STATE OF MINNESOTA

2009 Health Reimbursement Arrangement (HRA) Plan

SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Your employer (the "Employer") is pleased to provide the State of Minnesota Health Reimbursement Arrangement (HRA) Plan ("the HRA Plan") for eligible employees. Under federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA" plan.

This Summary Plan Description (SPD) describes the basic features of the HRA 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 HRA Plan and a brief description of your rights as a Participant. If there is a conflict between the official, complete plan document and this Summary Plan Description, the official HRA Plan document will control. Definitions of capitalized terms used in this SPD are contained in Part IV.

PART I. GENERAL INFORMATION ABOUT THE PLAN

I-1. What is the purpose of the HRA Plan?

The purpose of the HRA Plan is to reimburse Eligible Employees, up to certain limits, for their own, their spouses' and their covered Dependents' Health Care Expenses. Reimbursements for Health Care Expenses paid by the Plan generally are excludable from taxable income.

I -2. When did the HRA Plan take effect?

The HRA Plan became effective January 1, 2009.

I -3. Who can participate in the HRA Plan?

Employees of the State and of its IBUs enrolled in the Advantage Health Plan on January 1, 2009 will receive the HRA. Former employees and retirees enrolled in the Advantage Health Plan on January 1, 2009 are also included.

If you are a Participant, you may also be reimbursed for eligible Health Care Expenses incurred by your Spouse and Dependents.

I-4 What dependents are covered under the HRA?

You may cover eligible dependent expenses in the HRA if he or she qualifies as a dependent under Section 152 of the Internal Revenue Code by meeting *one of* criteria listed below, OR is a child who has not attained age 27 by the end of the year. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

Note: for State of Minnesota (and some other states) income tax purposes, this expanded age definition income tax exclusion has not been adopted at the state tax level. The definition of dependents under state law remains as indicated below. If you have a child who is under age 27 as of the end of the calendar year and who is not a dependent under the definition stated below and said dependent has received reimbursement under this HRA, you may have additional taxable income for purposes of Minnesota state income taxes.

1. To be considered as a dependent under Section 152, the individual must be either a "qualifying child" or a "qualifying relative." A qualifying child is an individual who meets one of the following criteria:

- **Will be less than 19 years of age during the entire calendar year(s) in which coverage is provided; or**
- **Will be less than 24 years of age during the entire calendar year(s) in which coverage is provided and is a regular full-time student; or**
- **Is permanently and totally disabled In addition,**
- **The individual must reside with you.**
- **The individual must provide 50% or less of his/her own support.**
- **The individual must be one of the following:**
  - **your child (natural, stepchild, adopted child, or child placed for adoption); or**
  - **your sibling (brother, sister, stepbrother, or stepsister); or**
  - **a descendent of your child or sibling (e.g., grandchild, great grandchild, niece, nephew).**
- **The individual must be a citizen, national, or resident of the United States, or a resident of Canada or Mexico. (Special rules apply to adopted children.)**
- **The individual must be younger than you.**

In the case of divorced parents, the child is the qualifying child of the parent with whom the child resided for the longest period during the year. If the child resides with both parents for the same amount of time during the year, the child is the qualifying child of the parent with the parent with the highest income.

2. A Qualifying Relative is an individual who meets at least one of the following criteria:
   - **Resides with you and is part of your household; or**
   - **Is related to you as your child, descendent of a child, sibling, parent, parent's ancestor (e.g., grandparent), step parent, niece, nephew, uncle, aunt, or in-law (son, daughter, father, mother, brother, sister).**

     In addition,
   - **The individual must receive more than 50% of his/her support from you.**
   - **The individual does not satisfy the requirements of qualifying child with respect to any individual.**
   - **The individual must be a citizen, national, or resident of the United States, or a resident of Canada or Mexico**.

   If during the year your dependent ceases to be a dependent, you must immediately discontinue the HRA for your dependent.

   Special rule for divorced parents-
   If both parents together provide more than 50% of his or her support, the individual can qualify as a dependent.

I -5. What benefits are offered through the HRA Plan?

While you are a Participant, the HRA Plan will maintain an "HRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible Health Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Eligible Health Care Expenses must first be submitted to and, if covered, reimbursed by any health insurance plan you participate in. Additionally, if you participate in an employer sponsored Medical Dental Expense Account (MDEA), you must submit your eligible Health Care Expenses for reimbursement by the MDEA plan before any benefits are payable from the HRA Plan. If you participate in the MnSCU HRA Plan, you will be reimbursed for your expenses after you have first exhausted your MDEA (if you have one) and State HRA balances. To the extent that your Health Care Expenses have been previously reimbursed by a health insurance plan, an MDEA plan, by this HRA Plan or the MnSCU Plan, they are not reimbursable through this Plan.

This HRA contribution will be made on a one time basis on January 1, 2009 until such time that it is determined that it will continue beyond that date.

The amount available for reimbursement of Health Care Expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

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 be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent period of coverage.

I -6. How will the HRA Plan Work?

The HRA Plan will reimburse you for eligible Health Care Expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- You will receive a debit card (the Benny ™ card) that you may use to pay for eligible expenses from funds in your HRA Account
- You may also submit a paper claim for reimbursement by completing a reimbursement request form, completing the form in its entirety, making sure to sign and date it. Attach a statement from the provider indicating the date the service was provided, a description of the service, and the charge for the service to the Claims Processing Administrator; To print a reimbursement request form, go to Eide Bailly's website: www.eidebaillybenefits.com/som.
- You can also enter your reimbursement request on the Eide Bailly website. After entering the reimbursement request online, follow the directions to fax or mail in your documentation by the deadline.
- A request for payment must relate to Health Care Expenses incurred during the time you were covered under this Plan; and
- A request for payment must be submitted by February 29, 2012 for expenses included during the 2011 calendar year. HRA balances will carry forward into the new year.

Claims must be submitted by using the debit card or in writing. The Claims Processing Administrator will require that Participants submit claims on a form provided by the Claims Processing Administrator. The claim must set forth:

- The person or persons on whose behalf the Health Care Expenses were incurred;
- The nature and date of the Health Care Expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such Health Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Medical-Dental Expense Account coverage, if any, for such Health Care Expenses has been exhausted.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party showing that the Health Care Expenses have been incurred and showing the amounts of such Health Care Expenses, along with any additional documentation that the Claims Processing Administrator may request. Generally, no paper claim for reimbursement can be made unless and until the aggregate claims for reimbursement total at least $50, although there is an exception made for the final reimbursement claim for a Plan Year. There is no minimum reimbursement amount for the using the debit card.

You must acquire and retain documentation for any expense used with the card (e.g. invoice and receipts) in case any questions should arise regarding the purchase and verification is needed.

If Eide Bailly Employee Benefits requires additional information regarding the debit card purchase, Eide Bailly will send you a letter requesting additional information. You will have 30 days to respond to Eide Bailly's request. If Eide Bailly receives no response from this first inquiry, a second notice will be sent to you. You will be given an additional 14 days to respond to Eide Bailly's second request. If you do not respond to this second request, your debit card will be de-activated. To have the card reactivated, you must respond to Eide Bailly's letter and supply the requested information.

If the requested information is not provided to Eide Bailly by the timeframes described above, you will need to repay the amount of that debit card transaction to your HRA account. If it is not repaid, the amount will be withheld from your paycheck. You can also submit a substitute claim to offset this amount.

Should you lose your card, if it is stolen or if you need additional cards for dependents, there will be a $10.00 replacement fee for two cards, deducted from your HRA account.

I-7 What happens if I have money left in my HRA account at the end of the year, will it carry forward into the next year?

If you have money left in your HRA account, the balance will carry forward into the next year.

I -8. Are there any limitations on benefits available from the HRA Plan?

Only Health Care Expenses are covered by the HRA Plan. A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible expenses are (a) copayments, deductibles, and coinsurance charges; (b) prescription and some over-the-counter drugs and medicines; (c) dental expenses; (d) dermatology; (e) physical therapy and (f) contact lenses or glasses used to correct a vision impairment. New Guidelines Effective January 1, 2011. Federal Health Care Reform has changed how and what type of over-the-counter (OTC) drugs can be reimbursed through the HRA.

The HRA will no longer reimburse for OTC medicine (except insulin) without a prescription. This change did not impact the eligibility for reimbursement of over the counter supplies (e.g. saline solution or bandages) and they continue to be eligible under the HRA.

The Claims Processing Administrator can provide you with more information about which expenses are eligible for reimbursement.

Some examples of expenses that are <u>not</u> eligible include the following:

- Premiums that a participant pays under any employer sponsored group plan, except that premiums for long term care insurance shall be reimbursable.
- COBRA or benefit continuation premiums that a Participant pays under any employee group plan.
- Premiums that a participant pays for disability insurance
- Parental fees
- 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 IRS Code § 213

I-9. How do I become a Participant?

If you meet the eligibility requirements described in Section I-3, you will automatically become a Participant.

I-10. What if I terminate my employment during the Plan Year?

If you terminate employment or retire, your participation in this Plan will continue until you spend down your account balance. If you have family coverage through the Advantage plan and you die, your spouse and dependents may spend down your account balance. If you have family coverage through the Advantage plan and you get a divorce

or have dependents that are no longer eligible, your ex-spouse or dependents may elect COBRA coverage as described in Section 1-9 below.

I-11. What is COBRA? If my spouse or dependent have a COBRA Qualifying Event, can they continue to participate in the HRA Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your spouse, or your children incur an event known as a "Qualifying Event," and if such person is covered under the HRA Plan, then the person incurring such event will be entitled under COBRA to elect to continue their coverage under the HRA Plan if they pay the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except under the application of COBRA rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your divorce or legal separation from your spouse;
- Your dependent child's ceasing to qualify as a dependent.

The length of COBRA continuation depends upon the qualifying event:

- When the qualifying event is the divorce or legal separation, or a dependent child losing eligibility as a dependent child, continuation lasts for up to 36 months.
- Your ex-spouse or dependents are responsible for informing the Plan Administrator of the COBRA qualifying event within 60 days after the qualifying event. Continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to continuation coverage arose and who continues to be disabled at the end of the 18 months.

If you elect COBRA continuation you will be charged a monthly premium to maintain your HRA benefit. A 2 percent surcharge may be added to each monthly contribution to help defray the administrative expenses. As part of the COBRA continuation, you will also be eligible to continue the HRA benefit in the plan year following your COBRA-qualifying event, with an HRA contribution made to your account by the State of Minnesota. You will then be eligible to submit claims during that year, as long as your COBRA payments remain current. If you fail to make a required

monthly payment, your COBRA continuation coverage will terminate and you will cease to be a Participant in the Plan.

I-12. Will I have any administrative costs under the HRA Plan?

If you have a balance in your 2009 HRA and you are not eligible to receive the 2011 HRA contribution, you will be charged a $2.65 monthly fee which will be deducted from your HRA

I-13. How long will the HRA Plan remain in effect?

The Employer is making a one-time contribution to the HRA Plan however, the future of the Plan depends to a certain extent upon the terms of the applicable collective bargaining agreement or compensation plan. The Employer reserves the right to amend the HRA Plan at any time and in any manner that it deems reasonable, in its sole discretion.

I-14. Are my benefits taxable?

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

I-15 My spouse has a High Deductible Health Plan (HDHP) and wants to contribute to a HSA. Is that allowable?

The State HRA is considered a Low Deductible Health Plan (LDHP). HSA rules require that in order to be eligible to contribute to an HSA, the individual cannot have any LDHP, including an HRA or MDEA. If your spouse has a HDHP you can elect to have your HRA or MDEA account be limited to dental, vision and preventative care expenses. This Limited HRA or Limited MDEA allows your spouse to still maintain HSA eligibility. If you want to change your HRA to a Limited HRA or MDEA or a Limited MDEA, contact Eide Bailly and complete the form to make this change. You can change your limited HRA or limited MDEA back to general purpose anytime during the year.

I-16. What happens if my claim for benefits is denied?

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the HRA Plan are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Claims Processing Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Claims Processing Administrator. The Claims Processing Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Claims Processing Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Claims Processing Administrator will make the decision based on the information that it has. This extended period of time to provide additional information on a claim does not apply to claims submitted during the run out period at the end of the plan year.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Claims Processing Administrator will include the following information:

- The specific reason for the denial;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the HRA Plan's review procedures and the time limits applicable to such procedures; and
- If the Claims Processing Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement

that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination. A copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to appeal the Claims Processing Administrator's denial of your claim.

D. What are the requirements of my appeal?

Your appeal must be in writing to the Plan Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Claims Processing Administrator's act or omission;
- The date of the notice that the Claims Processing Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claims Processing Administrator's act or omission.

You should also include any documentation that you have not already provided to the Claims Processing Administrator.

E. Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Plan Administrator within 180 days after the date of the denial notice or the Claims Processing Administrator's act or omission. *If you do not file your appeal within this 180-day period, you lose your right to appeal.* Your appeal will be heard and decided by the Benefit Plan Committee ("Committee") appointed by the Employer.

F. How will my appeal be reviewed?

Anytime before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the Plan Administrator. The HRA Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Plan Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim,

regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial determination made by the Claims Processing Administrator and will be conducted by a fiduciary of the HRA Plan who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination.

G. When will I be notified of the decision on my appeal?

The Committee must notify you of the decision on your appeal within 60 days after receipt of your request for review.

H. What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Committee will include the following information:

- The specific reason for the denial upon review;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination. A copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

No action may be brought against the Plan, the Employer, the Plan Administrator, or the Claims Processing Administrator until you first follow the above claim procedures and receive a final determination from the Plan Administrator.

I-17. Who is the Administrator?

The Employer is the Administrator and the named fiduciary for the HRA Plan.

PART II. ADMINISTRATIVE INFORMATION

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. The Plan Administrator's failure to enforce any provision of this Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents.

- Name of Plan: State of Minnesota 2009 Health Reimbursement Arrangement (HRA) Plan
- Sponsoring Employer: State of Minnesota
- Plan Administrator: State of Minnesota
- Contact Person: State of Minnesota
- Plan Administrator's Telephone Number: 651-355-0100
- Plan Year: January 1 through December 31
- Agent for Service of Process: Service may be made on the Administrator at this address: 400 Centennial Office Building, 658 Cedar Street, St. Paul, MN 55155
- The financial records of the HRA Plan are kept on a Plan Year basis. The Plan Year ends on each December 31.

Type of Plan: This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code § 105 and 106 and the regulations issued there under, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.

Type of Administration: The Administrator pays applicable benefits from the general assets of the Employer.

Funding: The HRA Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which benefits are paid.

PART III. HIPAA PRIVACY RIGHTS

Use and Disclosure of Protected Health Information

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization (see the definition of "PHI" in Part V). For additional information about your privacy rights, please either refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official: Contracts and Networks Manager, Employee Insurance Division, Minnesota Management and Budget

If you wish to authorize the HRA Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

Permitted Uses and Disclosures

The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official.

Disclosures to the Employer

After the Employer has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Employer without your authorization to the extent that the PHI is necessary for the Employer to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Employer than is necessary for the Employer to fulfill its administration functions, and the HRA Plan may not disclose PHI to the Employer for purposes of any employment

related actions or in connection with any other employee benefit provided by the Employer.

To the extent that your PHI is disclosed to the Employer, the Employer will:

- Not use or further disclose PHI other than as permitted or required by the official HRA Plan document or as required by law;
- Ensure that any agents to whom the Employer provides PHI received from the HRA Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- Not use or disclose PHI in connection with any other benefit provided by the Employer unless authorized by you;
- Report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI;
- Make PHI available to you in accordance with the requirements of the Privacy Rule;
- Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- Make internal practices, books, and records relating to the Employer's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the HRA Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the HRA Plan that the Employer still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

The Employer may only disclose your PHI to the following Employer employees and may only do so to the extent that the Employer employees perform HRA Plan administration functions:

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

If an Employer employee does not comply with the requirements of the Privacy Rule, then the Employer may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately.

PART IV. DEFINITIONS

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

- **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.
- **Claims Processing Administrator** ("CPA") means Eide Bailly LLP.
- **Committee.** The Benefit Plan Committee of the Employer, appointed by the Employer to decide appeals.
- **Dependent** means any individual who qualifies as an eligible dependent under the IRS Code 152 definition of dependent or is a child who has not attained age 27 by the end of the year . 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."

To be considered as a dependent under Section 152, the individual must be either a "qualifying child" or a "qualifying relative." A qualifying child is an individual who:

- Will be less than 19 years of age during the entire calendar year(s) in which coverage is provided; or
- Will be less than 24 years of age during the entire calendar year(s) in which coverage is provided and is a regular full-time student (for more information on full-time student status, see the attached page); or
- **Is permanently and totally disabled;**
- The individual resides with you.
- The individual provides 50% or less of his/her own support.
- The individual is one of the following:
    - your child (natural, stepchild, adopted child, or child placed for adoption); or
    - your sibling (brother, sister, stepbrother, or stepsister); or
    - a descendent of your child or sibling (e.g., grandchild, great grandchild, niece, nephew).
- The individual is a citizen, national, or resident of the United States, or a resident of Canada or Mexico. (Special rules apply to adopted children.)
- The individual is younger than you.

2. A Qualifying Relative is an individual who meets at least one of the following criteria:

- Resides with you and is part of your household; or

- Is related to you as your child, descendent of a child, sibling, parent, parent's ancestor (e.g., grandparent), stepparent, niece, nephew, uncle, aunt, or in-law (son, daughter, father, mother, brother, or sister).
- The individual receives more than 50% of his/her support from you.
- The individual does not satisfy the requirements of Qualifying child with respect to any individual.
- The individual is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

If during the year your dependent ceases to be a dependent, you must immediately discontinue requesting HRA reimbursement for your dependent.

- **Eligible Employee**. An individual is eligible to participate in this Plan if the individual satisfies the definition of an Employee in this Plan, and the eligibility conditions for the Minnesota Advantage Health Plan, the provisions of which are specifically incorporated herein by reference.
- **Employee.** An individual who is a) an active State of Minnesota employee, an under 65 retiree, a member of the Former Employees with Disabilities (FEWD) group, a COBRA participant, an Independent Billing Unit (IBU) em*p*loyee, or an employee on leave of absence, and , b) enrolled in the Minnesota Advantage Health Plan on January 1, 2009; or c) an individual on USERRA qualifying leave from a position satisfying clause a) or b) of this paragraph.
- **Employer.** State of Minnesota or its successor(s).
- **Health Care Expenses.** See Section 1-6 for a description of Health Care Expenses.
- **HRA Account**. The recordkeeping account established in your name by the Employer on the basis of which your eligible Health Care Expenses will be paid or reimbursed.
- **IBU.** This is an independent billing unit of the State covered by this plan.
- **Participant.** A person who is an Eligible Employee who becomes a Participant in the Plan in accordance with Section I-7.
- **PHI.** This generally includes all information, whether written or oral, in connection with the HRA Plan that (1) is created or received by the HRA Plan; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you.

- **Plan.** The State of Minnesota Health Reimbursement Arrangement (HRA) Plan set forth herein and as amended or restated from time to time.
- **Plan Administrator** State of Minnesota, Minnesota Management & Budget
- **Plan Year.** 12-month period ending on December 31.
- **Privacy Rule**. The regulations that were issued by the Department of Health and Human Services in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- **Spouse.** 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).

PART V. MISCELLANEOUS

EFFECT OF PLAN ON YOUR EMPLOYMENT RIGHTS

The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document. The Plan is not a contract of employment between you and the Employer.

PROHIBITION AGAINST ASSIGNMENT OF BENEFITS

No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

OVERPAYMENTS OR ERRORS

If it is later determined that you and/or your Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan.

If you do not refund the overpayment or erroneous payment, the HRA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

NOTICE OF PRIVACY PRACTICES
for the
STATE OF MINNESOTA 2011 HRA PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE EFFECTIVE DATE OF THIS NOTICE IS JANUARY 1, 2011.

Introduction

Under the federal Medical Data Privacy Regulations, or "Privacy Regulations," the State of Minnesota Pre-Tax Plan (the health flexible spending account) is required to give you this NOTICE OF PRIVACY PRACTICES which tells you about how the Plan protects the privacy of your health information and your rights under the new Privacy Regulations. (The Privacy Regulations can be found at 45 *Code of Federal Regulations* Parts 160 and 164.)

The Privacy Regulations govern the use and disclosure of your individually identifiable health information that is transmitted or maintained by the Plan. This is called "Protected Health Information" or "PHI" under the Regulations.

1. When the Plan Uses and Discloses Your PHI

A. Uses and Disclosures Required by the Privacy Regulations

The Plan is required to give you access to certain PHI if you ask so you can inspect and copy it.

The Plan is required to release your PHI to the Secretary of the federal Department of Health and Human Services to review the Plan's compliance with the Privacy Regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations.

The Plan and its "business associates" have the right to and will use PHI without your consent, authorization, or opportunity to agree or object so the Plan can carry out "treatment, payment, and health care operations." **The Plan can also disclose PHI to the Plan Sponsor and to certain agents of the Plan Sponsor (e.g., staff members of the Employee Insurance Division of the Management and Budget Department in the Enrollment and Billing, Benefits Services, or Purchasing Units).** The Plan Document has been amended to protect your PHI as required by federal law.

A health flexible spending account is involved with the reimbursement of plan participants' unreimbursed medical and dental expenses. PHI can be disclosed by the business associate to the Plan Sponsor for such purposes.

C. Uses and Disclosures that Require Your Written Authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist.

Your authorization will also generally be obtained before the Plan will release your PHI to persons not specifically authorized to receive the information under the Privacy Regulations, such as your spouse. When your authorization is required for a release of your PHI, you will also have the right to revoke the authorization at any time.

D. Uses and Disclosures that Require that You Have an Opportunity to Agree or Disagree before the Information is Used or Released.

The Plan can disclose your PHI to family members, other relatives and your close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for that care; and you have either agreed to the disclosures or have been given an opportunity to object and have not objected.

E. Other Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required.

The Plan can use and disclose your PHI without your consent, authorization or request under the following circumstances; however, as a general rule the Plan will release PHI in these situations only when necessary to protect a person's health or safety:

1) When required by law, such as releases to the Secretary of Health and Human Services.
2) When permitted for purposes of public health activities, including when necessary to report if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.
3) To report information about abuse, neglect or domestic violence to public authorities.
4) To a public health oversight agency for oversight activities such as civil, administrative or criminal investigations; inspections; licensing or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5) When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
6) When required for law enforcement purposes (for example, to report certain types of wounds).
7) For other law enforcement purposes, including identifying or locating a suspect, fugitive, material witness or missing person.
8) To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Disclosure is also permitted to funeral directors, as necessary to carry out their duties with respect to the decedent.
9) For research, subject to certain conditions.
10) To prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
11) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

2. Your Rights

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

These requests should be made to the Plan's "Contact Person" listed at the end of this Notice.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

Designated Record Set includes your medical records and billing records maintained by or for a covered health care provider; enrollment, payment, billing, and claims adjudication; or other information used in whole or in part by or for the Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan's Contact Person.

If the Plan denies you access, you or your personal representative will be provided with a written denial stating the basis for the denial, a description of how you can exercise those review rights and a description of how you can complain to the Secretary of the U.S. Department of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set as long as the PHI is maintained in the designated record set. The request must be made in writing and must provide your reasons supporting your request.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan cannot comply with the deadline. If the request is denied in whole or part, the Plan will provide you with a written denial that explains the basis for

the denial. You or your personal representative can then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests to amend your PHI in a designated record set should be made to the Plan's Contact Person at the Plan Administrator's office. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

D. The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also give you an accounting of the Plan's disclosures of your PHI during the six years prior to the date of your request. However, the accounting need not include PHI disclosures made (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Plan gives you a written statement about the reasons for the delay and the date by which accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each additional accounting.

E. The Right to Receive a Paper Copy of This Notice Upon Request.

Please contact the Plan's Contact Person at the Plan Administrator's office to receive a paper copy of this Notice.

F. Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of this authority may take one of the following forms: (1) a power of attorney for health care purposes notarized by a notary public; (2) a court order of appointment of the person as the conservator or guardian of the individual; or (3) an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2003, and the Plan is required to comply with the terms of this notice. The Plan, however, reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan before that date. If a privacy

practice is changed, a revised version of this notice will be provided by mail to all past and present covered persons for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

A. Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

This minimum necessary standard will not apply in the following situations:

1) disclosures to or requests by a health care provider for treatment;
2) disclosures made to the Secretary of the U.S. Department of Health and Human Services;
3) uses or disclosures that are required by law; and
4) uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe the information can be used to identify an individual. In other words, if the information is de-identified, it is not individually identifiable health information and, therefore, not PHI.

The Plan can also use or disclose "summary health information" to the Plan Sponsor for modifying, amending or terminating the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals and from which identifying information has been deleted in accordance with the Privacy Regulations.

4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan's Contact Person. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

5. Whom to Contact for More Information

If you have any questions, please contact the Plan's Contact Person, Mary Regnier, Minnesota Management & Budget Department. The address is 658 Cedar Street, St. Paul, MN 55155, and the telephone number is 651-355-0100.

Conclusion

PHI uses and disclosures by the Plan are regulated by the federal HIPAA law. This notice attempts to summarize the Privacy Regulations. The Privacy Regulations will supersede any discrepancy between the information in this notice and the regulations.