October 2016

Working Copy

MINNESOTA SERVICE COOPERATIVES
VEBA PLAN

October 5, 2016

As Amended

Note: Material added or modified by Amendments is shown in italics. Modified section numbers are not generally shown in italics.

This Working Copy reflects only the most current provisions of the Plan document and does not reflect every change made by every amendment. Specifically, the Working Copy does not reflect changes made by prior amendments which were changed subsequently by more recent amendments.

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MINNESOTA SERVICE COOPERATIVES
VEBA PLAN

PREAMBLE

WHEREAS, certain Minnesota Service Cooperatives (each individually referred to herein as the "Service Cooperative," and collectively, as the "Service Cooperatives") established the VEBA Plan for adoption by participating employers that are political subdivisions of a state, an integral part of a political subdivision, or an entity whose entire income is excludible from gross income under section 115(1) of the Internal Revenue Code (the Code) (each individually referred to herein as the "Employer," and collectively, as the "Employers");

WHEREAS, the Plan is funded through a trust intended to qualify for exemption from tax as a voluntary employees' beneficiary association under Section 501(c)(9) of the Code (the "Employee Benefits Trust Agreement or Trust");

WHEREAS, the Plan is a multiple employer plan with terms and conditions that may vary among adopting Employers;

WHEREAS, contributions to the Trust are made solely by the Employer and are not provided pursuant to salary reduction election or otherwise under a cafeteria plan under Section 125 of the Code;

WHEREAS, the Plan provides for reimbursements up to the balance of an employee's/retiree's account during a coverage period, and any unused portion of the account is carried forward to increase the maximum reimbursement amount in subsequent coverage periods;

WHEREAS, it is intended that coverage and reimbursement of medical care expenses of an employee and the employee's Dependents under the Plan be excluded from the employee's gross income under Sections 106 and 105 of the Code;

WHEREAS, the Joint Powers Agreements entered into between the Service Cooperatives and their participating members authorize the Service Cooperatives to amend the employee benefit programs made available to participating members; and

WHEREAS, the VEBA Plan has been amended eleven times since its initial adoption by employers in 2002.

NOW, THEREFORE, the VEBA Plan is presented below as a working copy incorporating all amendments as follows:

ARTICLE 1
DEFINITIONS

The following terms, whenever capitalized, shall have the meaning set forth below unless otherwise specified herein.

1.1 “Account Balance” means the amount in the Employee Account.

1.2 “Adoption Agreement” means the agreement signed by the Employer adopting the VEBA Plan, which is attached hereto and made a part hereof.

1.3 “Benefits” means any amounts paid to a Participant or Dependent as reimbursement for Eligible Health Expenses incurred by the Participant or Dependent.

1.4 “Claims Administrator” means the third party administrator retained by the Service Cooperative.

1.5 “Contributions” means Employer contributions to Employee Accounts in the Employee Benefits Trust for reimbursement of Eligible Health Expenses incurred by Participants or Dependents.

1.6 “Code” means the Internal Revenue Code of 1986, as amended.

1.7 “Dependent” is either a “qualifying child” or a “qualifying relative” of the Participant. A “qualifying child” is: (a) a child (including stepchild, adopted child, or eligible foster child), or a sibling (or stepsibling), or a descendant of either; who has (b) resided in the principal abode of the Participant for more than half of the relevant calendar year; (c) not attained age 19 (or is a student who has not attained age 24 as of the end of the year); and (d) not provided more than half of his or her support for that year. A child who does not satisfy the qualifying child definition may be a qualifying relative.

A “qualifying relative” is an individual who: (a) is a child (including stepchild, adopted child, or eligible foster child), a sibling (including stepsiblings), the Participant’s father or mother or an ancestor of either of them, a stepparent, a niece or nephew, an aunt or uncle, certain in-laws of the Participant, or an individual, other than a spouse, who resides in the principal abode of the Participant and is a participant of the household; (b) receives more than half of his or her support for the year from the Participant; and (c) is not a qualifying child of any other person for the calendar year.

For purposes of the Plan, the term Dependent also includes a Participant’s Spouse (unless the Participant has elected the Employee-Plus-Children VEBA Option), dependents of a Participant’s dependent, and married dependents filing jointly. If both the Participant and his or her Spouse are employees of the Employer, and either or both maintain an Employee Account under the VEBA Plan, either or both may be reimbursed from the other’s account for Eligible Health Expenses (unless either or both have elected the Employee-Plus-Children VEBA Option).

Added by the Second Amendment;

*Effective March 30, 2010, for purposes of the Plan, the term Dependent shall include any Participant's child (as defined by Code § 152(f)(1)) who has not attained age 27 as of the end of the taxable year. *Eff. March 30, 2010*

1.8 "Effective Date" means the date the VEBA Plan becomes effective as set forth on the Adoption Agreement executed by each employer.

1.9 "Eligible Employee" means an Employee eligible to participate in the Plan, pursuant to the terms and conditions outlined in collective bargaining agreements or personnel policies of the Employer that establish eligibility, and may include active, retired, and former employees, political subdivision board members, and elected and appointed officials.

1.10 "Eligible Health Expenses" In general, "Eligible Health Expenses" means expenses incurred by an Employee or his or her Dependents for medical care, as defined in Code Section 213(d), after the date the Employee becomes a Participant and during the Plan Year. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished with the medical care or services giving rise to the claimed expense, regardless of when the expense is actually paid.

An Employer may offer one or more of the VEBA coverage options below, and the definition of "Eligible Health Expenses" will vary depending on which of the following VEBA coverage options are offered, and if more than one option is offered, the definition will vary depending upon which VEBA coverage option the Participant elects prior to the beginning of the Plan Year.

- *General-Purpose VEBA Option.* For purposes of this Option, "Eligible Health Expenses" means expenses incurred by a Participant or his or her Dependents for medical care, as defined in Code Section 213(d).

- *Limited (Vision/Dental/Preventive Care/Post-Deductible) VEBA Option.* For purposes of this Option, "Eligible Health Expenses" means expenses incurred by a Participant or his or her Dependents for medical care, as defined in Code Section 213(d); provided, however, that such expense is limited to one or more of the following categories of coverage, as determined by the Employer: vision care, dental care, preventive care (as defined in Code Section 223(c)) or Eligible Health Expenses incurred after the Participant satisfies the applicable minimum deductible for self-only or family coverage described in Code Section 223(c), as adjusted for changes in cost-of-living under Code Section 223(g).

- *Employee-Plus-Children VEBA Option.* For purposes of this Option, "Eligible Health Expenses" means expenses incurred by a Participant or a child of the Participant who is the Participant's Dependent (but not by the Participant's Spouse) for medical care, as defined in Code Section 213(d).

If an Employer offers VEBA coverage options in addition to the General-Purpose VEBA Option, and a Participant fails to elect any of the VEBA Options listed above during the open enrollment period before the beginning of a Plan Year, such Participant will be deemed to have elected the General-Purpose VEBA Option for the duration of that Plan Year. Notwithstanding the foregoing, the Employer may limit reimbursement under the VEBA to health insurance premiums that are not reimbursed through a cafeteria plan under Section 125 of the Code to the extent deemed necessary by the Employer in its sole discretion to meet nondiscrimination requirements under Section 105 of the Code.

As modfied by the Fourth and Sixth Amendments Amendment

*For expenses incurred after December 31, 2010, Eligible Health Expenses for medicines or drugs are restricted to prescribed drugs, insulin, and over-the-counter drugs that are prescribed. This effective date applies regardless of whether the Plan Year for the employer's plan is a fiscal or calendar year. *Eff. Jan 1, 2011*

*"Eligible Health Expenses" under the Health Reimbursement Arrangement for Active Employees shall be limited to one or more of the following co-payments, co-insurance, deductibles, and medical care (as defined under Code § 213(d)) that does not constitute essential health benefits. *Eff. Jan. 1, 2014*

1.11 "Employee" means a person performing services for Employer and classified by Employer as an employee. Persons performing services and not classified as employees, including but not limited to leased employees within the meaning of Section 414(n) of the Code and persons classified in good faith as independent contractors, shall not be considered Employees for purposes of the Plan. In the event that a person performing services for Employer and not classified as an employee is reclassified as an employee by Employer or any governmental agency or instrumentality (whether prospectively or retroactively), such person shall first be considered an Employee for purposes of the Plan as of the later of the date on which such reclassification occurs and the date on which the reclassification is effective. The term Employee shall not include any person covered by a collective bargaining agreement between the employee's representative and Employers under which benefits were the subject of good faith bargaining between the parties, unless such agreement provides for coverage under this Plan.

Notwithstanding the above, the term Employee may include former and retired employees, political subdivision board members, and elected and appointed officials.

1.12 "Employee Account" means the bookkeeping account maintained by the Employee Benefits Trust Agreement in the name of a Participant, which reflects all Contributions made to the Trust in the name of the Participant, investment earnings and losses, administrative expenses, if any, and distributions.

1.13 "High Deductible Health Plan" means the major medical health plan of the Employer that will be offered in combination with the Health Reimbursement Arrangement for Active Employees.

1.14 "Participant" means an Eligible Employee who is participating in this Plan in accordance with the provisions of Article 2.

1.15 "Plan Administrator" means the Employer.

1.16 "Plan Year" means the annual accounting period of the Plan. For general administrative and governmental reporting purposes, the Plan Year shall be from July 1 to June 30 of each year. Adopting Employers may establish their own Plan Year in the Adoption Agreement.

1.17 "Retirement Date" means the date on which an Eligible Employee terminates public service. For this purpose, termination of public service includes the following:

1) termination of employment;
2) retirement;
3) when an Eligible Employee becomes totally disabled or dies; and
4) the commencement of a medical leave of absence as determined by collective bargaining agreements or personnel policies of the Employer.

The Retirement Date may vary among employees of participating Employers if provided for in collective bargaining agreements or personnel policies.

1.18 "Spouse" means an individual who is legally married to a Participant, but shall not include an individual separated from the Participant under a legal separation decree.

1.19 "Surviving Dependent" means a Participant's Spouse (or other Dependent, if the Spouse has died or become legally incapacitated) in the event of the death or legal incapacitation of such Participant.

1.20 "Trust" or "Employee Benefits Trust Agreement" means the Minnesota Service Cooperative Employee Benefits Trust.

ARTICLE 2
ELIGIBILITY

2.1 **Eligibility for Retired Employees**.

As Clarified by the Eleventh Amendment

Eligible Employees will enter the VEBA Plan and become Participants with respect to the Postretirement Health Care Savings Arrangement on the earlier of the following two dates:
**Eff Jan. 1, 2017*

1) The date on which a Contribution is made to the Eligible Employee's retiree account; or

2) The Eligible Employee's Retirement Date.

2.2 Opt-Out Right for Retired Employees

Added by the Sixth Amendment

*Upon attainment of their Retirement Date, and at least annually thereafter, former Eligible Employees shall have the right to irrevocably opt out of and waive future reimbursements from their accounts in the Postretirement Health Care Savings Arrangement. Upon the earlier of attainment of Medicare eligibility or death, any such account shall be reinstated and permit reimbursement of all Eligible Health Expenses. *Eff. Jan. 1, 2014*

2.3 **Eligibility for Active Employees**. If the Employer elects the Health Reimbursement Arrangement for Active Employees feature on the Adoption Agreement, Eligible Employees will automatically be enrolled in the VEBA Plan and become Participants with respect to that feature on the date they become covered under the High Deductible Health Plan.

Sixth Amendment

*No Contributions may be made on behalf of any active Any Employee unless they are enrolled in the High Deductible Health Plan. *Eff. Jan. 1, 2014*

2.4 **Separate Accounts**.

Eleventh Amendment

Separate accounts will be established for the Postretirement Health Care Savings Arrangement and the Health Reimursement Arrangement for Active Employees. Assets in both accounts may be commingled, and a single investment direction will apply to both accounts.

Following the Participant's Retirement Date, the Participant's account balance in the Health Reimbursement Arrangement for Active Employees shall be transferred to the Postretirement Health Care Savings Arrangement. Separate accounts shall continue to be maintained for Participants only as necessary to facilitate any election of continuation coverage under the Health Reimbursement Arrangement for Active Employees.

*Upon return to active employment following a Participant's Retirement Date, the any balances maintained for the Participant in the Postretirement Health Care Savings Arrangement shall be transferred to the Health Reimbursement Arrangement for Active Employees. *Eff. Jan. 1, 2017*

Explanatory note: The prior version of Section 2.4 was similar, and balances have always been transferred to the Postretirement Health Care Savings Arrangement upon termination of employment or retirement. But the language has been simplified and streamlined to ensure this result now that different rules apply between retirees and active employees (effective for plan years beginning on January 1, 2017, spouses and dependents of active employees may not be reimbursed from the VEBA unless they are enrolled in the employer's group health plan; the same rule does not apply to former employees in the Postretirement Health Care Savings Arrangement).

An employer may agree in collective bargaining or personnel policies to adopt these arrangements in stages, as follows: first, the Employer may adopt the Postretirement Health Care Savings Arrangement, and provide Contributions on behalf of active Employees; next, at such time as account balances under the first arrangement attain a predetermined limit, or upon such other event that may be agreed upon, the Employer may transfer these balances to accounts established under the Health Reimbursement Arrangement for Active Employees.

If and to the extent that the Employer establishes arrangements where the maximum limit for the amount of reimbursement that is attributable to Contributions varies among groups or individual Participants, each such arrangement shall constitute a separate plan of the Employer, the terms of which shall otherwise be governed by this document. Notwithstanding the above, the Employer may designate two or more plans as constituting a single plan for purposes of meeting the nondiscrimination requirements of Code Section 105(h).

2.5 Opt-Out Right for Active Employees

Sixth Amendment

*An Active Employee may irrevocably opt out of and waive future reimbursements, except as provided below, from the Health Reimbursement Arrangement for Active Employees at least annually (the "Opt-Out Right"). Upon the earlier of attainment of Medicare eligibility or death, any such account shall be reinstated and permit reimbursement of all Eligible Health Expenses. *Eff. Jan. 1, 2014*

2.6 **Dependents**. Dependents are automatically enrolled in the VEBA Plan on the date the Participant enters the Plan, whether or not the Dependent is enrolled in the High Deductible Health Plan; provided, however, that if the Employer chooses to offer an Employee-Plus-Children VEBA Option, the Participant's Spouse will not be enrolled in the VEBA Plan if the Participant elects the Employee-Plus-Children VEBA Option.

2.7 **Adding New Dependents**. New Dependents may participate in the VEBA Plan, whether or not enrolled in the High Deductible Health Plan, as of the following dates:

1) New Spouse and stepchildren: as of the date of marriage, if the Claims Administrator receives an application for coverage within 30 days of the date of marriage, otherwise, as of the date the Claims Administrator receives an application for coverage; provided, however, that if the Employer chooses to offer an Employee-Plus-Children VEBA Option, the Participant's new Spouse will not

be enrolled in the VEBA Plan if the Participant elects the Employee-Plus-Children VEBA Option.

2) Newborn children: as of the date of birth.

3) Adopted children: on the date of placement, if the Claims Administrator receives an application for coverage within 90 days of the date of date of placement, otherwise, as of the date the Claims Administrator receives an application for coverage.

4) Handicapped children or Dependents: on the first day of the month following the date the Claims Administrator receives an application, if the handicapped dependent is otherwise eligible under the VEBA Plan.

2.8 **Special Enrollment Periods**. Eligible Employees and Dependents will enter the VEBA Plan on the earlier of the date they enroll in the Employer's High Deductible Health Plan pursuant to any special enrollment period, or the date they enroll in the VEBA Plan pursuant to this Article 2.

ARTICLE 3
CONTRIBUTIONS

3.1 **Contributions**. Employer shall make Contributions for the benefit of Participants as required or provided for by collective bargaining agreements or personnel policies. Contributions shall be held in Employee Accounts in the Trust. No Contributions shall be made after a Participant's Retirement Date except to the extent such Contribution is attributable to accrued severance pay, vacation pay, sick pay or similar amounts paid or payable upon termination of employment.

As amended by the Second, Fifth and Seventh Amendments

Notwithstanding the above, Employer may continue contributions to nondiscriminatory classifications of former employees under the Health Reimbursement Arrangement for Active Employees as part of a severance agreement. [Note: applies to "bona fide" severance arrangements under Code Section 457]

Nothwithstanding the foregoing, Contributions may be provided to Participants after their Retirement Date if provided for in a collective bargaining agreement.

Contributions may be provided to Participants who are enrolled in the Employer's High Deductible Health Plan after their Reitrement Date if provided for in a collective bargaining agreement or personnel policy provided that (1) Contributions (to the VEBA) are uniform in amount for all retirees enrolled in the High Deductible Health Plan regardless of the share of premiums paid by the Participant and the Employer, and (2) if Employer contributions towards premiums vary based on personnel policies or collective bargaining agreements in effect on a Participant's Retirement Date, each class of Participants receiving a different level of Employer

*contribution towards premiums must include more than nominal numbers of Participants from middle and lower wage brackets prior to their Retirement Date. *Eff. Jan. 1, 2008, Mar. 10, 2010, May 1, 2014.*

3.2 **Suspension of Contributions**. Contributions on behalf of a Participant shall be suspended as of the date the Participant ceases to meet the eligibility requirements to receive contributions under the Plan as set forth in the applicable collective bargaining agreement or personnel policy (provided, this section shall not be interpreted to suspend Contributions of unused severance pay, sick pay or similar amounts to which a Participant may be entitled after termination of employment.) A Participant who ceases to meet the eligibility requirements shall not forfeit amounts credited to his or her Employee Account on that date, and remains eligible under Article 4 for reimbursement of Eligible Health Expenses from the Employee Account. Contributions will resume if a Participant again becomes eligible to receive Contributions under the Plan.

3.3 **Return of Contributions to Employer**. Contributions made to the Trust by the Employer may be returned to the Employer in the following circumstances:

1) A contribution is made to the Trust by the Employer because of a mistake of fact and is returned to the Employer within one (1) year after payment of such contribution; or

2) A contribution is conditioned on qualification of the Plan as exempt from tax under Section 501(a) of the Code, and the contribution is returned within one year after the date of denial of qualification of the Plan. Provided, if the qualification of a Plan as exempt from tax under Section 501(a) of the Code is denied, the Trust Agreement may be restated as a governmental trust under Section 115 of the Code, and in such event, all assets of the Plan will remain in the Trust Fund pursuant to the terms of the restated Trust Agreement.

3) The Trust is terminated and all obligations to Participants and Dependents have been satisfied, provided that any such amount may only be used for the provision of additional benefits permitted under Section 501(c)(9).

3.4 **Investment of Accounts**. The Employer may allow Participants (or Surviving Dependents) to direct the investments for a portion of their Account Balances or their entire Account Balances pursuant to the terms and conditions of arrangements made available through the Claims Administrator. The Claims administrator shall make arrangements for a third party investment advisor to select such investment options as it deems appropriate and shall arrange for notification to Participants of such investment options. No investment advice shall be provided to Participants by the Employer, the VEBA Committee, the Trustee, the Claims Administrator, or any other party except where such party has expressly agreed to provide such advice. Nor shall any such party have liability or responsibility for Participants' investment decisions or investment performance. The investment options may be modified from time to time or eliminated by the investment advisor, and new investment options may be added from time to time. The Claims Administrator or its investment advisor shall arrange for notification to Participants of such changes and solicit new investment elections, if appropriate. The Claims

Administrator or its investment advisor shall ensure that Participants receive sufficient information to make informed decision with regard to the available investment options. A monthly investment account service fee may be charged to the Account Balance of each Participant who directs the investment of their Account Balance in investment options. The Plan Administrator, in its discretion, may pay this investment account service fee on behalf of Participants.

ARTICLE 4
BENEFITS

4.1 **Benefits Provided by the Plan**. Each Participant or Dependent shall be entitled to reimbursement of documented Eligible Health Expenses up to the balance of the Employee Account in the Trust, subject to the following:

1) No reimbursement is available for claims that are incurred before the Participant or Dependent becomes eligible for and enters the Plan;

2) The amount of reimbursement available for a Participant or Dependent during any Plan Year shall be reduced by the amount of any prior reimbursement in that year to any other Participant or Dependent with rights to the Employee Account;

As amended by the Eighth and Ninth Amendments

*3) No reimbursement is available for claims that are incurred more than 18 months before the date reimbursement is requested (provided, in the event a Participant dies without a Dependent, and to the extent not forfeited prior to December 22, 2015, reimbursement is available for unreimbursed claims incurred by the Participant from the date of the Participant's initial enrollment in the VEBA Plan. *Eff. Jan. 1, 2008 and Dec. 22, 2015.*

4) Contributions designated for the Postretirement Health Care Savings Arrangement are only available to reimburse Eligible Health Expenses on or after the Participant's Retirement Date.

5) If Contributions are prorated over the Plan Year, the Employer may adopt uniform and nondiscriminatory rules for accelerating the timing of such Contributions when one of more claims for Eligible Health Expenses exceeds the balance of an Employee Account. The total amount of Contributions to which a Participant is entitled for a Plan Year may not be altered as a result of the timing of Contributions.

6) If an Eligible Employee enters the Plan as a Participant on a date after the first day of the Plan Year, the Employer may prorate the amount of the Employer Contribution to reflect the late entry. The Employer may also adopt uniform and nondiscriminatory rules to accelerate the timing of such Participant's prorated share of Contributions when one or more claims for Eligible Health Expenses exceeds the balance of an Employee Account. The total amount of Contributions

to which a Participant is entitled for a Plan Year may not be altered as a result of the timing of Contributions.

7) If permitted under collective bargaining agreements or personnel policies of the Employer, a Participant (or Surviving Dependent) may elect, before the beginning of the Plan Year, to forgo the payment or reimbursement of Eligible Health Expenses incurred during the Plan Year, or to limit the payment or reimbursement from the Plan to certain Eligible Health Expenses that qualify as permitted insurance, permitted coverage or preventive care as described in Code Section 223(c)(1)(B) and Notices 2004-23 and 2004-50 ("Excepted Medical Expenses"). The option of limiting coverage under the VEBA as described above shall be available only to those Participants (or Surviving Dependents) covered by a High Deductible Health Plan within the meaning of Code Section 223(c)(2). Eligible Health Expenses incurred during the suspended Plan Year (other than the Excepted Medical Expenses if they are allowed to be paid or reimbursed by the VEBA Plan), cannot be paid or reimbursed by the VEBA Plan at any time in any Plan Year. However, the Employer may continue to make Contributions to the Participant's Employee Account during the suspended Plan Year and these amounts will be available for the payment or reimbursement of the Excepted Medical Expenses incurred during the suspended Plan Year as well as Eligible Health Expenses incurred in later VEBA Plan Years in which no suspension is in effect.

Added by the Eighth Amendment

8) Effective for Employers first adopting the VEBA plan on or after December 16, 2015, Participants employed by such Employers shall not be eligible for the reimbursement of health care expenses incurred by Dependents under the Health Reimbursement Arrangement for Active Employees unless, at the time the claim is incurred, said Dependents are enrolled in a major medical health plan of the Employer. This limitation will apply to all remaining Participants enrolled in the Health Reimbursement Arrangement for Active Employees effective for the Plan Years beginning on or after January 1, 2017. The requirement that Dependents be enrolled in the Employer's major medical health plan to be eligible for reimbursement of health care expenses does not apply to the Postretirement Health Care Savings Arrangement. Eff. Dec. 22, 2015 [Note: the term "Dependents" includes spouses].

4.2 **Hardship Distributions**. If a Participant has a positive balance in a separate account maintained under the Postretirement Health Care Savings Arrangement, the Participant will be entitled to any distribution necessary to alleviate financial hardship due to medical expenses incurred by the Participant or his or her Dependents. In order to demonstrate financial hardship, the Participant must certify that the financial need cannot be satisfied by liquidation of other resources that are reasonably available to the Participant, including the assets of the Participant's Spouse and children (to the extent not held under an irrevocable trust or pursuant to the Uniform Gift to Minors Act), and to the extent that such liquidation would not itself cause an immediate and heavy financial need.

4.3 **Claims for Benefits**. Medical care providers shall be authorized to submit claims for reimbursement directly to the Claims Administrator. Participants (or Surviving Dependents) may also submit written claims for benefits as specified by the Claims Administrator, and pursuant to the procedures set forth in Section 4.4 below. Upon receipt of a properly documented claim from a Participant (or Surviving Dependent), the Claims Administrator shall pay the Participant (or Surviving Dependent) the benefits provided under this Plan as soon as administratively feasible subject to the availability of funds in the account of the Participant (or Surviving Dependent).

4.4 **Required Information**. Each claim for benefits that is not submitted directly by a medical care provider shall contain a written statement containing the following information:

1) the person or persons on whose behalf Eligible Health Expenses have been incurred;
2) the nature of the expenses so incurred;
3) the date the expense was incurred;
4) the name of the service provider;
5) the amount of the requested reimbursement; and
6) a statement that such expenses have not otherwise been paid through insurance or reimbursed from any other source, and that reimbursement will not be sought from another source.

4.5 **Termination of Coverage**. A Participant's (or Surviving Dependent's) coverage shall terminate on the date after the Retirement Date on which the balance of the Employee Account in the VEBA Plan reaches zero. The Participant (or Surviving Dependent) will be considered to have exhausted all available benefits under the VEBA Plan on that date.

Coverage will also terminate, and the balance of the account will revert to the VEBA Plan, on the date on which an Employee Account is determined by the Plan Administrator to have been abandoned. Any such forfeited amounts shall be applied to reduce administrative expenses or future Contributions under the Plan.

4.6 **Dependent Termination of Coverage**. A Dependent's coverage shall terminate on the earliest of the following dates:

1) The date the Participant (or Surviving Dependent) ceases to be covered;

2) On the last day of the month in which the dependent ceases to be a Dependent as defined in the Plan;

3) The date on which the Dependent becomes covered as a Participant under the Plan; or

4) If the Employer chooses to offer an Employee-Plus-Children VEBA Option, the coverage of the Participant's Spouse will be terminated on the first day of a Plan Year for which the Participant elects the Employee-Plus-Children VEBA Option.

If a Dependent's coverage is terminated, health expenses incurred by the Dependent on or after the date of termination of coverage shall not be eligible for reimbursement. Eligible Health Expenses that are incurred prior to a Dependent's termination of coverage may be submitted for reimbursement from available funds within eighteen months of the date they were incurred.

4.7 **Administrative Expenses**. The Adoption Agreement sets forth whether administrative expenses will be paid by the Employer or allocated to Employee Accounts.

4.8 **Death of the Participant**. When a Participant dies with a positive balance in his or her separate account in the VEBA Plan, the Participant's Dependents shall be entitled to the reimbursement of Eligible Health Expenses from the Employee Account as of and following the date of death up to the level of Contributions and earnings, if any, in the Employee Account. For this purpose, Eligible Health Expenses includes those unreimbursed expenses incurred by the Participant in the 18 months prior to death.

As amended by the First, Third, Ninth and Tenth Amendments

4.9 ***Disposition of Account upon Death****. If a Participant dies with no Dependents, or upon the death or loss of dependent status of the last Surviving Dependent, the unused balance of the Participant's Employee Account, to the extent not forfeited prior to December 18, 2015, shall be available to reimburse Eligible Health Expenses incurred by designated beneficiares of the Participant in a manner consistent with Section 105(j) of the Code. If there is no beneficiary designation on file, designated beneficiaries shall be the then living descendents, per stirpes. If a designated beneficiary determined in this manner dies before his or her share of the account is exhausted, the balance shall be divided equally among other designated beneficiaries so determined on the date of the Participant's death. If no other designated beneficiaries so determined exists, the balance shall revert to the VEBA plan.*

Except as provided in a collective bargaining agreement, any unused balance that reverts to the VEBA Plan as described above shall be allocated uniformly to the accounts of Eligible Employees who are members of the same collective bargaining unit as the deceased Participant. Except as provided in a personnel policy, any unused balance that reverts to the VEBA Plan as described above shall be used to offset future employer contributions to the VEBA. If no future contributions are made to the VEBA within one year from the date of the Participant's death, the unused balance shall be allocated uniformly to the accounts of Eligible Employees who are members of the same class of nonunion Eligible Employees as the deceased Participant, provided that class of nonunion Eligible Employees meets the nondiscrimination requirements under Section 105 of the Code. * Eff. Jan. 1, 2008

Explanatory note: These rules have been amended over time to reflect IRS positions requiring forfeiture on death when there are no longer dependents. The current version has been completely re-written to reflect a law change enacted on December 18, 2015. Note that when a nonunion employee dies and there are no further beneficiaries, any remaining amounts are used to offset future employer contributions. If there are no future employer contributions, the unused balance is allocated to the employees who were in the same class of employees as the deceased participant, provided that the class meets nondiscrimination requirements under Section 105 of the Code. If the class does not meet those requirements, it will be expanded as necessary to meet that requirement (for example, the class could be expanded to cover more than nominal numbers of employees in middle and lower compensation ranges so that it meets the fair cross section section test).

ARTICLE 5
CONTINUATION COVERAGE

5.1 **Qualifying Events**. Coverage may be continued if coverage ends due to any of the qualifying events listed below. In order to be eligible to continue coverage, a Participant or Dependent must be covered under the Plan before the qualifying event. In all cases, continuation ends if the VEBA Plan ends or required charges are not paid when due.

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends (except gross misconduct dismissal), retirement, leave of absence, layoff or reduction in hours	Employee and dependents	Earlier of: 1. 18 months, or 2. enrollment date in other group coverage.
	Totally disabled dependent[1]	Earlier of: 1. 29 months after the employee leaves employment, or 2. date total disability ends, or 3. date of enrollment in Medicare, or 4. date coverage would otherwise end.

[1] If the dependent is disabled at the time the employee leaves employment or becomes disabled within the first 60 days of continuation coverage, continuation for the dependent may be extended beyond 18 months of continuation. In order to qualify, the disabled dependent must meet the following notice requirements during the 18 months of continuation:

a) The dependent must apply for Social Security benefits and be determined to have been totally disabled at the time of the qualifying event or within the first 60 days of continuation coverage.

b) The dependent must notify the Claims Administrator of the disability determination within 60 days of the determination and during the initial 18-month continuation period.

Qualifying Event	Who May Continue	Maximum Continuation Period
Divorce	Former spouse and any dependent children who lose coverage	Earlier of: 1. enrollment date in other group coverage, or 2. date coverage would otherwise end.
Death of employee	Surviving spouse and dependent children	Earlier of: 1. enrollment date in other group coverage, or 2. date coverage would otherwise end if the employee had lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months from the date of losing eligibility, 2. enrollment date in other group coverage, or 3. date coverage would otherwise end.
Total disability of employee[2]	Employee and dependents	Earlier of: 1. date total disability ends, or 2. date coverage would otherwise end.
Early retirement	Early retiree[3] and dependents	Earlier of: 1. enrollment date in other coverage, or 2. date coverage would otherwise end.

[2] Total disability means the employee's inability to engage in or perform the duties of the employee's regular occupation or employment within the first two (2) years of disability. After the first two (2) years, it means the employee's inability to engage in any paid employment or work for which the employee may, by education and training, include rehabilitative training, be or reasonably become qualified. For employees disabled prior to January 1, 1992, total disability means the employee's inability to engage in or perform the duties of the employee's regular occupation or employment from the date of disability.

[3] An early retiree is an employee who at termination of employment has met the age and service requirements necessary to receive an annuity from a Minnesota pension plan.

5.2 **Notification**. Qualified beneficiaries[4] must notify the Employer within 60 days of a qualifying event, such as divorce that would result in a loss of coverage for a dependent. Qualified beneficiaries that wish to continue coverage must notify the Employer in writing. Employer must notify qualified beneficiaries of the option to continue coverage within 10 days of receiving notice of a qualifying event.

Qualified beneficiaries have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will render the qualified beneficiary ineligible to choose continuation at a later date. Qualified beneficiaries have 45 days from the date of choosing continuation to pay the first continuation charges, except that surviving dependents of a deceased employee have 90 days to pay the first continuation charges. After this initial grace period, qualified beneficiaries must pay charges monthly in advance to the employer to maintain coverage in force.

5.3 **Charges for Continuation** Charges for continuation will be equal to the annual Employer contribution, plus a two (2) percent administration fee (if the qualifying event for continuation is the employee's total disability, the administration fee is not required). All charges are paid directly to the Employer. The Employer will provide qualified beneficiaries, upon request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

5.4 **Additional Qualifying Events**. If additional qualifying events occur during continuation (i.e., divorce, death of the former Employee, or a Dependent child loses eligibility), a qualified beneficiary may be entitled to election rights of his or her own and an extended continuation period. This applies only when the initial qualifying event for continuation is the employee's termination of employment, reduction in hours, retirement, leave of absence, or layoff.

When a second qualifying event occurs, such as the death of the former covered employee, the dependent must notify the employer of the additional event within 60 days after it occurs in order to continue coverage. Continuation charges must be paid in the same manner as for the initial qualifying event. Unless the initial qualifying event provides for longer coverage (in which case the longer coverage applies), a second qualifying event entitles the qualified beneficiaries to 36 months of coverage beginning on the date the original maximum coverage period began.

5.5 **Coordination with High Deductible Health Plan**. If Eligible Employees are required to enroll in the Employer's High Deductible Health Plan before receiving Contributions to the Health Reimbursement Arrangement for Active Employees, the Employer may, on a uniform and consistent basis, require that such Eligible Employees elect and maintain in force

[4] A qualified beneficiary is any individual covered under the VEBA Plan on the day before the qualifying event, as well as a child who is born to or placed for adoption with the covered employee during the period of continuation coverage.

continuation coverage under the High Deductible Health Plan as a condition precedent to electing and maintaining continuation coverage under the Health Reimbursement Arrangement for Active Employees.

5.6 **Non-Replication of Account Balance**. Regardless of whether a qualifying event causes the family unit to separate, a qualified beneficiary can only elect to continue the coverage that existed before the qualifying event. This means that, for example, upon a qualifying event of divorce, the spouse losing coverage will continue to have access to the Account Balance that existed before the qualifying event until that Account Balance is depleted.

Employer contributions that are made to the Plan following the election of continuation coverage by a former spouse or Dependent will be separated into a subaccount. This means that Employer contributions made for the former spouse or Dependent will not be available for use by the Employee. Similarly, contributions made to the Plan for the Employee after the divorce or a Dependent child's loss of eligibility will not be available to the former spouse or Dependent.

5.7 **Special Rule for Preexisting Conditions**. If qualified beneficiaries obtain other group coverage that excludes benefits for preexisting conditions, they may choose to remain on continuation coverage for a preexisting condition until the date continuation would otherwise end or until the preexisting clause of the new plan is met, whichever occurs first. This Plan is primary and determines benefits first for the preexisting condition. The Plan is not primary for any other condition. For a newborn child born during continuation, the other group coverage plan is primary starting on the date of birth.

ARTICLE 6
LEAVES OF ABSENCE

6.1 **Uniformed Services Leave**. A Participant on Uniformed Services Leave shall be entitled to all benefits and rights provided by its Employer to other Participants on leave of absence.

1) Uniformed Services Leave means a leave of absence for service in the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

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

6.2 **Leave of Less than 31 Days**. If the Uniformed Services Leave is for less than 31 days, a Participant remains eligible for Contributions to the Employee Account that the Participant would otherwise have been entitled to, if any, had he or she remained in active employment with the Employer during this period.

6.3 **Leave of More than 30 Days**. If the Uniformed Services Leave is for more than 30 days, the Participant may elect to continue eligibility for Contributions to his or her Employee Account under the Plan, if any such Contributions would otherwise have been payable had he or she remained in active employment with the Employer during this period, for the lesser of the following periods:

1) 24 months beginning on the day that the Uniformed Services Leave commences, or

2) a period ending on the day after the Participant fails to return to employment within the time allowed by USERRA.

Employers may require Participants on Uniformed Services Leave of more than 30 days to pay 102% of the cost of Employer's Contribution to the Plan, if any such Contributions would otherwise have been payable had he or she remained in active employment with the Employer during this period. In no event may any required premium be paid through a flexible spending plan subject to Section 125 of the Code.

6.4 **Family and Medical Leave of Absence**. Irrespective of any other provision of the Plan, if a Participant is on a leave of absence covered by the Family and Medical Leave Act of 1993 (the FMLA), and approved in writing by the Employer, he or she will remain eligible for Contributions under the Plan, if any such Contributions would otherwise have been payable had he or she remained in active employment with the Employer during this period.

The Participant may continue to participate in the Plan and be eligible for Contributions, if any, until the end of the leave period required by the FMLA.

6.5 **Teacher Mobility Act**. Coverage may be continued for five (5) years after the leave of absence begins for teachers on leave under the terms of Minnesota statute §122A.46 (Teacher Mobility Act).

6.6 **Temporary Lay-Off**. In addition to the events outlined above, a Participant may choose to continue his or her coverage during a period of temporary lay-off or vacation for one (1) month after the end of the Plan month during which the lay-off or vacation began.

ARTICLE 7
COORDINATION OF BENEFITS

7.1 **General Rule**. The VEBA Plan only reimburses Eligible Health Expenses incurred by a Participant or Dependent that are not covered by other insurance available to the Participant or Dependent, including amounts set aside for a health flexible spending arrangement maintained through a cafeteria plan under Section 125 of the Code (i.e., a Health FSA). If only a portion of an Eligible Health Expense has been reimbursed elsewhere (e.g., because insurance imposes co-payment or deductible limitations), then the VEBA Plan can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Plan.

7.2 **Special Ordering Rule for Cafeteria Plans**. If the Employer sponsors a Health FSA, the Employer may direct that Eligible Health Expenses be paid from the Health FSA before they are reimbursed from the Plan by making the appropriate election on the Adoption Agreement prior to commencement of the Health FSA plan year. If the Employer so directs, the Plan may not reimburse Eligible Health Expenses covered by the Health FSA until after expenses exceeding the dollar amount of the Health FSA have been paid. Any such election under the Adoption Agreement shall be deemed to be automatically renewed from year to year until the Employer amends the Adoption Agreement.

7.3 **Coordination of Medicare**. Irrespective of any other provision of the Plan, to the extent permitted by law, the coverage provided by the Plan shall apply as follows:

1) Determine the benefits which would have been payable for eligible charges incurred under the terms of the Plan in the absence of Medicare;

2) Deduct the benefits payable for such eligible charges under the provisions of Medicare;

3) The remaining balance, not to exceed the Participant or Dependent's account balance in the Trust (and subject to the availability of other coverage), shall be payable under the Plan.

Provided, however, that Participants or Dependents who are in their first 30 months of Medicare coverage due to End State Renal Disease (ESRD) are treated as if they are not yet eligible for Medicare since Medicare must be their secondary insurance for those first 30 months.

ARTICLE 8
CLAIMS PROCEDURE

8.1 **Claim Procedures**. Claims for benefits under this Plan are to be submitted to the Claims Administrator. Payment of claims under this Plan will be made by the Trust.

8.2 **Appeals**. If a Participant (or Surviving Dependent) disagrees with any action the Claims Administrator has taken on his or her claim, the Claims Administrator will review the resolution of the claim using the process outlined below. Participants may request an external review of the final determination the Claims Administrator makes about their request after they have exhausted the Claims Administrator's appeal process. Participants (or Surviving Dependents) may contact the Commissioner of Commerce at any time by calling 1-800-657-3602 or 651-296-4026.

1) **Initial Review**. Participants (or Surviving Dependents) that disagree with the action the Claims Administrator has taken on their claim may call the Claims Administrator for an explanation of the claim's resolution. The Claims Administrator will try to review the resolution of the claim within 10 days.

2) **Appeals**. Participants (or Surviving Dependents) may appeal the denial of their claims by submitting a written request for review to the Claims Administrator. The Claims Administrator will notify the Participant (or Surviving Dependent) within 10 days that they have received his or her written request for review. Within 30 days of receiving the written request and all necessary information, the Claims Administrator will notify the Participant (or Surviving Dependent) in writing of its determination and the reasons for the determination. If the Claims Administrator is unable to make a determination within 30 days due to circumstances outside its control, the Claims Administrator may take up to 14 additional days to make a determination. If the Claims Administrator takes more than 30 days to make a determination, the Claims Administrator will inform you in advance of the reasons for the extension.

Participants (or Surviving Dependents) that disagree with the action the Claims Administrator takes on their written request for review may appeal the determination in writing and request either a hearing or a written reconsideration. If a hearing is requested, the Participant (or Surviving Dependent) and any person he or she chooses may present testimony or other information. The Claims Administrator will provide the Participant (or Surviving Dependent) written notice of its determination and all key findings within 45 days after the Claims Administrator receives the written request for a hearing. If a Participant (or Surviving Dependent) requests a written reconsideration, the Participant (or Surviving Dependent) may provide the Claims Administrator with any additional information the Participant (or Surviving Dependent) believes is necessary. The Claims Administrator will provide the Participant (or Surviving Dependent) with written notice of its determination and all key findings within 30 days after the Claims Administrator receives the request for a written reconsideration. The Participant (or Surviving Dependent) is entitled to examine all pertinent documents and to submit issues and comments in writing. At the Participant's (or Surviving Dependent's) request, the Claims Administrator will provide you a complete summary of the appeal decision.

3) **External Review**. If an appeal concerns a covered health care service or claim and the Participant (or Surviving Dependent) disagrees with the Claims Administrator's appeal determination, the Participant (or Surviving Dependent) or his or her authorized representative may submit the appeal determination to external review. The state of Minnesota has contracted with an independent organization to conduct the external review of such appeals. This independent organization meets the state's requirements to conduct external review of health-related disputes. Participant (or Surviving Dependent) requests for external review must be submitted to the Commissioner of Commerce along with a filing fee of $25. The commissioner may waive the fee in cases of financial hardship.

Participants may request external review by contacting the Department of Commerce at:

Minnesota Department of Commerce
Attention Enforcement Division
Suite 500
85 Seventh Place East
St. Paul, Minnesota 55101

The external review organization will notify the Participant (or Surviving Dependent) and the Claims Administrator that it has received a request for external review. Within 10 business days of receiving notice from the external review organization, the Participant (or Surviving Dependent) and Claims Administrator must provide the external review organization any information to be considered. Both the Participant (or Surviving Dependent) and the Claims Administrator will be able to present a statement of facts and arguments. Participants (or Surviving Dependents) may be assisted or represented by any person of their choice at their expense. The external review organization will send written notice of its decision to the Participant (or Surviving Dependent) , the Claims Administrator, and the commissioner within 40 days of receiving the request for external review. The external review organization's decision is binding on the Claims Administrator, but not binding on the Participant (or Surviving Dependent).

ARTICLE 9
MISCELLANEOUS

9.1 **Tax Effects**. Neither the Employer nor the Service Cooperatives makes any warranty or other representation as to whether or any payments received by a Participant (or Surviving Dependent) will be treated as includable in gross income for federal or state income tax purposes.

9.2 **Multiple Employer Plan**. The VEBA Plan is a multiple employer plan, and each Plan adopted by each Employer shall constitute a separate and distinct plan for purposes of compliance with the rules applicable to health reimbursement arrangements under IRS Notice 2002-45, as amplified.

9.3 **Nondiscrimination**. The Plan shall not discriminate in favor of highly compensated employees as defined in Section 105(h) of the Code, as to eligibility to participate or as to benefits.

9.4 **Amendment or Termination**. Except as limited by any collective bargaining agreement, and subject to the terms of the Trust, the Employer shall have the right to terminate, suspend, withdraw, amend or modify this Plan, upon mutual agreement with the Service Cooperatives, in whole or in part at any time.

9.5 **No Employment Rights**. No one has a right to continued employment with the Employer merely because of her or his rights under the Plan or any Plan action.

9.6 **Exclusive Rights**. No one has a right to Plan benefits except as specified in this document.

9.7 **Right to Offset Future Payments**. In the event of an erroneous payment or amount of payment to a person or entity, the Plan may reduce future payments payable to or on behalf of that person by the amount of the error. In the case of an erroneous payment or mount of payment to or on behalf of a Dependent, the Plan may reduce future payments to or on behalf of the covered Participant. The right to offset does not limit the Plan's right to recover an erroneous payment in any other manner.

9.8 **Right to Recover Payments**. If the Plan makes a payment for covered expenses in a total amount exceeding what is necessary at the time to satisfy the Plan's intent, the Plan may recover the excess from the person to or for whom the payments were made, insurance companies, or other persons or organizations, as applicable. A "payment", for this purpose, includes the reasonable cash value of any benefits provided in the form of services.

9.9 **Misstatements, Misrepresentation, or Fraud**. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, corrective action shall be taken by the Claims Administrator, including, where appropriate, an equitable adjustment of the Participant's (or Surviving Dependent's) Account Balance. A Participant (or Surviving Dependent) who receives a Plan benefit as a result of false or incomplete information or a misleading or fraudulent representation must repay all amounts the Plan paid and is liable for all collection costs including attorneys' fees and court costs.

9.10 **Legal Remedy**. Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust all claim, review, and appeal procedures provided by the Plan.

9.11 **Captions and Headings; Singular or Plural Form**. Captions and headings used in the Plan are for convenience and reference only and should not be considered in interpreting the Plan's provisions. Singular words used in the Plan should be construed as also plural wherever applicable, and vice-versa.

9.12 **Indemnification**. The Claims Administrator, the Service Cooperatives, and the Employer shall indemnify and hold harmless employees performing administrative duties under this Plan from any loss, claim, or suit arising out of the performance of obligations imposed hereunder and not arising from such person's willful neglect or misconduct, or gross negligence.

9.13 **Nature of Relationship**. The Claims Administrator, the Service Cooperatives, and the Employer assume no obligations other than those stated in the Plan and are not liable for any party's acts or omissions, nor do the Claims Administrator, the Service Cooperatives, or the Employer make any warranty about health care services and supplies that Participant or Dependents obtain reimbursement for as Plan benefits. The Claims Administrator does not have

any control or influence over the health care services or supplies that are provided to Participants or Dependents.

9.14 **Several Fiduciary Liability**. To the extent permitted by law, neither the Claims Administrator, the Service Cooperatives, the Employer, nor any other person shall incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of this Plan.

Dated: _____

_____
Paul Brinkman, Chairperson
Minnesota Service Cooperatives VEBA Committee

HIPAA PRIVACY AND SECURITY APPENDIX
TO
MINNESOTA SERVICE COOPERATIVES VEBA PLAN

INTRODUCTION

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E ("Privacy Rule") provide that a covered health plan can only disclose protected health information to the sponsor of the plan if the plan's terms and provisions restrict the use and disclosure of the protected health information by the sponsor. HIPAA and the Security Standards and Implementation Specifications at 45 C.F.R. part 160 and part 164, subpart C ("Security Rule") provide that a covered health plan can only disclose electronic protected health information to the sponsor of the plan if the plan's terms require the sponsor to safeguard the electronic protected health information.

Minnesota Service Cooperatives VEBA Committee and all adopting Employers sponsors the Health Reimbursement Arrangement for Active Employees and the Postretirement Health Care Savings Arrangement to provide health reimbursement benefits to eligible employees and retirees (the "Plan").

SECTION 1 — DEFINITIONS

1.1. **Definitions**. When the following terms are used in this Appendix with initial capital letters, they shall have the meanings set forth below. Terms used, but not otherwise defined, in this Appendix shall have the same meanings as those terms in the Plan document and in the Privacy Rule or the Security Rule.

1.1.1. **Administrative Functions** – shall include, but is not limited to, the following uses and disclosures:

(a) for the purposes of Payment;

(b) for Health Care Operations;

(c) to a Business Associate who has signed a contract limiting its ability to use and disclose PHI and requiring them to implement appropriate safeguards;

(d) to a covered health care provider, a covered healthcare clearinghouse, or another covered health plan for payment activities of such covered entity receiving the information;

(e) to another group health plan sponsored by the Plan Sponsor, which, with the Covered Entity, form an organized health care arrangement;

(f) to provide participants with information about treatment alternatives or other health-related benefits and services that may be of interest;

(g) as Required By Law;

(h) to respond to court or administrative order, subpoena, discovery request or other lawful process if (i) the information sought is relevant and material to a legitimate law enforcement inquiry, (ii) the request is specific and limited in scope reasonably practicable in light of its purpose, and (iii) de-identified (as defined in the Privacy Rule) information could not reasonably be used;

(i) to public health authority, law enforcement official or other appropriate government authority for public health activities; to lessen a serious and imminent threat to individual or public health or safety; to report abuse, neglect or domestic violence or other law enforcement purposes;

(j) to the extent authorized by and necessary to comply with workers' compensation laws or similar programs;

(k) to a health oversight agency for health oversight activities authorized by law;

(l) to the Secretary of the Department of Health and Human Services for the purpose of determining compliance with the Privacy Rule; and

(m) and any other activities considered administrative functions under the Privacy Rule.

If Covered Entity is permitted or required to use or disclose Protected Health Information or Summary Health Information to a third party in accordance with the Privacy Rule, and an Identified Person is required to act on behalf of Covered Entity, then such use or disclosure by Identified Person shall be considered an Administrative Function unless the Privacy Rule expressly provides that such use or disclosure is not considered an Administrative Function.

Administrative Functions shall not include: (i) employment-related functions or functions in connection with any other benefits or benefit plan; and (ii) enrollment functions performed by the Plan Sponsor on behalf of its employees.

1.1.2. **Business Associate** – any entity or person who, on behalf of the Covered Entity, performs or assists in the performance of a function or activity involving the use or disclosure of PHI or uses PHI to provide legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to the Covered

Entity. It does not include any Identified Employee or other member of the Employer's workforce.

1.1.3. **Covered Entity** – Health Reimbursement Arrangement for Active Employees and the Postretirement Health Care Savings Arrangement.

1.1.4. **Electronic Protected Health Information ("ePHI")** – "Electronic Protected Health Information" shall mean information that comes within paragraph 1(i) or 1(ii) of the definition of "protected health information," as defined in 45 C.F.R. § 160.103.

1.1.5. **Employer** – the Plan Sponsor and any business entity that adopts one of the group health plans with the consent of the Plan Sponsor, and any successor thereof that adopts one of the group health plans sponsored by the Plan Sponsor.

1.1.6. **Health Care Operations** – means:

(a) Conducting quality assessment and improvement activities, including population based activities relating to improving health or reducing health care costs, case management and care coordination, contacting participants with information about treatment alternatives; and related functions that do not include treatment.

(b) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop loss and excess of loss insurance).

(c) Conducting and arranging for legal services and auditing functions, including fraud and abuse detection and compliance programs.

(d) Business planning and development, such as conducting cost management and planning related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

(e) Business management and general administrative activities of the entity, including, but not limited to:

(i) management activities relating to the implementation of and compliance with the Privacy Rules;

(ii) customer service activities;

(iii) resolution of internal grievances; and

(iv) the sale, transfer, merger or consolidation of all or a part of the covered entity with another covered entity or an entity that

following such transaction will become a covered entity and related due diligence.

(f) Reviewing the performance of any group health plan sponsored by the Employer that participates in an organized health care arrangement.

1.1.7. **Identified Persons** – employees or classes of employees or other persons under Plan Sponsor's control identified in Schedule I to the extent they are performing Administrative Functions for or on behalf of Covered Entity. The Plan Sponsor shall have the authority to amend Schedule I from time to time to add or remove Identified Persons from Schedule I.

1.1.8. **Payment** – refers to most activities related to making or securing payment for providing health care and includes:

(a) Determination of premiums;

(b) Obtaining or providing reimbursement for the provision of health care;

(c) Coverage determination, eligibility determination, coordination of benefits, determination of cost sharing amounts, claims adjudication, review of claims appeals, subrogation of claims;

(d) Assisting participants with claims issues and coverage questions;

(e) Claims management, collection activities, obtaining payment under a contract for reinsurance (including stop loss insurance and excess loss insurance) and related health care data processing;

(f) Review of health care services for medical necessity, coverage, appropriateness of care, or justification of charges; and

(g) Utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services, medical cost containment, utilization management.

1.1.9. **Plan Sponsor** – adopting public Employers.

1.1.10. **Privacy Rule** – the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E. A reference to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.

1.1.11. **Protected Health Information or PHI** – means health information including demographic information collected from an individual, that:

(a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that either identifies the individual or with respect to which there is a reasonable basis to believe the information can be sued to identify the individual;

provided that Protected Health Information shall not include: (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) health care records of post-secondary degree students, as described at 20 U.S.C. 1232g(a)(B)(iv); and (iii) employment records held or maintained by the Employer.

1.1.12. **Required By Law** – a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law. Required By Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

1.1.13. **Security Incident** – "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. § 164.304.

1.1.14. **Security Rule** – the Security Standards and Implementation specifications at 45 C.F.R. part 160 and part 164, subpart C. A reference to a section in the Security Rule means the section as in effect or as amended, and for which compliance is required.

1.1.15. **Summary Health Information** – Individually Identifiable Health Information that summarizes the claims history, claims experiences, or type of claims experienced by individuals for whom benefits have been provided under the Covered Entity and from which certain identifiers have been deleted, except that geographic information may only be aggregated to the level of a five-digit zip code.

SECTION 2 — USE AND DISCLOSURE OF PHI

2.1. **Disclosure of Summary Health Information to Plan Sponsor Without Authorization**. Without an authorization from the subject of the PHI, Covered Entity and Identified Persons may disclose Summary Health Information to Plan Sponsor for purposes of:

(a) obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Covered Entity; or

(b) modifying, amending, or terminating the Covered Entity, any health care component of the Covered Entity.

2.2. **Disclosure of PHI to Plan Sponsor Without Authorization**. Covered Entity may disclose PHI to Plan Sponsor for purposes of determining whether an individual is participating in the Covered Entity.

2.3. **Disclosure of PHI to Identified Persons Without Authorization**. Subject to the minimum necessary requirement set forth in Section 2.5 and the Plan Sponsor certifying to the implementation of the requirements set forth in Section 3, Covered Entity may disclose PHI to Identified Persons for the purpose of performing Administrative Functions.

2.4. **Pursuant to an Authorization**. Pursuant to an authorization that satisfies the requirements of the Privacy Rule, Covered Entity may disclose PHI to Plan Sponsor, to an Identified Person, or to any other person identified in the authorization ("recipient") and such recipient may further use or disclose such PHI for any purpose specified in the authorization. The terms of this Amendment (including but not limited to Sections 3 and 4) shall not apply to disclosures of PHI made pursuant to an authorization.

2.5. **Minimum Necessary Use and Disclosure**. Covered Entity shall make reasonable efforts to limit the disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure as required by the Privacy Rule.

SECTION 3 — CERTIFIED OBLIGATIONS OF PLAN SPONSOR

3.1. **Certification**. Plan Sponsor certifies that it has adopted and implemented the terms and provisions set forth in this Amendment.

3.2. **PHI Certification**. With respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) created, received, maintained, used or disclosed by the Plan Sponsor and/or any Identified Person from or on behalf of the Covered Entity, Plan Sponsor agrees to the following requirements and limitations:

(a) **Prohibition on Unauthorized Use or Disclosure**. Plan Sponsor and/or any Identified Person will not use or further disclose such PHI, except as permitted or required by this Amendment or as Required By Law.

(b) **Subcontractors and Agents**. Plan Sponsor will ensure that any agents, including a subcontractor, to whom such PHI is provided agree to the same restrictions and conditions that apply to Plan Sponsor.

(c) **Prohibition on Employment-Related Actions**. Plan Sponsor and/or any Identified Person will not use or disclose such PHI for employment-related actions and decisions in connection with any other benefit or employee benefit plan sponsored by Plan Sponsor.

(d) **Duty to Report Violations**. To the extent Plan Sponsor and/or an Identified Person becomes aware of any use or disclosure that is inconsistent with the uses or disclosures permitted under this Amendment, Plan Sponsor and/or the Identified Person will report such inconsistent uses or disclosures to Covered Entity.

(e) **Access to PHI**. Upon a request by an individual participating in Covered Entity, Plan Sponsor and/or any Identified Person responsible for handling requests for access will provide such individual with access to his or her PHI, in accordance with Covered Entity's privacy policies and procedures.

(f) **Amendment of PHI**. Upon a request by an individual participating in Covered Entity, Plan Sponsor and/or any Identified Person responsible for handling requests for amendment will respond to such individual's request and incorporate any approved amendments to such PHI, in accordance with the Covered Entity's privacy policies and procedures.

(g) **Accounting of Disclosures**. Upon a request by a an individual participating in Covered Entity, Plan Sponsor and/or any Identified Person responsible for accounting for disclosures of PHI will provide such individual with an accounting of disclosures, in accordance with the Covered Entity's privacy policies and procedures.

(h) **Inspection of Books and Records**. Plan Sponsor will make internal practices, books, and records relating to the use and disclosure of such PHI available to the Secretary of the Department of Health and Human Services for purposes of determining Covered Entity's compliance with the Privacy Rule.

(i) **Retention of PHI**. Plan Sponsor and/or any Identified Person will, if feasible, return or destroy all such PHI that it maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, Plan Sponsor and/or any Identified Person will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) **Firewall**. Plan Sponsor will ensure that adequate separation between Covered Entity, Identified Persons, and Plan Sponsor is established and maintained in accordance Section 4.

3.3. **ePHI Certification**. With respect to any ePHI (other than enrollment/disenrollment information and Summary Health Information which are not subject to these restrictions) created, received, maintained or transmitted by Plan Sponsor and/or any Identified Person from or on behalf of Covered Entity, Plan Sponsor agrees to the following requirements and limitations:

(a) **Subcontractors and Agents**. Plan Sponsor will ensure that any agents, including independent contractors and subcontractors, to whom ePHI is provided from the Covered Entity, agree to implement reasonable and appropriate security measures to protect the ePHI.

(b) **Safeguards**. Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity, as described in the Covered Entity's security policies and procedures.

(c) **Duty to Report Violations**. Plan Sponsor will report to the Covered Entity any Security Incident of which it becomes aware, except that, for purposes of this reporting requirement, the term "Security Incident" shall not include inconsequential incidents that occur on a daily basis such as scans or "pings" that are not allowed past Plan Sponsor's firewall.

SECTION 4 — ADEQUATE SEPARATION

4.1. **Adequate Separation of Covered Entity, Identified Persons and Plan Sponsor**. Covered Entity shall allow only the Identified Persons listed on Schedule I (as amended from time to time) to have access to or use of PHI.

4.2. **Compliance Requirements**.

4.2.1. **Access and Use**. Identified Persons shall have access to and use of PHI only for the purposes of performing Administrative Functions for the Covered Entity and certain other functions Required By Law. Plan Sponsor will ensure the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures to the extent that Identified Persons have access to ePHI.

4.2.2. **Compliance**. For purposes of performing any Administrative Function, an Identified Person shall comply with the requirements of Section 3 and the privacy and security policies and procedures of the Covered Entity.

4.2.3. **Resolution of Any Issues of Noncompliance**. Identified Persons shall be sanctioned or disciplined up to and including termination of employment for failure to comply with the privacy and security policies and procedures of the Covered Entity.

SCHEDULE I

IDENTIFIED PERSONS

Individuals designated (formally or informally) by the adopting Employer who have access to Protected Health Information.