HRAs*: "Medical Care Expenses" means expenses incurred by a Participant or the Participant's Spouse or Dependents, limited to vision, dental and preventive care expenses deductible under Code § 213. If a State employee enrolls in the HSA sponsored by the State of Minnesota, the Employee's HRA account will automatically be converted to a Limited HRA for any claims submitted in the year in which the Employee is enrolled in the HSA. If an HRA participant meets the deductible he/she can elect the Full HRA by contacting the CPA in writing for claims submitted through the last day of February.

Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account.

(c) *Medical Care Expenses Exclusions.* "Medical Care Expenses" shall not include the expenses listed as exclusions under Appendix A to this Plan.

(d) *Cannot Be Reimbursed or Reimbursable from Another Source.* Medical Care Expenses can be reimbursed only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance, or any other accident or health plan (see Section 7.9 if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), the Plan can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.

(e) Mental Health Parity and Addition Equity Act. Regardless of any limitations on benefits for Mental Disorders/Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders/Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

7.3 Maximum Benefits

(a) *Maximum Benefits.* The maximum annual dollar amount that may be credited to an HRA Account for an Employee who participates for an entire Period of Coverage shall be as determined under the applicable bargaining agreement or compensation plan in effect on the first day of each Plan Year. Unused amounts may be carried over to the next Period of Coverage, as provided in Section 7.5.

(b) *Changes.* For each Plan Year, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Enrollment Form, the SPD or another document.

7.4 Establishment of Account

The Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) *Crediting of Accounts.* At the beginning of each Plan Year, as provided in Section 3.1, the Employer will make a contribution, as determined under the applicable bargaining agreement or compensation plan, to the Participant's HRA Account. If a Participant is eligible to receive an employer contribution to an HSA, the Participant's HRA Account will be designated as a Limited Purpose HRA Account (LPHRA). A Participant who is not receiving an employer contribution to an HSA may designate their HRA account as either an LPHRA or a General-Purpose HRA by notifying the CPA. An Employee who provides written notice of the Employee's election not to participate in the Plan prior to the time that Participant HRA accounts are credited shall not have his/her account credited.

(b) *Debiting of Accounts.* A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

7.5 Carryover of Accounts

If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Period of Coverage.

When a Participant's coverage is terminated under Section 3.2 all expenses incurred up until such time shall be eligible for reimbursement under the terms of this document. If any balance remains in a terminated Participant's account, and the terminated Participant has not re-established eligibility to participate in the Plan for the next Plan Year, the HRA account balance shall be forfeited; however, if the individual is a PHSA Participant, any remaining balance shall carryover to the HRA Account for the next Plan Year and will be available for reimbursement for the duration of the individual's PHSA continuation period. Eligibility for funds forfeited under this provision shall not be restored upon establishment of the Employee's eligibility to participate in the Plan in subsequent Plan Years.

In addition, any Plan benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited.

7.6 Reimbursement Procedure

(a) *Debit cards.* Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

1) **Card only for medical expenses.** By use of the card, each Participant agrees that such card shall only be used for Medical Expenses and that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.
2) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the HRA or a Medical Dental Expense Account (MDEA) administered by MMB. Such card may be cancelled if such Participant has a change in status that results in the Participant's loss of eligibility to participate in the HRA.
3) **Maximum dollar amount available.** The maximum dollar amount of coverage available on the card shall be the maximum amount for the Plan Year. At the discretion of the Administrator, the card may also be useable to pay Medical Expenses under the MMB HRA and/or MDEA Plans. Amounts available under the MMB HRA and/or MDEA shall be in addition to and administered separately from the amounts available under the HRA.
4) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.
5) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:
   i. Co-payments for doctor and other medical care;
   ii. Purchase of drugs;
   iii. Purchase of medical items such as eyeglasses, syringes, crutches, etc.
6) **Substantiation.** Purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

7) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
   i. Repayment of the improper amount by the Participant;
   ii. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
   iii. Claims substitution or offset of future claims until the amount is repaid; and
   iv. if subsections (i) through (iii) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

(b) *Timing.* Within 30 days after receipt by the Claims Processing Administrator (CPA) of a reimbursement claim from a Participant, the CPA will reimburse the Participant for the Participant's eligible Medical Care Expenses or the CPA will notify the Participant that the claim has been denied (see Section 13.1 regarding procedures for claim denials and appeals procedures). This time period may be extended for an additional 15 days for matters beyond the control of the CPA, including in cases where a reimbursement claim is incomplete. The CPA will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(c) *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the CPA in such form as the CPA may prescribe, by no later than the last day of February following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:
- the person or persons on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Expenses has been exhausted; and
- any other information reasonably needed to maintain legal compliance or effectively administer the Plan.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that CPA may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $50.

(d) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.

7.7 Reimbursements After Termination

(a) *General.* When a Participant ceases to be a Participant under Section 3.2, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage until the end of the month coinciding with or following the effective date of termination, provided that the Participant (or the Participant's estate) files a claim by the last day of February following the close of the Plan Year in which the Medical Care Expense was incurred. Thereafter, if any balance remains in the account, such balances shall be managed pursuant to section 7.5.

(b) *PHSA.* Notwithstanding any provision to the contrary in this Plan, to the extent required by PHSA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the Plan because of a PHSA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the Plan the day before the qualifying event for the periods prescribed by PHSA (subject to all conditions and limitations under PHSA). However, in the event that such coverage is modified for all similarly-situated non-PHSA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to

continue the same coverage that is provided to similarly-situated non-PHSA Participants. At the beginning of Plan Year, Qualified Beneficiaries shall be credited with the annual contribution amount that is made available to similarly-situated non-PHSA beneficiaries, and any unused reimbursement amounts from the previous Coverage Period shall be carried over (provided that the applicable premium is paid). A premium for continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by PHSA. At its discretion, the Employer may offer an alternative plan which Participants and eligible Dependents may elect in lieu of PHSA. To the extent that the Employer offers an alternative plan, a brief summary of such alternative plan shall be attached to this Plan as an appendix.

7.8 Named Fiduciary; Compliance With PHSA, HIPAA, etc.

(a) *Named Fiduciary.* The State of Minnesota is the named fiduciary for the Plan.

(b) *Laws Applicable to Group Health Plans.* Benefits shall be provided in compliance with PHSA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

7.9 Coordination of Benefits; State HRA to Reimburse First

Benefits under this Plan are intended to pay solely for eligible Medical Care Expenses not previously reimbursed or reimbursable elsewhere, including by a Health FSA sponsored by MMB or a different HRA plan sponsored by MMB, until after amounts available for reimbursement under the Health FSA and the different HRA plan sponsored by MMB have been exhausted.

ARTICLE VIII. HIPAA PRIVACY AND SECURITY

8.1 Employer's Certification of Compliance

The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 CFR § 164.504(f)(2)(ii), and that Employer agrees to conditions of disclosure set forth in this Article VIII.

8.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Employer or the Administrator information on whether the individual is participating in the Plan.

8.3 Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the Employer or the Administrator, provided that the Employer or the Administrator requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 CFR § 164.5 14(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.51 4(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

8.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions

of this Article VIII (including, but not limited to the restrictions on Employer's use and disclosure described in 8.5) and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64.

8.5 Restrictions on Employer's Use and Disclosure of Protected Health Information

(a) Employer will neither use nor further disclose a Covered Individual's Protected Health Information or Electronic Protected Health Information, except as permitted or required by the Plan document, or as required by law.

(b) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to Protected Health Information or Electronic Protected Health Information.

(c) Employer will not use or disclose a Covered Individual's Protected Health Information or Electronic Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.

(d) Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.

(e) Employer will make Protected Health Information or Electronic Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 C.F.R. § 164.524.

(f) Employer will make a Covered Individual's Protected Health Information or Electronic Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information or Electronic Protected Health Information, in accordance with 45 C.F.R. § 164.526.

(g) Employer will track disclosures it may make of a Covered Individual's Protected Health Information or Electronic Protected Health Information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(h) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 C.F.R. Part 164, Subpart E.

(i) Employer will, if feasible, return or destroy all Protected Health Information or Electronic Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information or Electronic Protected Health Information, when the Covered Individual's Protected Health Information or Electronic Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information or Electronic Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information or Electronic Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(j) Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

8.6 Adequate Separation Between Employer and the Plan

(a) Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Covered Individual's Protected Health

Information or Electronic Protected Health Information received from the Plan or a business associate servicing the Plan:

- Privacy Official;
- Employees in the Employer's Human Resources Department;
- Employees in the Employer's Office of General Counsel; and
- Any other class of employees designated in writing by the Privacy Official.

(b) The employees, classes of employees or other workforce members identified in Section 8.4(a), above, will have access to a Covered Individual's Protected Health Information or Electronic Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 8.2(a), above.

(c) The employees, classes of employees or other workforce members identified in Section 8.4(a), above, will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of this Article VIII.

8.7 Security Measures for Electronic Protected Health Information

The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a Covered Individual's Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on the Plan's behalf.

8.8 Notification of Security Incident

The Employer will report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Employer's information systems, of which the Employer becomes aware.

ARTICLE IX-XII. [RESERVED1

ARTICLE XIII. APPEALS PROCEDURE

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the SPD. The Administrator is responsible for appeals.

ARTICLE XIV RECORDKEEPING AND ADMINISTRATION

14.1 Administrator

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Administrator

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided

that, notwithstanding the first paragraph in this Section 14.2, the Administrator shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

(f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

14.4 Provision for Third-Party Plan Service Providers

The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

14.5 Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

14.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

14.7 Inability to Locate Payee

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due. In addition, any Plan benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited.

14.8 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the Plan or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV. GENERAL PROVISIONS

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by the Employer, except fees for additional or replacement debit cards will be paid by the Participant.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer, consistent with the applicable bargaining agreement or personnel plan.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the State of Minnesota Minnesota Management and Budget (MMB) or by any person or persons authorized by MMB to take such action.

15.4 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of Minnesota to the extent not superseded by the Code or any other federal law.

15.5 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

15.9 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Minnesota State Colleges and Universities HRA Plan, Minnesota State Colleges and Universities has caused this Plan to be executed in its name and on its behalf, on this _____ day of _____, 2005.

MINNESOTA STATE COLLEGES AND UNIVERSITIES

By:_____
Its Vice Chancellor

STATE OF MINNESOTA, DEPARTMENT OF EMPLOYEE RELATIONS

By:_____
Its Commissioner

Appendix A

Exclusions — Medical Expenses That Are Not Reimbursable

The Minnesota State Colleges and Universities HRA Plan document contains the general rules governing what expenses are reimbursable. This Appendix, as referenced in the Plan document, specifies certain expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

Exclusions:

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

- Premiums that a participant pays under any group plan, except that premiums for long term care insurance shall be reimbursable.
- COBRA or benefit continuation premiums that a Participant pays under any group plan
- Premiums that a participant pays for disability insurance.
- Over the counter medicines, except that insulin and over the counter purchased pursuant to a prescription are reimbursable.
- Pregnancy testing kits.
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Massage therapy (unless prescribed by a doctor to treat a medical condition).
- Home or automobile improvements.
- Custodial care.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, unless prescribed by a physician for a specific medical condition.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code § 213.

Appendix B

Summary Description of Alternative Plan

Participants who have experienced a qualifying event will be provided the opportunity to elect coverage under an alternative plan as set forth in the summary plan description in lieu of PHSA continuation coverage at no expense to the Participant. A Participant who elects the alternative plan may continue to submit claims for the balance remaining in his/her HRA account through the end of the calendar year in which the qualifying event occurs. The alternative plan will cover Medical Care Expenses incurred during the remainder of the Plan Year to the extent that funds are available in the Participant's HRA account. If a Participant elect this option, his/her HRA coverage will expire at the end of the Plan Year.