

Eden Prairie ISD #272

VEBA Direct

VEBA Retirement Summary

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INTRODUCTION

The Company's VEBA Direct (the "Plan") provides health reimbursement arrangements for Eligible Retirees, their Spouses and Dependents to be reimbursed for Eligible Medical Expenses. The VEBA Direct Plan is funded solely through Employer Contribution Credits. There are no Participant contributions.

This *Summary* describes the Plan. Through the Plan, you can receive tax-free reimbursement from the Company for uninsured Eligible Medical Expenses for yourself and eligible family members. Defined terms are capitalized. Definitions are as stated in the *Plan Document*. For a complete understanding of Plan terms, you should review this *Summary* and the *Plan Document*. A copy of the *Plan Document* can be requested from the Plan Administrator.

DETAILS REGARDING THE VEBA DIRECT BENEFIT

- (a) **Eligible medical expenses.** To be eligible for reimbursement, an expense must be for medical care provided to diagnose, treat, or prevent disease or for sickness or injury and must be included on the list of eligible medical expenses for this Plan. Please refer to <https://learn.hellofurther.com/> for a list of eligible expenses.
- (b) **Your options for VEBA Direct reimbursements:**
- **Debit Card:** When you open a VEBA Direct with Further, you are automatically enrolled with a Further debit card. Once activated, your VEBA Direct debit card can be used for eligible medical expenses up to your available VEBA Direct balance.
 - **Online:** To receive reimbursement for VEBA Direct expenses, you may submit your form by signing into the Member Online Service Center via www.HelloFurther.com and submitting your claim online.
- (b) **Manual Withdrawal:** To receive reimbursement for medical expenses, you must submit a completed claim form and independent third-party documentation of the expense (see "Obtaining Reimbursements" section).
- (c) **Expenses cannot be reimbursed from any other source, including tax credits or tax deductions.** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud, and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

ELIGIBLE RETIREES

Only Eligible Retirees may participate in the Plan. An Eligible Retiree's participation in the Plan shall [cease or be frozen] for any period during which the individual is an active Employee of Company. You are eligible if you meet the following conditions:

- employed by the Company for at least one year;
- is not an active Employee of the Company;
- and satisfies any other eligibility requirements stated in this *Summary*.

DEPENDENTS

- (a) The VEBA DIRECT can reimburse medical expenses incurred for yourself or your Dependents.
- (b) "Dependent" includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

ENROLLMENT AND PARTICIPATION

You must enroll yourself and your eligible Dependents in the Plan within 30 days of becoming an Eligible Retiree. You will be eligible to receive benefits under the Plan for Eligible Medical Expenses incurred following your Entry Date. If you do not enroll within 30 days of becoming eligible, you will not be entitled to enroll at a later date unless you experience a qualifying event.

ELECTION CHANGES DURING THE PLAN YEAR

- (a) **Mid-Year coverage change events.** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a "Qualifying Election Change"). For complete details, request a copy of the Plan Document from the Plan Administrator or contact the Claims Administrator for assistance.
- (b) **Time limit for making a coverage change.** To change your coverage level, you must request a coverage level change not later than 30 days after the event permitting the change (even if you are on leave at the time). You cannot change your coverage level more than 30 days after an event that permits the coverage level change.
- (c) **Coverage change process.** The Plan Administrator will provide instructions for requesting a coverage change. The Plan Administrator will determine whether a coverage change is permitted.

- (d) **Change in level of coverage.** In the event you change coverage options (e.g., single contract to family contract) during the plan year and the annual credit for your new coverage is a larger amount, then your account will be credited with the difference between the annual credit amount for your previous coverage and the annual credit amount for your new coverage. This additional credit will be made effective on the effective date of your new coverage. The change in your full annual credit amount will be effective on the first day of the following plan year.

In the event you change coverage options (e.g., family contract to single contract) during the plan year and the annual credit for our new coverage is a smaller amount, then your account will not be impacted by this change (meaning the account will not be reduced to reflect the change in coverage) during the remainder of the current plan year. The change to your annual credit amount will be effective on the first day of the following plan year.

OBTAINING REIMBURSEMENTS

- (a) **Amount available for reimbursement.** The amount available for reimbursement is limited to the balance in your VEBA DIRECT at the time that you submit a claim.
- (b) **Expense must be eligible for reimbursement under this plan.** Only Eligible Medical Expenses will be reimbursed. Please refer to <https://learn.hellofurther.com/> for a list of eligible expenses.
- (c) **Expense must have been incurred during your period of coverage.** You may only use your VEBA DIRECT to pay for Eligible Medical Expenses that you incurred while covered under the Plan. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter.
- (d) **Expense cannot be reimbursed out of other accounts.** The VEBA DIRECT cannot be used to reimburse expenses that are reimbursed from any other Account, including a Medical FSA.
- (e) **Claim submission requirements must be satisfied.**
- (1) *Claims must be submitted to Claims Administrator.* Claims should be sent or faxed directly to the Claims Administrator at the address or number listed on the bottom of the claim form. (The only exception is if you elect “crossover” of medical or dental claims, in which case the High Deductible Health Plan automatically submit requests for reimbursement of non-covered expenses (e.g., deductible amounts) to your VEBA DIRECT).
- (2) *Claims must be submitted during the Plan’s Claims Submission Period.* **Claims should be submitted within 18 months after the Date of Service.**

- (3) *Documentation must be provided.* To receive reimbursement for Eligible Medical Expenses, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill, receipt or an Explanation of Benefits) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.
- (4) *Claims cannot be reimbursed by Health Insurance.* You cannot request reimbursement of an expense that has been or will be reimbursed by health insurance.
- (f) **Method of reimbursement.** The Claims Administrator will reimburse Eligible Medical Expenses through a check or, if you so choose, direct deposit. Reimbursements will be issued as scheduled by the Claims Administrator.
- (g) **Recovery of improper reimbursements.** You will be required to repay the Plan for reimbursements the Claims Administrator determines to have been improper. The Claims Administrator may use one or more of the following recovery methods: (i) your repaying the amount to your VEBA DIRECT or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursements to you for Eligible Medical Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement will be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

(a) Initial determination on claim for reimbursement.

- (1) *Time Period.* The Claims Administrator will make its decision on the claim within 30 days after receipt of the claim. The 30-day period for the initial determination may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Administrator; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Administrator expects to render its decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

- (2) *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notice of the denial to you, which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure. If a denial is based on an internal rule or guideline or medical judgment, information regarding the internal rule or guideline or medical judgment will either be included in the written response or you will be able to obtain a copy of the internal rule or guideline or an explanation of the medical judgment on request and free of charge.

(b) **Appeal Rights and Procedures.**

- (1) *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Claims Administrator. You must send a written request for an appeal review to the Claims Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.
- (2) *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.
- (3) *Person Conducting Review.* The review will be conducted by a named fiduciary for the Plan who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination. In deciding an appeal of any adverse benefit determination that is based, in whole or in part, on a medical judgment, the administrator will consult with a medical care professional who has appropriate training and experience in the applicable medical field and who is neither the individual who was consulted in connection with the initial adverse determination nor a subordinate of such individual.
- (4) *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the decision on appeal in writing within 60 days after the Claims Administrator received your appeal. The notice will include the reason for the decision.
 - (i). *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through Further. If you are not

satisfied with our decision, you may elect to further appeal to Further by sending a letter within 30 days or the later of your run out end date requesting our Further Corporate Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the Further Corporate Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

- (ii) *External Review Process.* If you still disagree with the Claims Administrator's decision, you have the right to an external review of the Claims Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the VEBA DIRECT Plan's eligibility requirements. Your external appeal must be filed with the Claims Administrator within four (4) months of the date you were served with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether the adverse benefit determination qualifies for external review. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review. The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

TERMINATION OF PARTICIPATION

- (a) Your participation in this Plan will end if:
- (1) you no longer qualify as an Eligible Retiree;
 - (2) your Employer stops participating in this Plan;
 - (3) you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan;
 - (4) the Company terminates the Plan; or

(5) if the certifications you made to participate are no longer accurate.

Upon termination of participation, any balance remaining in your VEBA Direct Plan, after all eligible claims have been processed, will be forfeited.

- (b) **Termination of coverage upon your death.** Upon your death, your eligible Dependents will continue to have access to your VEBA Direct Plan account. They may be reimbursed for Eligible Health Expenses you incurred in the 18 months prior to death.

If you die without a Spouse or other eligible Dependent, your VEBA Direct Plan account will revert to the VEBA Direct Plan or to your designated non-tax beneficiary. For collectively bargained groups, and unless otherwise provided for in a collectively bargaining agreement, any amounts that revert to the VEBA Direct Plan upon death will be allocated uniformly to the accounts of members in the VEBA Direct Plan who are Eligible Retirees of the Employer, and who are current or retired members of the same collective bargaining unit. For nonunion Eligible Retirees, and unless otherwise provided for in a personnel policy, any such amounts will be allocated uniformly to members of the VEBA Direct Plan who are Eligible Retirees of the Employer.

NOTICE OF COBRA CONTINUATION COVERAGE.

- (a) **Continuation.** You or your covered Dependents may continue this coverage if coverage ends due to any of the qualifying events listed below. You and your eligible Dependents must be covered under this Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the Plan ends or required charges are not paid when due.
- (b) **Qualifying Events.** If you are the Eligible Retiree and are covered, you have the right to elect continuation coverage if you lose coverage because the Company terminates the Plan or if they file bankruptcy. If you are the spouse of a covered Eligible Retiree, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:
- The death of the Eligible Retiree.
 - Entering of decree in the event of a divorce or legal separation from the Eligible Retiree. (Also, if the Eligible Retiree eliminates coverage for his or her spouse in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the later divorce and can establish that the coverage was eliminated earlier in anticipation of the divorce, then continuation coverage may be available for the period after the divorce.)
 - The Eligible Retiree becomes enrolled in Medicare.

In the case of a Dependent child of a covered Eligible Retiree, the Dependent child has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the Eligible Retiree.
- Parents' divorce or legal separation.
- The Eligible Retiree becomes enrolled in Medicare.
- The Dependent ceases to be a "Dependent child" under the Plan.

(c) **Your Notice of Obligations.** You and your Dependents must notify the Employer of any of the following events within 60 days of the occurrence of the event:

- Divorce or legal separation.
- A Dependent child no longer meets the Plan's eligibility requirements.

Note: Refer to "Disability Extensions" in "Extension of Maximum Coverage Periods" below for three (3) additional notification requirements.

If you or your Dependents fail to provide this notice during this 60-day notice period, any Dependent who loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your Dependents fail to provide this notice, and if any claims are mistakenly paid for expenses incurred after the date coverage was to terminate, then you and your Dependents will be required to reimburse the Plan for any claims paid.

When you notify the Employer that a divorce or a loss of Dependent status will cause a loss of coverage, then the Employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the Employer of a qualifying event or disability determination and the Employer determines that there is no extension available, the Employer will provide an explanation as to why you or your Dependents are not entitled to elect continuation coverage.

(d) **Employer's and Plan Administrator's Notice Obligations.** The Employer has 30 days to notify the Plan Administrator of events they know have occurred, such as termination of employment or death of the Eligible Retiree. This 30-day notice to the Plan Administrator is not often used because usually the Plan Administrator is the Employer. After plan administrators are put on notice of the qualifying event, they have 14 days to send the qualifying event notice. The qualified beneficiaries must be allowed 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage would end due to the qualifying event or the date of the qualifying-event notice, whichever is later. The Employer will also notify you and your Dependents of the right to elect continuation coverage after receiving notice that one of the following events occurred and resulted in a loss of coverage: the Eligible Retiree's termination of employment

(other than for gross misconduct), reduction in hours, death, or the Eligible Retiree's becoming enrolled in Medicare.

- (e) **Election Procedures.** You and your Dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. If you or your Dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.

You or your Dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse may not decline coverage for the other spouse and a parent cannot decline coverage for a non-minor Dependent child eligible for coverage. In addition, a Dependent may elect continuation coverage even if the covered Eligible Retiree does not elect continuation coverage.

You and your Dependents may elect continuation coverage even if covered under another Employer-sponsored group health plan or enrolled in Medicare.

- (f) **How to Elect.** Contact the Employer to determine how to elect continuation coverage.

- (g) **Type of Coverage.** Ordinarily, the continuation coverage that is offered will be the same coverage that you or your Dependent had on the day before the qualifying event. Therefore, anyone who is not covered under the Plan on the day before the qualifying event generally is not entitled to continuation coverage. (Exceptions: 1) If coverage was eliminated in anticipation of a qualifying event such as divorce and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse had lost coverage earlier. The ex-spouse must notify the Employer within 60 days after the later divorce and establish that the coverage was eliminated earlier in anticipation of divorce; and 2) A child born to or placed for adoption with the covered Eligible Retiree during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period.)

Qualified beneficiaries must be provided the same rights and benefits as similarly situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly situated active Eligible Retirees or their Dependents, then continuation coverage will be modified in the same way. (Examples: 1) If the Employer offers an Open Enrollment Period that allows active Eligible Retirees to switch between plans without being considered late entrants, all qualified beneficiaries on continuation should be allowed to switch plans as well; and 2) If active Eligible Retirees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation should also be afforded this same right.)

- (h) **Maximum Coverage Periods.** The maximum duration for continuation coverage is described below. Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of Continuation Coverage before the End of the Maximum Coverage Period." In other instances, the maximum coverage period can be extended as described under the heading "Extension of Maximum Coverage Periods."
- (1) 18 Months. If you or your Dependent loses coverage due to the Eligible Retiree's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.
 - (2) 36 Months. If a Dependent loses coverage because of the Eligible Retiree's death, divorce, legal separation, the Eligible Retiree became enrolled in Medicare or because of a loss of Dependent status under the Plan, then the maximum coverage period (for spouse and Dependent child) is three (3) years from the date of the qualifying event.
- (i) **Extension of Maximum Coverage Periods.** Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.
- (1) The general rule is that the maximum coverage period runs from the date of the triggering (qualifying) event, even if the actual loss of coverage per the terms of the Plan does not occur until later. The Employer has 30 days from the date of the triggering event to notify the Plan Administrator of the qualifying event.
 - (2) *Extended Notice Rule:* Under the extended notice rule, the maximum coverage period runs from the date that a qualified beneficiary's loss of coverage occurs (rather than the triggering event), if the Employer also sends its notice of the qualifying event to the Plan Administrator within 30 days after the loss of coverage instead of 30 days after the occurrence of the triggering event. Use of this delayed commencement of coverage period coupled with the extension of the Employer's notice period has the effect of extending the maximum coverage period.
 - (i) This extension is applicable only when loss of coverage is due to termination of employment, reduction of hours, death of the Eligible Retiree, or the Eligible Retiree's Medicare enrollment, and the extension applies to all qualified beneficiaries.
 - (ii) Example: The triggering event, termination of employment, occurs on January 5. The loss of coverage under the terms of the Plan, however, does not occur until January 31. Under the Extended Notice Rule, the Employer must notify the Plan Administrator of the qualifying event

within 30 days after coverage is lost and the maximum coverage period begins when coverage is lost, January 31.)

- (3) *Disability Extension:* This extension is applicable when the qualifying event is the Eligible Retiree's termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your Dependent who is a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan Administrator of the Social Security Administration disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the qualifying event (the Eligible Retiree's termination of employment or reduction of hours); 3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator.

Notice Obligation: The qualified beneficiary must notify the Plan Administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the Eligible Retiree's termination of employment or reduction of hours.)

Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of 1) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the formerly disabled qualified beneficiary is no longer disabled; or 2) the end of the coverage period that applies without regard to the disability extension.

- (4) *Multiple Qualifying Events:* This extension is applicable when the qualifying event is the Eligible Retiree's termination of employment or reduction of hours (each of which triggers an 18-month maximum coverage period) is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the Eligible Retiree, divorce, legal separation, the Eligible Retiree becoming enrolled in Medicare or a Dependent child losing Dependent

status). The extension applies to the Eligible Retiree's Dependents that are qualified beneficiaries.

If a second qualifying event occurs within an 18-month or 29-month coverage period that gives rise to a 36-month maximum coverage period for the Dependent, then the maximum coverage period (for the Dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of continuation coverage will occur.

- (5) *Pre-Termination or Pre-Reduction Medicare Enrollment:* This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the Eligible Retiree's Medicare enrollment. The extension applies to the Eligible Retiree's Dependents who are qualified beneficiaries. If the qualifying event occurs within 18 months after the Eligible Retiree becomes enrolled in Medicare, regardless of whether the Eligible Retiree's Medicare enrollment is a qualifying event (causing a loss of coverage under the group Plan), the maximum period of continuation for the Eligible Retiree's Dependents who are qualified beneficiaries is three (3) years from the date the Eligible Retiree became enrolled in Medicare. (Example: Eligible Retiree becomes enrolled in Medicare on January 1. Triggering/qualifying event, Eligible Retiree's termination of employment or reduction of hours is May 15. The Eligible Retiree is entitled to 18 months of continuation from the date coverage is lost. The Eligible Retiree's Dependents are entitled to 36 months of continuation from the date the Eligible Retiree is enrolled in Medicare.) If the qualifying event (Eligible Retiree's termination of employment or reduction of hours) is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment or occurs before Medicare enrollment, no extension is available.
- (6) *Employer's Bankruptcy:* The bankruptcy rule technically is an initial qualifying event rather than an extending rule. However, because it would result in a much longer maximum coverage period than 18 or 36 months, it is included here. If the Employer files Chapter 11 bankruptcy, it may trigger COBRA coverage for certain retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and Dependent children are entitled to coverage for the life of the retiree, and, if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the Plan, then that surviving spouse is entitled to coverage for life.

(j) **Termination of continuation coverage before the end of maximum coverage period.** Continuation coverage of the Eligible Retiree and Dependents will automatically terminate (before the end of the maximum coverage period) when any one of the following events occurs:

- The Employer no longer provides group health coverage to any of its Eligible Retirees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due. Charges for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a disability, the charges for continuation can be up to the group rate plus a 50% administration fee for months 19-29. All charges are paid directly to the Employer.
- After electing continuation, you or your Dependents become covered under another group health plan (as an Eligible Retiree or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable preexisting condition exclusions or limitations, then your continuation coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note: An exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the new group health plan.)
- You or your Dependent became entitled to a 29-month maximum coverage period due to the disability of a qualified beneficiary, but then the Social Security Administration makes the final determination that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Eligible Retirees or their Dependents who have coverage under the Plan for a reason other than the continuation coverage requirements of federal law.
- Voluntarily dropping your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be sent from the Plan Administrator. The notice will contain the reason continuation coverage has been terminated, the date of the termination, and any rights to elect alternative coverage that may be available.

(k) **Children born to or placed for adoption with the covered Eligible Retiree during continuation period.** A child born to, adopted by or placed for adoption with a covered Eligible Retiree during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered Eligible Retiree is a qualified beneficiary and has

elected continuation coverage for himself/herself. The child's continuation coverage begins on the date of birth, adoption, or placement for adoption and it lasts for as long as continuation coverage lasts for other family members of the Eligible Retiree. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

- (l) **Open enrollment rights and special enrollment rights.** Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly situated active Eligible Retirees to change their coverage options or to add or eliminate coverage for Dependents at Open Enrollment. Special enrollment rights will apply to those who have elected continuation. Except for certain children described above, Dependents who are enrolled in a special enrollment period or Open Enrollment Period do not become qualified beneficiaries – their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as Dependents.
- (m) **Address changes, marital status changes, dependent status changes and disability status changes.** If your or your Dependent's address changes, you must notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important continuation notices and other information). Also, if your marital status changes or if a Dependent ceases to be a Dependent eligible for coverage under the terms of the Plan, you or your Dependent must notify the Plan Administrator in writing. In addition, you must notify the Plan Administrator if a disabled Eligible Retiree or family member is no longer disabled.
- (n) **Special second election period.** Special continuation rights apply to certain Eligible Retirees who are eligible for the health coverage tax credit. These Eligible Retirees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an Eligible Retiree becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the Plan Administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

- (o) **Questions.** If you have general questions about continuation of coverage, please call the telephone number on the back of your identification card for assistance.
- (p) **Overview.** The following chart is an overview of the information outlined in the previous sections. For more details, refer to the previous sections.

Qualifying Event/ Extension	Who May Continue	Maximum Continuation Period
<ul style="list-style-type: none"> Divorce or legal separation 	Former spouse and any Dependent children who lose coverage	Earliest of: <ol style="list-style-type: none"> 36 months; or Enrollment date in other group coverage; or Date coverage would otherwise end.
<ul style="list-style-type: none"> Death of Eligible Retiree 	Surviving spouse and Dependent children	Earliest of: <ol style="list-style-type: none"> 36 months; or Enrollment date in other group coverage; or Date coverage would otherwise end if the Eligible Retiree had lived.
<ul style="list-style-type: none"> Dependent child loses eligibility 	Dependent child	Earliest of: <ol style="list-style-type: none"> 36 months; or Enrollment date in other group coverage; or Date coverage would otherwise end.
<ul style="list-style-type: none"> Dependents lose eligibility due to the Eligible Retiree's enrollment in Medicare 	All Dependents	Earliest of: <ol style="list-style-type: none"> 36 months; or Enrollment date in other group coverage; or Date coverage would otherwise end.
<ul style="list-style-type: none"> Retirees of the Employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing) 	Retiree Dependents	Lifetime continuation Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
<p>Extensions to 18-month maximum continuation period:</p> <ul style="list-style-type: none"> Disability, as determined by the Social Security Administration, of Eligible Retiree or Dependent(s) 	Disabled individual and all other covered family members	Earliest of: <ol style="list-style-type: none"> 29 months after the Eligible Retiree leaves employment; or Date disability ends; or Date coverage would otherwise end.

OTHER LEGAL NOTICES.

(q) **HIPAA Privacy Rule Notice of Privacy Practices.** The Plan is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the Plan's *Notice of Privacy Practices*

(which summarizes the Plan's Privacy Rule obligations, your Privacy Rule rights, and how the Plan may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

- (r) **Company's right to terminate or amend the plan.** The Company reserves the right to amend or terminate the Plan at any time and without notice.
- (s) **No guarantee of employment.** Participation in this Plan is not a guarantee of employment.
- (t) **Plan Administrator's Discretion.** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

PLAN SPECIFICATIONS

Plan year: July 1 to June 30

Your Further Group Number: 017999

**Addendum for Eden Prairie Retiree VEBA
Effective July 1, 2019**

IMPORTANT: In part due to the unique plan design and the sponsoring employer being a Minnesota public sector employer, many provisions of the VEBA Direct Retiree Plan Document, including the VEBA Direct VEBA Retirement Summary, do not apply and/or do not describe the necessary terms, conditions, and features of the Eden Prairie's retiree access funded HRA. This Addendum modifies the VEBA Direct Retiree Plan Document through replacement of certain sections and the addition of other terms and conditions such that the VEBA Direct Retiree Plan Document plus the Addendum adequately reflect the term, conditions and features of Eden Prairie's retiree access funded HRA. Unless specifically provided in this Addendum otherwise, the effective date of the Addendum is July 1, 2019.

The provisions of the VEBA Direct Retiree Plan Document, including the corresponding provisions of the VEBA Direct VEBA Retirement Summary impacted by this Addendum, include:

Notwithstanding any provision to the contrary and specifically Section 1.2 (B), this Plan is a stand-alone plan, excepted from HIPAA Administrative Simplification, and excepted from the ACA mandates. Provisions referring to, or relying upon, HIPAA Administration Simplification (including but not limited to Special Enrollment), do not apply.

Notwithstanding any provision to the contrary and specifically Section 2.8, COBRA applies to this Plan through the Public Health Services Act ("PHSA").

Notwithstanding any provision to the contrary and specifically Section 2.12, for purposes of the Plan, the phrase "Eligible Employee" refers to an Employee that has terminated service with the Employer and pursuant to personnel policy (for non-bargained employees) or the bargaining agreement (for collectively bargained employees) is entitled to coverage under this Plan.

Notwithstanding any provision to the contrary and specifically Section 2.16, Section 4.3, and Section 4.5, Employer Contribution Credits are established through personnel policy (for non-bargained employees) or the bargaining agreement (for collectively bargained employees), including but not limited to dates by which Employer Contribution Credits must be made, any applicable maximums, limitations on Eligible Medical Expenses, and any other special provisions. Section 4.3(B) does not apply.

Notwithstanding any provision to the contrary and specifically Section 2.17, Section 6.1, and Section 7.2, ERISA does not apply to this Plan.

Notwithstanding any provision to the contrary and specifically Section 2.18, only an Eligible Employee, as modified above, can participate in this Plan.

Notwithstanding any provision to the contrary and specifically Section 2.24, Section 2.26, Section 3.1, and Section 5.1, "Participant" and "Eligible Employee desiring to participate", refer to an Eligible Employee who has terminated service with the Employer and pursuant to personnel policy (for non-bargained employees) or the bargaining agreement (for collectively bargained employees) is entitled to coverage under this Plan, and therefore, automatically becomes a Participant under the Plan.

Notwithstanding any provision to the contrary and specifically Section 2.31, Employer Contribution Credits define both the cost of coverage under this Plan and, once allocated to the Participant's Account, the benefits available under this Plan.

Notwithstanding any provision to the contrary and specifically Section 2.32, there is no service requirement under the Plan. All requirements related to eligibility are addressed as part of the definition of Eligible Employee as modified above.

Notwithstanding any provision to the contrary and specifically Section 3.2, terms relating to eligibility for coverage and the amount and timing of Employer Contributions Credits are described in personnel policy (for non-bargained employees) or the bargaining agreement (for collectively bargained employees).

Notwithstanding any provision to the contrary and specifically Section 4.1, "Plan Benefits" for purposes of the Plan refers to the Employer Contribution Credits allocated to, and available for distribution from, a Participant's Account.

Notwithstanding any provision to the contrary and specifically Section 4.3, the Plan may accept contributions from Participants for the limited purposes of COBRA continuation coverage and correcting a mistaken payment by the Plan.

Notwithstanding any provision to the contrary and specifically Section 4.4, if necessary, a Participant may have more than one Account established, each with separate and specific terms and conditions.

Notwithstanding any provision to the contrary and specifically Section 4.6, reimbursements are made from the Participant's Account balance available at the time payment is to be made.

Notwithstanding any provision to the contrary and specifically Section 4.6(B) and Section 2.13, unless specifically limited by the terms of a Participant's Account, or pursuant to personnel policy (for non-bargained employees) or the bargaining agreement (for collectively bargained employees), Eligible Medical Expenses consist of expenses satisfying Code Section 213(d) medical care, as limited by IRS guidance. In addition, Eligible Health Expenses as used in this Plan, is synonymous with Eligible Medical Expenses.

Notwithstanding any provision to the contrary and specifically Section 4.7, no amount shall be paid from this Plan other than as a benefit due under this Plan.

Notwithstanding any provision to the contrary and specifically Section 4.8, upon termination of eligibility under the Plan, the Participant's Account may still be accessed by the Participant (or a Dependent if the Participant has died) for the reimbursement of Eligible Health Expenses until such time as the Participant Account is exhausted. This opportunity is referred to as "spend down." However, where COBRA continuation coverage is also available, ability to spend down the Account must be elected in lieu of otherwise available COBRA continuation coverage.

Notwithstanding any provision to the contrary and specifically Section 4.9, the Plan is funded through a trust. At any point in time, a Participant's Account balance is part of the Plan assets funded through that trust.

Notwithstanding any provision to the contrary and specifically Section 4.10, should the Employer desire to move administration of the Plan to a different service provider, the Plan may be amended and the Plan assets held in the trust may be moved to a new trust so as to continue being available to pay benefits under the Plan.

Notwithstanding any provision to the contrary and specifically Section 7.11, upon the Participant's death, no benefits under this Plan shall be made available to persons other than the Participant's Dependents. And, there shall be no access to a Participant's Account balance other than through spend down, as described above, or COBRA continuation coverage.

Notwithstanding any provision to the contrary and specifically Section 7.14, "employee" includes "former employees," like retirees. Application of the nondiscrimination requirements to a plan benefitting retired employees shall follow the Treasury Regulations applicable to Section 105(h).

In addition, for purposes of this Plan, a reference to “the summary” or “Summary Plan Description” shall not change the terms of the Plan as modified by this Addendum and shall not conflict personnel policy (for non-bargained employees) or the bargaining agreement (for collectively bargained employees)

In addition, for purposes of this Plan, references to “VEBA Direct” are references to the Plan. And for purposes of this Plan, “Plan” refers to the health reimbursement arrangement (“HRA”) through which certain retired Employees have access to their Participant Account.

In addition, for purposes of Section 2.27, any “Plan Rule” shall be documented in writing, consistent with applicable law, consistent with the language of the Plan, uniformly and consistently applied, and available upon request to the Plan Administrator at no charge.

In addition, Section 7.1 shall have the following sentence added to the end:

This separate document shall be consistent with applicable law, consistent with the language of the Plan, uniformly and consistently applied, and available upon request to the Plan Administrator at no charge.

Finally, notwithstanding any provision to the contrary, it is the intention of the Employer that this Plan be maintained, operated, and administered in accordance with applicable law.

Eden Prairie School District

Date _____, 2019

By _____

Its _____