SUMMARY DESCRIPTION
OF THE
CITY OF MINNEAPOLIS
MINNEFLEX PLAN

Effective January 1, 2017

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INTRODUCTION

The City of Minneapolis Minneflex Plan (the "Plan") provides you with the opportunity to pay certain benefit costs with pre-tax dollars. This means that your premiums (or other contributions) are deducted from your pay before Social Security and income taxes care calculated.

Please Note: The City of Minneapolis has authorized the adoption of this Plan by the Municipal Building Commission, the Minneapolis Park and Recreation Board, the Minneapolis Board of Estimate and Taxation and the Minneapolis Youth Coordinating Board. These boards and agencies are also referred to as Employer throughout this document.

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

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

If you have questions after reading the summary, please contact:

City of Minneapolis Benefits Office
Room 100, 250 South Fourth Street
Minneapolis, MN 55415
Phone number: 612-673-3333
Email: benefits@minneapolismn.gov

PART I.
GENERAL INFORMATION ABOUT THE PLAN

1.1 What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay their share of the cost of coverage for various benefits with pre-tax dollars.

1.2 What benefits are offered through the Plan?

This Plan makes the following optional benefits available:

- Medical benefits
- Dental benefits
- Group life insurance benefits
- Dependent care expense reimbursement benefits
- Medical expense reimbursement benefits

The Plan allows you to pay your share of the cost for **medical, dental and group life insurance** benefits under with pre-tax dollars through salary reduction.

The City of Minneapolis Dependent Care Expense Reimbursement Plan allows a Participant to fund an account with pre-tax dollars through salary reduction that may be used to reimburse the Participant for eligible dependent care expenses.

The City of Minneapolis Medical Expense Reimbursement Plan allows a Participant to fund an account with pre-tax dollars through salary reduction which may be used to reimburse the Participant for eligible medical expenses.

1.3 Who can participate in the Plan?

Only "Eligible Employees" may participate. If the policy or collective bargaining agreement governing your employment provides for coverage under this Plan, you will be eligible to participate in the Plan. Eligible Employees who actually participate in the Plan are called "Participants." There are certain exceptions. They are described in the underlying Plan document. You will be notified if you fall within one of the exceptions.

"**Employee**" means a common-law employee of the Employer who is on the Employer's W-2 payroll. The term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for certain benefits after an employee ceases to be employed by the Employer.

1.4 How do I become a Participant and how long does participation last?

Eligible Employees are generally eligible to participate in the Plan on the first day of the month following 30 days of employment. Waiting periods and participation start dates can be found in the policy or collective bargaining agreement governing your employment. To become a Participant, you must enroll within the time period established and communicated to you by the Plan Administrator.

"Plan Administrator" means the City of Minneapolis unless the City designates a person or persons other than the City to be the Plan Administrator. **The City may from time to time retain "Claims Administrators" to administer all or a portion of the Plan. The Claims Administrators are listed in Part VI of this summary.**

As a condition to participation in the Plan, you must also:

(1) Observe all Plan rules and regulations;

(2) Agree to inquiries by the Claims Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by this Plan;

(3) Submit to the Claims Administrator all notifications, reports, bills, and other information that the Employer may reasonably require; and

(4) Agree to repay any overpayments or incorrect payments you receive from the Plan.

Participation continues in the medical, dental and group term life portions of this Plan until you elect not to participate, you are no longer an Eligible Employee, your contributions cease, or the Plan terminates.

Participation continues in the medical expense reimbursement plan and dependent care expense reimbursement plan until you fail to make an election during the open enrollment period, elect not to participate, you are no longer an Eligible Employee, your contributions cease, or the Plan terminates.

1.5 What is open enrollment?

After the initial enrollment period described above, you may enroll or make changes to your benefit elections annually during open enrollment. The annual open enrollment period is typically held during the first three weeks of November with changes effective the following January 1st. You will be notified in advance regarding the timing of the open enrollment period, the costs of the various benefits and the procedures for making enrollment or election changes.

If you do not make an election during the annual open enrollment period, your then current elections for medical, dental and life insurance coverage will continue into the next Plan Year. You must make a new election each year to continue participation in the Dependent Care Expense Reimbursement Plan and the Medical Expense Reimbursement Plan.

NOTE: Open enrollment forms received after the start of the Plan Year will not be accepted.

1.6 Can I change my election during the Plan Year?

Generally, you cannot change your benefit plan elections during the Plan Year. You may change your elections only during the annual open enrollment period, and then, only for the coming Plan Year. There are several exceptions to this general rule. The exceptions to the general rule are determined under regulations issued by the IRS.

You may change or revoke your previous election during the Plan Year if one or more of the following changes in status occur:

- Change in legal marital status, including marriage, divorce, legal separation or annulment;
- Change in number of dependents;
- Termination or commencement of employment by you, your spouse or your dependent;
- A reduction or increase in hours worked by you, your spouse or your dependent including, but not limited to, a switch between part-time and full-time;

- A dependent satisfies or ceases to satisfy the plan requirements for unmarried dependents such as age limitations; or
- A change in place of residence or work for you, your spouse or your dependent.

If a change in status occurs, you must inform the Plan Administrator of the change within 30 days of the event. Your election change must be on account of and consistent with the status change.

In addition, you may be able to change your election mid-Plan Year due to the following:

- If the cost of a benefit significantly increases, or if coverage under certain of the optional benefits is significantly reduced or terminated, you may be able to make a corresponding change to your election or to elect coverage under a similar optional benefit.

- If you, your spouse, or new dependent child enrolls in the group health plan due to a "special enrollment," you may be able to make a corresponding change in your election.

- If a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody addresses accident or health coverage for your dependent child, you may be able to make a corresponding change in your election.

- Under certain circumstances, if the employer of your spouse or dependent changes the coverage it provides, you may be able to make a corresponding change in your election.

The Plan Administrator may modify your election downward during the Plan Year if you are a member of the "highly paid" group of employees (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of federal income tax law. In addition or as an alternative, the Plan Administrator may recharacterize some of your benefits as taxable income if necessary to prevent the Plan from becoming discriminatory within the meaning of federal income tax law.

1.7 Who holds the funds I have set aside under the Plan?

The funds you contribute to pay your portion of the cost of benefit plan coverage are held by the Employer until the Employer pays for such coverage. The funds you contribute by means of salary reduction to reimburse eligible medical expenses and eligible dependent care expenses are also held by the Employer until paid to you as a reimbursement. All payments are made from the general assets of the Employer. There is no separate trust.

1.8 What if I terminate my employment during the Plan Year?

If your employment with the Employer terminates during the Plan Year, your active participation in this Plan ceases. You will not be able to participate in this Plan, other than as permitted under the continuation provisions that apply to group health plan coverages.

1.9 Will I have any administrative costs under the Plan?

No. The entire cost of administering the Plan is paid by the Employer, from Plan forfeitures, or a combination of both.

1.10 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan (including each of the optional benefits) indefinitely, it has the right to amend or terminate the Plan in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended or terminated accordingly. You will be informed if any changes are made to the Plan.

1.11 Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are intended to not be currently taxable to you. However, the City cannot guarantee the tax treatment to any Participant, as individual circumstances may produce differing results. If you are uncertain, you should consult your own tax adviser.

You should realize that any medical expense you pay or are reimbursed on a pre-tax basis under this Plan cannot be claimed as a medical expense deduction on your income tax return.

Any reimbursements made with pre-tax dollars for dependent care expenses affect your ability to claim the dependent care credit. This is explained further in the description of the Dependent Care Expense Reimbursement Plan later in this summary.

1.12 What is the impact on my Social Security benefits?

Your contributions to the Plan reduce the amount of pay that is subject to Social Security taxes. Because less Social Security taxes are withheld from your pay, your Social Security benefits may be affected at your retirement. However, contributions to the Plan usually have a minimal affect on your Social Security benefits.

1.13 How are claims determined?

NOTE: This claims procedure only covers issues related to the Dependent Care Expense Reimbursement Plan and Medical Expense Reimbursement Plan. Claims for other benefits (e.g., medical, dental, and group life insurance plans) are handled through the claims procedures in those separate plans.

Claim Submission. A claim for benefits must be made in writing and submitted to the Claims Administrator, SelectAccount.

Benefits Denials. The Claims Administrator will decide your claim within a reasonable time not longer than 30 days after it is received. If your claim is denied, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

1. the specific reason or reasons for the denial, and

2. a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary.

PART II.
DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

The Plan permits you to elect to receive reimbursement for some work-related dependent care expenses under the Dependent Care Expense Reimbursement Plan ("DC Plan"). Under the DC Plan, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses.

2.1 How do I become a Participant?

You become a Participant in the DC Plan by electing benefits during the initial or annual open enrollment periods.

2.2 What is my dependent care account?

If you elect benefits under the DC Plan, a dependent care account ("DC Account") will be established in your name to keep a record of your benefits. When you complete an election form, you specify the amount of benefits you wish to pay with your salary reduction.. Coincident with the first two paydays of each month, an amount equal to your salary reduction for that payroll period will be credited to your DC Account.

For example, suppose your annual election is $2, 400 for eligible dependent care expenses. You would have a $100 credited to your DC Account on the first two paydays each month to pay benefits under the DC Plan.

The amount that is available in your DC Account at any particular time will be whatever has been credited to such DC Account less any reimbursements for Eligible Expenses.

The DC Account is a bookkeeping account only. The Employer pays benefits under the DC Plan from its general assets. There is no trust.

2.3 What are the maximum benefits I may receive?

The maximum benefit you may receive in a calendar year is $5,000 if you:

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the DC Plan, your spouse maintains a separate residence for the last six (6) months of the calendar year, and you file a separate tax return; or
- are single, or a head of household for tax purposes.

This maximum is reduced if any of the following situations exist:

- if you are married and reside with your spouse, but file separate tax returns, the maximum is reduced to $2,500; or
- if you or your spouse have earned income less than $5,000 per tax year, the maximum is reduced to the lesser of your earned income or your spouse's earned income.

NOTE: ***The maximum is a combined maximum***. If your spouse has a dependent care program available through his or her employer, the combined total under that program and this DC Plan is the maximum described above per tax year. ***It is your responsibility to monitor your combined maximum.***

2.4 Who is a "Qualifying Individual" for whom I can claim a reimbursement?

NOTE: The rules are not the same as the tax deduction or exemption rules. It is your responsibility to determine whether you can request reimbursement for expenses incurred with respect to a particular individual. If you enroll for dependent care benefits, it will be assumed that you are *the person* entitled to treat the child as a "qualifying individual" for purposes of reimbursement under the DC Plan.

You may be reimbursed for Eligible Expenses incurred on behalf of any individual who is either:

(a) your "child" who is under age thirteen (13);

(b) your dependent, if your dependent is mentally or physically unable to care for himself or herself and has the same principal place of abode as you for at least one-half of the year; or

(c) your spouse, if your spouse is physically or mentally incapacitated and has the same principal place of abode as you for at least one-half of the year.

"***Child***" generally includes your son, daughter, stepson, stepdaughter, eligible foster child, brother, sister, stepbrother, stepsister, or a descendant of any such person, who resides with you for at least one-half of the year, and does not provide over half of his/her own support during the year.

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

Situations where both people are the child's parents who do not file a joint return (e.g., divorce or separation). In general, the parent who has custody for the longest period during the calendar year (i.e., the "custodial" parent) is entitled to receive reimbursement for dependent care expenses. This is true even though the non-custodial parent may be allowed to receive the child tax credit and the dependency exemption for the child on their federal income tax return. However, if the custodial parent does not claim the child as a qualifying child for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the non-custodial parent may receive reimbursement for dependent care expenses under a dependent care expense reimbursement program.

Situations where only one or none of the people are the child's parent. If one person is the child's parent and the other is not, the child is the qualifying individual of the parent and the parent may receive reimbursement for the child's dependent care expenses. If neither person is the child's parent, the person with the highest adjusted gross income for the year in question may receive reimbursement for dependent care expenses. However, in both cases, if the person otherwise entitled to claim the child as a qualifying individual does not claim the child as a qualifying child for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the other person may do so and receive reimbursement for dependent care expenses under the DC Plan.

2.5 What is an "Eligible Expense"?

(a) **General Rule—Covered**. An "Eligible Expense" generally means expenses for the care of a Qualifying Individual incurred by you (or your spouse) to enable you (and your spouse) to be gainfully employed. If you are married, your spouse must be working, seeking employment, be a full-time student or be mentally or physically incapable of self-care.

Eligible Expenses generally include:

- Day care expenses;
- Cost of nursery school, preschool, or similar programs below the level of kindergarten;
- Cost of after-school care (including care for Qualifying Individuals in kindergarten and beyond);
- Cost of day camp, including specialty day camp;
- Cost of transportation provided by a care provider;
- Meals incidental to and inseparable from care;
- Employment taxes paid on behalf of a care provider;
- Cost of room and board provided to a care provider; or
- Certain indirect expenses, such as application and agency fees, if they must be paid to obtain the care.

(b) **General Rule—Not Covered**. The following are examples of expenses that are not eligible for reimbursement under the DC Plan:

- Education expenses
- Transportation expenses
- Miscellaneous household expenses (cost of food or clothing)
- Amounts paid for services provided by any person whom you or your spouse can claim as a dependent on your tax return, or by any relative who is under age 19
- Expenses either before your participation starts or after the end of the applicable Plan Year

(c) **Daily Allocation**. Usually, expenses must be allocated on a daily basis so that expenses incurred on a day you (or your spouse) were not at work may not be reimbursed.

Special Rule. If you pay for care on at least a weekly basis, without deduction for days on which care is not provided, you are not required to allocate expenses for short, temporary absences from work, such as vacations and sick days. You are also not required to allocate expenses on a daily basis if you (or your spouse) work on a part-time basis and you pay for care on at least a weekly basis without deduction for days on which care is not provided.

2.6 How do I receive my benefits under the DC Plan?

When you incur an expense that is eligible for payment, you submit a claim for benefits to the Claims Administrator. The claim form will typically include: (i) the amount, date and nature of the expense, (ii) the name of the person or entity to which the expense was paid, (iii) your statement that the expense has not been reimbursed or is not reimbursable through any other source, and (iv) other information the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim.

If there are enough dollars credited to your DC Account, you will be reimbursed for your Eligible Expenses at least bi-weekly according to the schedule established by the Claims Administrator. Reimbursements are paid by separate check or, if you elect, by direct deposit to your checking or savings account.

You cannot be reimbursed for any expenses above your ***available*** DC Account balance. If your claim was for an amount that was more than your current DC Account balance, the excess part of the claim will be carried over into following months, to be paid as your balance becomes adequate. You also cannot be reimbursed for any expenses that arise before you become a Participant in the DC Plan or for any expenses incurred after the close of the Plan Year.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

You may submit claims by mail, fax, email, or online. You may access account information –benefit payment services, claims history, direct deposit instructions, etc. – on the Member Online Service Center at selectaccount.com.

Claims Run-out Period: You may submit claims for Eligible Expenses incurred during the Plan Year until April 15th following the end of such Plan Year.

2.7 Will I be taxed on the DC Plan benefits I receive?

You will not normally be taxed on benefits under the DC Plan. However to qualify for tax-free treatment, you will be required to file IRS Form 2441 or a similar form with a list of names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you claimed a tax-free reimbursement.

2.8 If I participate in the DC Plan, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may choose to participate in the DC Plan and receive credit on your federal income tax return too. However, the tax credit and the DC Account cannot be used for the same expenses. (The household and dependent care credit is an allowance for a percentage of your annual eligible dependent care expenses as a credit against your federal income tax.) In addition, the amount of the household and dependent care credit is reduced dollar for dollar by the amount you put into your DC Account.

In certain cases, it may be more beneficial for you to claim a tax credit for your dependent care expenses rather than pay for those expenses through the DC Account. You may want to consult your tax advisor to determine the option that is best for you.

2.9 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the DC Plan, you may not make any further contributions to your DC Account. However, you may continue to submit claims for Eligible Expenses for a Qualifying Individual (as described in Sections 3.4 and 3.5) incurred during the Plan Year in which you ceased to be a Participant. Claims may be submitted until the earlier of: (i) the date your DC Account reaches zero, or (ii) the April 15th following the end of the Plan Year.

2.10 What if the dependent care expenses I incur during the Plan Year are less than the annual benefit I have elected?

Any amounts remaining in your DC Account after payment of all Eligible Expenses will be forfeited following the claims run-out period described in Section 2.6.

PART III.
MEDICAL EXPENSE REIMBURSEMENT PLAN

The Plan permits you to elect to receive reimbursement for some or all of your uninsured medical and dental expenses under the Medical Expense Reimbursement Plan ("ME Plan"). Under the ME Plan, you provide a source of pre-tax dollars by entering into a salary reduction agreement with your Employer. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. The coverage provided through the ME Plan is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3.1 How do I become a Participant?

You become a Participant in the ME Plan by electing benefits during your initial or subsequent annual open enrollment periods.

3.2 What is my medical expense account?

If you elect benefits under the ME Plan, a medical expense account ("ME Account") will be established in your name to keep a record of your benefits. When you complete an election form, you specify the amount of benefits you wish to pay with your salary reduction. The full amount of your election under the ME Plan will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the ME Plan received during the Plan Year.

The ME Account is a bookkeeping account only. Benefits under the ME Plan are paid from the Employer's general assets. There is no trust.

3.3 What are the maximum benefits I may receive?

For calendar year 2017, the maximum amount you may contribute is $2,600. The annual limit is established by federal law and may change in the future.

3.4 What if I am no longer eligible?

If your employment terminates, or you otherwise cease to be eligible for coverage under the ME Plan, your benefits under the ME Plan stop. You may, however, continue to submit claims for expenses incurred before you terminated or otherwise ceased to be eligible for coverage until the April 15th following the end of the Plan Year.

3.5 Can coverage be continued?

If you terminate employment, or otherwise cease to be eligible for coverage under the ME, you and any others who receive their coverage through you ***may*** be able to continue that coverage. These continuation rights are described in Section X of this summary.

3.6 What is an "Eligible Expense"?

(a) **Generally**. An "Eligible Expense" means an expense incurred during the applicable Plan Year by a Participant, Spouse, Child or Dependent for medical care as defined by Section 213 of the Internal Revenue Code. Medical care generally refers to the diagnosis, cure, treatment, or prevention of disease or for the purpose of affecting any structure of the body. An eligible expense generally includes any item for which you could have claimed a medical expense deduction on an itemized federal income tax return and for which you have not otherwise been reimbursed from health coverage, or some other source.

> **NOTE**: This includes expenses incurred by (i) your spouse, (ii) your biological child, step child, adopted child (including a child placed for adoption) or foster child provided the child will not reach age 27 as of the end of the current calendar year or (iii) your "tax dependent." A "tax dependent" for federal taxation purposes is an individual who qualifies as your dependent for purposes of Section 105 and 106 of the Internal Revenue Code as clarified in Revenue Procedure 2008-48. For state taxation purposes, a "tax dependent" means in individual who qualifies as your dependents as defined in the Internal Revenue Code incorporated into Minnesota Statutes, section 290.01, Subd 19.

(b) **Exceptions**. Despite the general rule stated above:

- An Eligible Expense ***does not*** include expenses for qualified long term care coverage; or, an expense incurred for the payment of premiums under any group or individual health plan.

- An Eligible Expense ***does not*** include the cost of providing residential services to a child with mental retardation, a physical disability, or an emotional disturbance in a facility licensed by the state.

- An Eligible Expense ***does*** include over-the-counter medical equipment and supplies, insulin, and over-the-counter medicines or drugs provided the over-the-counter drugs or medicines or drugs are prescribed and medical items for which a tax deduction is not available.

> **CAUTION**: IRS Publication 502 addresses medical care expenses a person may deduct on his or her income taxes. Many, ***but not all***, expenses that are tax deductible are also reimbursable under the ME Plan.

If you have questions regarding Eligible Expenses, you should contactSelectAccount at 800-859-2144.

3.7 How do I receive my benefits under the ME Plan?

When you incur an expense that is eligible for payment, you submit a claim for benefits toSelectAccount. The claim form will include: (i) the amount, date and nature of the expense, (ii) the name of the person or entity to which the expense was paid, (iii) your statement that the expense has not been reimbursed or is not reimbursable through any other source, and (iv) other information the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim.

If there are enough dollars credited to your ME Plan, you will be reimbursed for your Eligible Expenses at least bi-weekly according to the schedule established by the Claims Administrator. Reimbursements are paid by separate check or, if you so elect, by direct deposit to your checking or savings account.

Remember, you cannot be reimbursed for any expenses above the amount of your election. You also cannot be reimbursed for any expenses that arise before you become a Participant in the ME Plan or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the ME Plan, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

You may submit claims by mail, fax, email, or online. You may access account information –benefit payment services, claims history, direct deposit instructions, etc. – on the Member Online Service Center at selectaccount.com.

Claims Run-out Period: You may submit claims for Eligible Expenses incurred during the Plan Year by April 15th following the end of such Plan Year.

In lieu of the reimbursement process above, participants may use a **debit card** to pay for health care expenses. Each Minneflex health care spending account participant will receive a Health Care Card. The annual pre-tax amount designated by the employee will be pre-loaded onto the debit card. The use of the debit card eliminates the need for you to first pay for the expense and then request reimbursement. The debit card draws funds directly from your flexible spending account, thus improving cash flow.

3.8 Will using my debit card eliminate the need to provide copies of receipts for health care expenses?

No. Flexible spending accounts are governed by federal law and there are very specific rules regarding payments from these accounts. Among the rules is the requirement that each expense paid from a flexible spending account have third party documentation to verify the eligibility of the expense. Unless you purchase items at a merchant that uses the IRS-approved Inventory Information Approval System (IIAS), you will be asked by SelectAccount to provide copies of itemized receipts to verify the health care purchases you make with your debit card.

3.9 Can I use my debit card to purchase over-the-counter medicines or drugs?

No, you may no longer use your health care debit card to purchase over-the-counter medicines or drugs. You must purchase these items by paying for them yourself. Then, you can submit a claim, a receipt and a copy of your doctor's prescription to SelectAccount.

3.10 What if the Eligible Expenses I incur during the Plan Year are less than the annual benefit I elected?

Amounts greater than $25 but less than or equal to $500 that are remaining in your ME Account after payment of all Eligible Expenses for the Plan Year will be carried over to the next Plan Year following the claims run-out period described in section 3.7. Amounts less than $25 or greater than $500 remaining in your account after payment of all Eligible Expenses will be forfeited following the claims run-out period described in section 3.7.

PART IV.
CONTINUATION COVERAGE

A Participant, and any others who are covered through that Participant, ***may*** elect to continue coverage under the City of Minneapolis Medical Plan, City of Minneapolis Dental Plan, and City of Minneapolis

Medical Expense Reimbursement Plan (hereinafter referred to as the "Health Plans") in accordance with COBRA, PHSA, USERRA, and applicable state continuation laws.

4.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as it applies to State governmental entities through the Public Health Services Act ("PHSA") requires most employers with 20 or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. At the end of the maximum coverage period (described below), individual conversion coverage will be offered if it is otherwise available under the Plan.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of the law. It is intended that no greater rights be provided than those required by this law. It does not fully describe your continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the COBRA Administrator.

This notice covers the following group health plan(s) sponsored by your Employer:

- City of Minneapolis Medical Plan;
- City of Minneapolis Dental Plan; and
- City of Minneapolis Medical Expense Reimbursement Plan.

Each person covered under the Plan(s) should read this notice carefully.

Qualifying Events. Upon the commencement of a "qualifying event" each person that loses coverage may have rights as a "qualified beneficiary."

Qualifying event. A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the group health plan.

Qualifying beneficiary. A qualified beneficiary is the employee, employee's spouse and/or employee's dependent children who on the day before the qualifying event was covered under the group health plan. A spouse whose coverage was reduced or terminated in anticipation of divorce is also a qualified beneficiary. In addition, a child born to or placed for adoption with a qualified beneficiary ***who was the employee*** is a qualified beneficiary is if he or she was covered under the group health plan on the day before the qualifying event. Furthermore, an individual for whom the employee must provided coverage under the group health plan pursuant to a medical child support order is a qualified beneficiary.

Employee Loss. If covered by any of the group health plans described above, the employee has the right to elect continuation coverage if he or she loses coverage under such plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.

Spouse's Loss. If covered by any of the group health plans described above, a spouse has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

- the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

- the employee's death; or
- divorce or legal separation from the employee.

> **NOTE**: If an employee eliminates coverage for his or her spouse from coverage in anticipation of a divorce of legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

Dependent Child's Loss. If covered by any of the group health plans described above, a dependent child has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

- the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;
- the employee's death;
- divorce or legal separation of the employee and the child's other parent; or
- the child ceasing to be a dependent child under the terms of the plan.

Employer's Bankruptcy. Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the employer commences a Chapter 11 bankruptcy proceeding.

Responsibility to Notify. In certain circumstances, you are required to provide notification to the Plan in order to protect your rights under COBRA.

Notice of Qualifying Event. Under the law, the employee or a family member (or a representative acting on behalf of the employee or a family member) has the responsibility to inform the COBRA Administrator of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the latest of: (1) the date of the qualifying event; (2) the date coverage would be lost because of the qualifying event; or (3) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be provided in writing and be mailed to the COBRA Administrator at the address identified below. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event;
(4) include a detailed description of the event;
(5) identify the effective date of the event; and
(6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

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

Notice of Second Qualifying Event. In addition, the employee or a family member (of a representative acting on behalf of the employee or family member) must notify the Plan of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

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

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

Notice of Disability. Also, an employee or a family member (or a representative acting on behalf of the employee or a family member) must notify the COBRA Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (1) the date of the disability determination; (2) the date of the qualifying event; (3) the date coverage would be lost because of the qualifying event; or (4) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. (Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.) The notice must be provided in writing and be mailed to the COBRA Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
(4) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;
(5) state the name of the disabled qualified beneficiary;
(6) identify the date upon which the disabled qualified beneficiary became disabled;
(7) identify the date upon which the Social Security Administration made its determination of disability; and

(8) include a copy of the determination of the Social Security Administration.

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

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the COBRA Administrator of that determination within thirty (30) days of the later of: (1) the date of such determination; or (2) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be in writing and be mailed to the COBRA Administrator at the address identified below. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

Failure to provide timely notification of a qualifying event ends the right to COBRA continuation coverage.

Election Rights. When a qualifying event occurs, or when the COBRA Administrator is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the COBRA Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Because the Employer and the Plan Administrator are the same entity, the COBRA Administrator has forty-four (44) days to provide the option to elect COBRA coverage. Under the law, qualified beneficiaries have at least sixty (60) days to elect continuation coverage measured from the later of (1) the date coverage would be lost because of a qualified event, or (2) the date a notice of election rights is provided. An election is considered "made" on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under the Plan ends.

NOTE: Each qualified beneficiary has an independent right to elect continuation coverage. Employees and spouses (if the spouse is a qualified beneficiary) may elect continuation coverage on behalf of all qualified beneficiaries and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

NOTE: Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered by Medicare effective on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if he or she first becomes covered by Medicare effective after the date on which COBRA is elected.

Duration. The law requires that qualified beneficiaries generally be allowed to maintain continuation coverage as follows:

Eighteen (18) Months. If the qualifying event is the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date coverage would otherwise be lost because of the qualifying event.

Disability Extension. For qualified beneficiaries receiving continuation coverage because of the employee's termination or reduction in hours, the continuation period may be extended eleven (11) months, for a total maximum of twenty-nine (29) months where a qualified beneficiary receives a determination

under the Social Security Act that at the time of the employee's termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

Pre-Qualifying Event Medicare Extension. The eighteen (18) month continuation period may be extended if the employee became entitled to (actually covered under) Medicare prior to the employee's termination of employment (other than for gross misconduct) or a reduction in hours. Qualified beneficiaries other than the employee are entitled to the greater of (1) eighteen (18) months measured from the qualifying event, or (2) thirty-six (36) months measured from the date of the employee's Medicare entitlement.

Thirty-Six (36) Months. For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is thirty-six (36) months measured from the date of the date coverage would otherwise be lost because of the qualifying event.

Second Qualifying Events. If during the initial eighteen (18) month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second qualifying event occurs (e.g., divorce or legal separation, death of employee, loss of dependent status) that would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred, the continuation period for the particular qualified beneficiaries affected by the second qualifying event may be extended to thirty-six (36) months.

Under no circumstances may the total continuation period be greater than thirty-six (36) months from the date coverage would otherwise be lost because of the original qualifying event that triggered the continuation coverage.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees or family members that have not experienced a qualifying event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will apply to those who have elected COBRA.

Cost. A person electing continuation coverage may have to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the plan of providing the coverage. The amount may be increased to 150% for the months after the eighteenth (18^{th}) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

Premature Ending. The law provides that continuation coverage shall automatically end for any of the following reasons:

- the Employer no longer provides group health coverage to any of its employees;
- the premium for continuation coverage is not paid on time (including any applicable grace period);
- after electing COBRA, the qualified beneficiary becomes covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any applicable pre-existing condition that you have;

NOTE: Under HIPAA, an exclusion or limitation of the other group health plan might not apply at all, depending on the length of the qualified beneficiary's creditable coverage prior to enrolling

in the other group health plan. If the other plan has applicable exclusions or limitations, then COBRA coverage terminates after the exclusion or limitation no longer applies (for example, after a twelve (12) month pre-existing condition waiting period expires).

- after electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare;

Notice Obligation: The employee or a family member must notify the COBRA Administrator immediately if any qualified beneficiary actually becomes covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a qualified beneficiary receives any medical benefits under the Plan after coverage is to cease under these rules, the Plan reserves the right to seek reimbursement from the qualified beneficiary.

- with respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled (this cuts short the coverage for all qualified beneficiaries with extended coverage); or

NOTE: This cuts short the coverage for all qualified beneficiaries with extended coverage.

- termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

Insurability & Conversion. A qualified beneficiary does not have to demonstrate insurability to elect continuation period. At the conclusion of the available continuation coverage, there must be an opportunity to convert to individual coverage if such coverage is offered under the Plan.

Trade Act of 2002. Pursuant to the Trade Act of 2002, certain employees and former employees who are receiving trade adjustment assistance ("TAA") may be eligible for a special second COBRA election and a tax credit for premiums paid for continuation coverage. TAA is generally available to those employees who have lost their jobs or suffered a reduction in hours because of import competition and shifts in production to other countries. If you are potentially eligible for these rights under the Trade Act, you will receive additional information regarding it at the time of your qualifying event.

Address Changes: Important information is distributed by mail. In order to protect your family's rights, if a qualified beneficiary's address changes, the qualified beneficiary or someone on its behalf should notify the Plan Administrator immediately.

4.2 What rules apply to the City of Minneapolis Medical Expense Reimbursement Plan?

Modified COBRA continuation coverage rules apply to the Medical Expense Reimbursement Plan. Continuation coverage is generally available on the same terms and conditions as described above. There are, however, several differences. For example, the beginning date of the continuation coverage is earlier. If elected, continuation coverage begins on the date of the qualifying event. Furthermore, the maximum duration of the continuation coverage is much shorter. If the account is "underspent" at the time of the loss, the maximum duration of COBRA is through the end of the Plan Year in which the loss takes place. If the account is "overspent" at the time of the loss, there is no requirement that COBRA be offered.

Underspent. An account is UNDERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is greater than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

Overspent. An account is OVERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is less than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

4.3 What are my continuation rights for medical and dental coverage under state law?

Minnesota has adopted requirements that employees and their dependents have the right to continue coverage under certain employer sponsored group medical plans. The Minnesota provisions are very similar to the federal COBRA requirements. They apply to group insurance policies, subscriber contracts and to health maintenance organization (HMO) coverages approved in Minnesota. In addition, they apply to public sector employers. However, they do not apply to self-funded group health plans, including medical expense reimbursement plans. There is no 20 employee threshold.

Minnesota law differs from COBRA in the following situations:

i. A former spouse and dependent children of a covered employee who were covered at the time of a marriage dissolution;
ii. A surviving spouse and dependent children with coverage at the time of the covered employee's death; and
iii. A covered employee, spouse and dependent children of the covered employee who were covered at the time the covered employee became totally disabled.

In each of these situations, there may be state continuation coverage that is more generous than the PHSA coverage. For example, the period of continuation coverage may be longer or the cost may be less under state continuation requirements. The continuation rights for yourself and those who are covered through you are described in the separate materials which have been provided to you either directly by the carrier (the insurance company or HMO) or by your Employer. If you have not been provided this information, you should contact the City of Minneapolis Benefits Office.

4.4 What are my continuation and/or conversion rights for group term life insurance coverage under state law?

The continuation and/or conversion rights for yourself and those who are covered through you are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the City of Minneapolis Benefits Office.

4.5 What are my continuation rights under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as amended, requires all employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "U-continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no

greater rights be provided than those required by this law. It does not fully describe your U-continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the City of Minneapolis Benefits Office.

This notice covers the following group health plan(s) sponsored by your Employer:

- City of Minneapolis Medical Plan;
- City of Minneapolis Dental Plan; and
- City of Minneapolis Medical Expense Reimbursement Plan.

Each person covered under the Plan(s) should read this notice carefully.

Service Leave Event. If covered by any of the group health plans described above, the employee has the right to elect U-continuation coverage for him/herself and his/her dependents if they lose coverage under such plan due to an absence from employment for service in the uniformed services (a "service leave").

Service in the Uniformed Services. Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. You have sixty (60) days to elect U-continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered "made" on the date sent. If U-continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If U-continuation coverage is not elected within this period, coverage under the Plan ends. However, if the no election is made in a situation in which you are not required (in accordance with USERRA) to provide advance notice of your service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

NOTE: Your dependents with coverage under the Plan(s) do not have an independent right to elect U-continuation coverage. Their coverage may be continued only if you elect U-continuation coverage.

Duration. The law requires that you generally be allowed to maintain U-continuation coverage for a twenty-four (24) month period beginning on the date of your absence from employment for the purpose of performing service begins.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or family members that are not on service leave.

Cost. A person electing U-continuation coverage may have to pay all or part of the cost of U-continuation coverage. If you perform service in the uniformed services for fewer than thirty-one (31) days, you will pay the same amount for the coverage that you normally pay. If your service exceeds thirty (30) days, the amount charged cannot exceed 102% of the cost to the plan of providing the coverage.

Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of within which to make the payment. The length of the grace period will be thirty days (30), unless a longer period is provided in the insurance policy or plan document applicable to the Plan.

Termination of the Continue Coverage. The U-continuation coverage may be terminated for any of the following reasons:

- the Employer no longer provides group health coverage to any of its employees;
- the premium for U-continuation coverage is not paid on time (including the grace period);
- your failure to return from service or apply for a position of employment as required under USERRA; or
- termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

Insurability. You do not have to demonstrate insurability to elect continuation coverage.

4.6 Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. This Plan shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. You will be provided with a complete explanation of FMLA rights and responsibilities.

NOTE: You should contact your Employer regarding any FMLA questions.

PART V.
ADMINISTRATIVE INFORMATION

Plan:

Plan Name:	City of Minneapolis Minneflex Plan
Plan Type:	Section 125 Cafeteria Plan
Plan Number:	501

Employer, Plan Administrator, and Agent for Service of Legal Process:

Name:	City of Minneapolis
Address:	200 South 4th Street, Suite 100
City, State Zip:	Minneapolis, MN 55415
Phone:	612-673-3333
EIN:	41-6005375
Agent for Service of Legal Process:	City Clerk of Minneapolis, 350 S. 5th St., Room 319, Minneapolis, MN 55415

Claims Administrator:

Benefit/plan	**Claims Administrator Address/Phone #**
City of Minneapolis Medical and Dependent Care Expense Reimbursement Plan	SelectAccount 1750 Yankee Doodle Rd 5140 Eagan, MN 55121 Telephone: 800-859-2144 E-mail: CustomerSolutions@SelectAccount.com
City of Minneapolis Medical Plan	Medica 407 Carlson Parkway, Minnetonka,MN 55305-5387 Telephone: 952-945-8000 Policy Numbers: 48391, 48394, , 69373, 69375, 91677, 91678, 91681, 91682, 91685, 91686, 91689, 91690
City of Minneapolis Dental Plan	Delta Dental of Minnesota 500 Washington Ave South Minneapolis, MN 55415 Telephone: 800-328-1188 Group Number: 0480
City of Minneapolis Group Term Life Plan	CIGNA Group Insurance PO Box 20643, Lehigh Valley, PA 15219 Telephone: 800-732-1603 Policy Numbers: FLX 962053, OK 963645
City of Minneapolis COBRA Administrator	121 Benefits 730 2nd Ave S, Suite 400 Minneapolis, MN 55402 1-800-300-2372, Option #2

This Plan does not have a trust; therefore, there are no trustees.