

**MINNEAPOLIS COLLEGE OF ART & DESIGN**

**FLEXIBLE BENEFIT PLAN**

**Amended and Restated Effective January 1, 2012  
(unless otherwise stated)**

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**MINNEAPOLIS COLLEGE OF ART & DESIGN**

**FLEXIBLE BENEFIT PLAN**

**Amended and Restated Effective January 1, 2012**

**Article I. The Plan**

Section 1.1 Amendment and Restatement. Minneapolis College of Art & Design (hereinafter the “Employer”), hereby amends and restates, effective January 1, 2012 (unless otherwise stated), the MINNEAPOLIS COLLEGE OF ART & DESIGN FLEXIBLE BENEFIT PLAN (the “Plan”), which is a plan of flexible compensation for the exclusive benefit of Eligible Employees of the Employer.

Section 1.2 Purpose. The purpose of the Plan is to increase the social insurance protection of Eligible Employees by giving those employees a choice of receiving different combinations of cash and taxable and nontaxable benefits offered under the Plan. The Plan is intended to qualify as a “cafeteria plan” within the meaning of Section 125(d) of the Internal Revenue Code of 1986, as amended (the “Code”), to provide benefits which are eligible for exclusion from employee income under Section 125(a) of the Code, and to comply with the provisions of Sections 79, 104, 105, 125, and 129 of the Code.

**Article II. Definitions**

Section 2.1 Definitions. Whenever used in the Plan, the following words and phrases shall have the meanings set forth below unless the context plainly requires a different meaning, and when the defined meaning is intended, the term is capitalized:

(a) “Code” means the Internal Revenue Code of 1986, as amended, or as it may be amended from time to time.

(b) “Compensation” of a Participant means the total base salary or wages paid to the Participant, including vacation pay, sick pay, and holiday pay and any other pay designated by the Employer (without regard to any salary reduction under this Plan or any Employer-sponsored Section 403(b) Plan).

(c) “Dependent” means an individual who qualifies as a dependent under the terms of Section 152 of the Code. Effective December 1, 2010, for purposes of Health Coverage under Section 5.2(a) and Dental Coverage under Section 5.2(f), the term Dependent also includes any child of a Participant, provided that such child shall cease to be a Dependent for these purposes as of the first day of the month following such child’s attainment of the age twenty-six (26).

(d) “Election” means an election pursuant to Article IV by an Eligible Employee to participate in the Plan and the designation by the Participant of Salary Reduction Contributions to be made on the Participant’s behalf among optional benefit coverages available under the Plan.

(e) “Eligible Employee” means an employee of the Employer who is employed in the United States and who is scheduled to work 1,000 hours or more each Plan Year, except for the following:

- (i) persons covered by a collective bargaining agreement to which the Employer is a party, unless such collective bargaining agreement expressly provides for inclusion of such persons in the Plan;
- (ii) leased employees (including, but not limited to, those individuals defined in Code Section 414(n));
- (iii) persons classified by the Employer as independent contractors, contract workers, temporary employees, casual employees, or adjunct faculty; or
- (iv) nonresident aliens who receive no earned income from the Employer that constitutes income from sources within the United States.

(f) “Employee” means a person who is classified by the Employer as a common law employee and who is on the Employer’s W-2 payroll.

(g) “Employer” means Minneapolis College of Art & Design.

(h) “Employment Related Dependent Care Expense” means an “employment-related expense,” as defined in Section 21(b) of the Code. As of the effective date of the amended and restated Plan, this means an amount paid for expenses of a Participant for household services or for the care of a Qualifying Individual, to the extent that such expenses are incurred to enable the Participant and the Participant’s spouse, if any, to be gainfully employed, within the meaning of Section 21(b)(2) of the Code, for any period for which there are one (1) or more Qualifying Individuals with respect to such Participant. If the Participant’s spouse is a full time student at an educational institution, or is physically or mentally incapable of self care, the requirement that the expenses enable the spouse to be gainfully employed is waived. Expenses incurred outside the Participant’s household shall constitute Employment Related Dependent Care Expenses only if incurred for a Qualifying Individual who regularly spends at least eight (8) hours per day in the Participant’s household. If the expense is incurred outside the Participant’s home at a facility that provides care for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any. Employment Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred for services provided by a child of such Participant who is under the age of nineteen (19) or an individual for whom the Participant or the Participant’s spouse can claim a deduction under Section 151(c) of the Code. Employment Related Dependent Care Expenses shall not include charges in connection with a Qualifying Individual’s food, clothing, entertainment, or education (for a child in Kindergarten or a higher grade), unless such charges are incidental, minimal, and inseparable from the cost of caring for a Qualifying Individual, or expenses for services at a camp where the Qualifying Individual stays overnight.

(i) “Grace Period” means the period that is two (2) months and fifteen (15) days following the end of the Plan Year. The Grace Period applies uniformly to all Participants who elect to participate in the Medical Reimbursement Plan described in Article VI.

(j) “Medical Care” means the diagnosis, cure, mitigation, treatment, or prevention of sickness, injury, or physical or mental defect. Expenses for Medical Care shall consist of

expenses for medical care as defined in Sections 213(d)(1)(A) and (B) of the Code, and shall include, but not be limited to, payments for the purpose of affecting any structure or function of the body, for any hospital or nursing charges, optometrical, ophthalmological, or auditory care, dental care, psychiatric care, prescription drugs, insulin, eyeglasses, hearing aid appliances, and similar prosthetic devices, and medical related transportation expense; provided that such expenses would otherwise qualify for the exclusion under Section 105(b) of the Code, and further provided that such expenses on behalf of the Participant's child who has attained age twenty-six (26) shall be Medical Care only until the last day of the month in which such child attains age twenty-six (26). Medical Care shall not include any cosmetic procedure that is not medically necessary, nor shall it include expenses for long term care or for insurance premiums for health coverage. Expenses incurred for a medicine or drug shall not be Medical Care unless such medicine or drug is insulin or a prescribed medicine or drug.

(k) "Key Employee" means a person as defined in Section 416(i)(1) of the Code.

(l) "Participant" means an Eligible Employee of the Employer who has satisfied the participation conditions of Article III. A person who becomes a Participant shall remain a Participant for the limited purpose of Plan claims procedures and determining any and all benefits that may be due under the Plan, until all benefits due the Participant under the provisions of the Plan have been paid to the Participant or otherwise have been satisfied.

(m) "Period of Coverage," with respect to any Plan Year, means the Plan Year; provided that,

- (i) for any Eligible Employee who becomes a Participant after the start of a Plan Year, the Period of Coverage shall mean the period commencing on the effective date of the Eligible Employee's participation and extending through the remainder of the Plan Year,
- (ii) the Period of Coverage for any Participant shall end upon termination of employment or the Participant ceasing to be an Eligible Employee, except in the case of medical reimbursement coverage under Article VI, if the Employee continues coverage in a manner consistent with this Plan,
- (iii) the Period of Coverage for any Participant who makes an Election change in accordance with Section 4.4, is the applicable period before or after the Election change and
- (iv) with respect to the calendar year 2010, due to a change in the Plan Year effective December 1, 2010, there shall be for the short plan year of December 1, 2010, to December 31, 2010, a Period of Coverage from December 1, 2010, to December 31, 2010.

(n) "Plan" means the "Minneapolis College of Art & Design Flexible Benefit Plan" as set forth herein and as amended or restated from time to time.

(o) "Plan Administrator" means the person or persons designated to administer the Plan pursuant to Article IX hereof.

(p) "Plan Year" means the calendar year, except that there shall be a short plan year of December 1, 2010, to December 31, 2010, due to the change from a Plan Year beginning each

December 1 to Plan Year beginning each January 1.

(q) “Qualifying Individual” means a “qualifying individual” as defined in Section 21(b) of the Code, which includes, on the effective date of this Plan, (i) a Dependent of a Participant described in Section 152(a)(1) of the Code who is under the age of thirteen (13), and (ii) a Participant’s Dependent or spouse who is physically or mentally incapable of caring for himself, and has the same principal place of abode as the Participant for more than one-half (1/2) of the taxable year; or (iii) a child described in (i) or (ii) of this paragraph whose parents are divorced, legally separated or separated under a written separation agreement. Such a child is treated for any taxable year as a Qualifying Individual of that parent who is the custodial parent (as defined in Section 152(e)(4)(A) of the Code), and shall not be treated as a Qualifying Individual of the parent who is the non-custodial parent.

(r) “Salary Reduction Contribution” means the amount by which a Participant may reduce his or her Compensation and elect to apply such Compensation on a pre-tax basis to the purchase of benefits described in Article V.

- (s) “Status Change” means any of the following:
- (i) an event that changes the marital status of the Participant, including marriage, death of the Participant’s spouse, divorce, legal separation or annulment;
  - (ii) an event that changes the Participant’s number of Dependents, including birth, adoption, placement for adoption, or death;
  - (iii) any of the following events that change the employment status of a Participant, or a Participant’s spouse or Dependent: termination or commencement of employment; a strike or lockout; commencement of or return from an unpaid leave; and a change in worksite;
  - (iv) any other change in employment status of a Participant, or a Participant’s spouse or Dependent (such as a reduction or increase in hours of employment, or a change from salaried to hourly-paid), if the event causes that individual to gain or lose eligibility under his or her employer’s flexible benefits plan or other employee benefit plan;
  - (v) an event that causes a Participant’s Dependent to satisfy or cease to satisfy the eligibility requirements of the Plan due to attainment of age, student status, or similar circumstance as provided in the plan or program; or, in the case of dependent care reimbursement coverage under Article VII, a Dependent ceases to be a Qualifying Individual;
  - (vi) a change in the place of residence of the Participant, or Participant’s spouse or Dependent which renders the person unable to use a qualified benefit plan (such as relocation outside the health plan service area);
  - (vii) for all benefits under this Plan except Medical Reimbursement coverage under Article VI, a change in coverage of a Participant’s spouse or Dependent made during the open enrollment period of

- the spouse's or Dependent's employer, provided that the period of coverage under the spouse or Dependent's employer plan is different from the period of coverage under this Plan; or
- (viii) such other events as may constitute status changes under applicable law and regulations, that the Employer, in its sole discretion, decides to recognize as Status Changes under the Plan.
  - (ix) With respect to an accident or health plan sponsored by the Employer, Status Change also means:
    - (a) the exercise of a right under the special enrollment rules of Code Section 9801(f) (HIPAA enrollment rights);
    - (b) the entitlement of a Participant or a Participant's spouse or Dependent who is enrolled in an accident or health plan of the Employer to coverage under Part A or B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid) (other than coverage for pediatric vaccines), or the loss of such entitlement by a Participant or Participant's spouse or Dependent; or
    - (c) a change required under a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for the child of a Participant who is a Dependent of the Participant and such coverage is, in fact, provided.

Section 2.2 Gender and Number. Pronoun references in the Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.

### **Article III. Eligibility and Participation Conditions**

Section 3.1 Participation Conditions. As a condition to participation and receipt of benefits under this Plan, an Eligible Employee agrees to:

- (a) Furnish to the Employer the application to participate provided for in Section 3.2 within thirty (30) days of becoming an Eligible Employee and thereafter during the Plan's open enrollment period for each year;
- (b) Designate a portion of his/her Compensation as Salary Reduction Contributions in accordance with the provisions of this Section and Section 4.1;
- (c) Observe all rules and regulations implementing this Plan;
- (d) Consent to inquiries by the Employer with respect to any physician, hospital, or other provider of Medical Care or other services involved in a claim under this Plan; and
- (e) Submit to the Employer, or such other agent as the Employer may designate, all reports, bills, and other information which the Employer may reasonably require.

Section 3.2 Application to Participate. As a condition of participation, each Eligible Employee shall execute and deliver to the Employer a written and signed application by which the Eligible Employee makes an Election to participate in the Plan, designates the required

amount of Compensation for the Plan Year in question as Salary Reduction Contributions as described in Section 4.1, makes a benefit Election, and supplies any other pertinent information that the Employer reasonably requires. Elections must be made before the first day of the Plan Year, or, for new Eligible Employees, within thirty (30) days of employment.

Section 3.3 Commencement of Participation. An Eligible Employee will become a Participant on the first day of the month following his or her date of hire, provided the Eligible Employee satisfies all participation conditions provided for in Section 3.1, or on the first day of any subsequent Plan Year.

Section 3.4 Coverage After Commencement of Participation. Employees who waived coverage under one of the Plan's component benefit plans listed in Section 5.2 when they first entered the Plan may elect such coverage during open enrollment for a subsequent Plan Year, or upon a Status Change or other change in circumstances permitting an Election change, only if they meet the eligibility requirements of the applicable component plan.

Section 3.5 Continuation of Coverage. The following rules shall govern continuation of coverage under the Plan under Section 4980B of the Code and other relevant law:

(a) *COBRA Coverage*. For purposes of the Medical Reimbursement Plan set forth in Article VI, a Participant whose coverage under such Plan would otherwise terminate may elect to continue coverage under the Plan under the rules of Section 4980B of the Code (enacted by the Consolidated Omnibus Reconciliation Act ("COBRA")). A Participant who chooses to continue participation in the Plan shall pay to the Plan Administrator an amount designated by the Employer, up to the maximum amount permitted under Section 4980B of the Code.

(b) *FMLA Leave*. A Participant who takes a leave described under the Family and Medical Leave Act of 1993 ("FMLA leave") and who fails to return to employment as an Eligible Employee upon the termination of the leave will become subject to the provisions of COBRA when the leave ends, with respect to the Participant's participation in the Medical Reimbursement Plan.

(c) *USERRA Leave*. A Participant who takes a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for less than thirty-one (31) days may continue on such benefit plans on the same terms as active Employees. A Participant who takes a USERRA leave for thirty-one (31) days or more may continue coverage under the provisions of USERRA and Section 4980B of the Code (COBRA). The amount of contributions required of such Participant will be equal to the cost of continuation coverage under COBRA for other Participants, as determined by the Employer.

A Participant whose coverage under a "Health Plan," (as that term is defined under USERRA) offered through this Plan was terminated during a military leave of absence (as defined under USERRA), shall be entitled to reinstate coverage under such Health Plan consistent with USERRA.

(d) *Cessation of Participation in Health Care Reimbursement Plan During*

*FMLA or USERRA Leave.* If a Participant ceases to participate in the Medical Reimbursement Plan during a FMLA or USERRA leave, he or she may not receive reimbursement for Medical Care expenses incurred during the period when the coverage is terminated, nor may he or she retroactively elect Medical Reimbursement Plan coverage for such claims if he or she subsequently re-enrolls in the Medical Reimbursement Plan upon return from leave.

Section 3.6 Participation During Leaves. If the Participant takes a paid or unpaid leave including USERRA and FMLA leave, the Participant may continue to participate in this Plan consistent with one of the following provisions:

(a) the Participant shall agree to make all required contributions for the benefits he or she has selected under the Plan on an after-tax basis during the leave at such times as the Employer may require pursuant to reasonable rules established by the Employer, or

(b) prior to the beginning of such leave, the Participant shall pay all contributions required for the benefits he or she has selected under the Plan for the duration of the leave, or if shorter, through the end of the Plan Year (i) on an after-tax basis or, (ii) if the Participant has Compensation from which such payment may be deducted, on a pre-tax basis.

Notwithstanding the foregoing, if the Employer continues to provide or maintain coverage under any benefit selected by a Participant during a Family or Medical Leave in circumstances where the Participant has elected to continue such coverage and has failed to make the required contributions, the Employer shall have the right to recover the cost of such coverage from the Participant at the end of the Family or Medical Leave through increased Salary Reduction Contributions or through any other method authorized by the Family and Medical Leave Act of 1993.

Section 3.7 Qualified Medical Child Support Orders.

(a) Procedures. The Employer shall establish reasonable procedures to determine the qualified status of Medical Child Support Orders (“Orders”) and to administer the provision of benefits under such Orders as are qualified. Such procedures shall be in writing and shall be deemed a part hereof.

(b) Definitions. For purposes of this section, the following terms have the following meanings:

(i) “Medical Child Support Order” means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which

(A) provides for child support with respect to a child of a Participant under the Plan or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates (or arguably may relate) to benefits under the Plan or

(B) enforces a law relating to medical child support described in

Section 1908A of the Social Security Act with respect to the Plan.

(ii) “Alternate Recipient” means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment or benefits under the Plan with respect to such Participant.

(iii) “Qualified Medical Child Support Order” means a medical child support order which

(A) creates or recognizes the existence of an Alternate Recipient’s right to or assigns to an Alternate Recipient the right to receive benefits for which a Participant or beneficiary is eligible under the Plan,

(B) clearly specifies the name and the last known mailing address (if any) of the Participant and the name and address of each Alternate Recipient covered by the Order, a reasonable description of the type of coverage to be provided by the Plan and each such Alternate Recipient, or the manner in which such type of coverage is to be determined, the period to which such order applies, and each plan to which such order applies, and

(C) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of the law relating to medical child support described in Section 1908A of the Social Security Act.

Section 3.8 Nondiscrimination. The Plan shall not discriminate in favor of highly compensated employees, as follows:

(a) Eligibility to Participate. The Plan will not discriminate in favor of highly compensated individuals, as defined in Code Section 125(e)(2), as to eligibility to participate.

(b) Contributions and Benefits. The Plan will not discriminate in favor of highly compensated participants, as defined in Code Section 125(e)(1), as to contributions and benefits.

(c) Benefits to Key Employees. Benefits provided to Key Employees under the Plan shall not exceed twenty-five percent (25%) of the aggregate of such benefits provided for all Participants in any Plan Year.

(d) Medical Reimbursement Plan. The Medical Reimbursement Plan set forth in Article VI will not discriminate in favor of highly compensated individuals, as defined in Code Section 105(h)(5), as to eligibility to participate or as to benefits.

(e) Dependent Care Reimbursement Plan.

i. No more than twenty-five percent (25%) of the amounts paid by the Dependent Care Reimbursement Plan shall be provided to Participants who are shareholders or owners (or their spouses or dependents) of more than five percent (5%) of the stock or of the capital or profit interest in the Employer.

ii. Benefits provided under the Dependent Care Reimbursement Plan shall not discriminate in favor of highly compensated employees, as defined

- in Code Section 414(q), with respect to eligibility to participate or with respect to contributions or benefits.
- iii. The average reimbursement under the Dependent Care Reimbursement Plan paid to a non-highly compensated employee shall be at least fifty-five percent (55%) of the average reimbursement paid to a highly compensated employee.

#### **Article IV. Plan Contributions and Benefit Election**

Section 4.1 Participant Election. The cost of any benefit elected by a Participant shall be paid for through the Participant's Salary Reduction Contributions. Each Participant shall make an Election within the applicable time period specified in Section 4.3 of this Plan. Through this Election, the Participant shall select optional benefit coverages described in Article V and designate a portion of the Participant's Compensation as Salary Reduction Contributions at a rate equal to the aggregate annual employee costs of all benefits that the Participant has elected under this Plan. Except as otherwise provided by the Employer, Salary Reduction Contributions shall reduce the Participant's Compensation ratably on each day during the Plan Year following the effective date of the Participant's participation.

Section 4.2 Default Election. A Participant who fails to submit an Election during the open enrollment period shall be deemed to have made the same Elections as he made the previous Plan Year with respect to medical coverage as provided in paragraph 5.2(a), supplemental life insurance as provided in paragraph 5.2(d), supplemental short-term disability insurance as provided in paragraph 5.2(e), and dental coverage as provided in paragraph 5.2(f), and to have elected not to participate in the Medical Reimbursement Plan and the Dependent Care Reimbursement Plan.

#### Section 4.3 Timing of Elections.

(a) New Elections. An Eligible Employee who first becomes eligible to participate in the Plan, or an Eligible Employee whose benefits were ended during a leave of absence, must make an Election to participate or re-enroll in the Plan within thirty (30) days after his or her hire date or date of return from an unpaid leave. Such Election will be processed as soon as administratively feasible, and shall be effective as of the hire date, but the Salary Reduction Contributions used to pay for the Election shall be taken from compensation not yet currently available on the date the Election is made. An Employee who terminates employment and is rehired within thirty (30) days after termination, or who returns to employment following an unpaid leave of absence of less than thirty (30) days, is not eligible for the new Election described in this paragraph 4.3(a).

(b) Election for Plan Year. Other Eligible Employees may enroll in the Plan or make an Election within the open enrollment period prescribed by the Employer prior to the first day of the Plan Year, which period shall commence no earlier than ninety (90) days prior to the first day of the Plan Year. Such Elections shall be effective as of the first day of the Plan Year following the receipt by the Plan Administrator of the Election. Elections received after the first day of the Plan Year shall be void.

Section 4.4 Revocation or Changes in Benefit Elections. A Participant's benefit election for any Plan Year shall be irrevocable during the Plan Year, except that

(a) the Employer may limit or reduce a Participant's contributions allocable to certain benefits in accordance with Section 4.8,

(b) if there is a Status Change, a Participant shall be entitled to change the Participant's election of benefits on a prospective basis (except as provided in paragraph 4.4.1(b)) in a manner that is consistent with the Status Change as described in paragraph 4.4.1, below, and

(c) if there is a significant cost or coverage change, a Participant shall be entitled to change the Participant's election of benefits on a prospective basis in a manner that is consistent with the significant cost or coverage change as described in paragraph 4.4.2, below.

Section 4.4.1 Status Changes.

(a) Consistency. A Participant's revocation of a benefit election during a Period of Coverage and new benefit election for the remaining portion of the Period of Coverage ("Election Change") is consistent with the Status Change if and only if: the Status Change affects eligibility for coverage under a plan or program of the Employer (including this Plan) or the employer of the Participant's spouse or Dependent, or in the case of the Dependent Care Reimbursement Plan described in Article VII, eligibility of dependent care expenses for the tax exclusions available under Section 129 of the Code; and the Election Change is on account of and corresponds with such Status Change.

(b) Birth or Adoption. For purposes of a Status Change described in Section 2.1(s)(ix)(a) and attributable to the birth or adoption of a new Dependent, an increase in the Participant's election to reflect the Dependent's enrollment may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

(c) Notice to Plan Administrator. An Eligible Employee desiring to change his Election upon the occurrence of a Status Change must notify the Plan Administrator of the occurrence of a Status Change within the time limits prescribed below:

- (i) For a Status Change due to:
- divorce, legal separation, death of a spouse or annulment,
  - termination or reduction in hours that results in the loss of benefits, or
  - events that may cause a Dependent to lose eligibility under an Employer plan, including reaching the limiting age for benefits,

the Eligible Employee must provide a written request for an Election change within thirty (30) days following the later of the occurrence of the event giving rise to the Status Change, or the receipt by the Eligible Employee of a notice of the availability of continuation coverage under an Employer plan. The Election will be effective on the first day of the month following the Plan Administrator's receipt and processing of the Election change request.

- (ii) For a Status Change due to the birth or adoption of a child, the Eligible Employee must provide a written request for an Election change within thirty (30) days following the occurrence of the event giving rise to the Status Change. The Election will be effective as of the date of the event.
- (iii) For a Status Change described in Section 2.1(s)(ix)(a) (“HIPAA special enrollment rights”) and attributable to a termination of Medicaid or CHIP coverage, or to eligibility for employment assistance under Medicaid or CHIP as described in Section 9801(f)(3) of the Code, the Eligible Employee must provide written notice of the Status Change not later than sixty (60) days after termination of Medicaid or CHIP coverage or determination of eligibility for employment assistance under Medicaid or CHIP. The Election will be effective no later than thirty (30) days after receipt of the notice of Status Change.
- (iv) For any other Status Change permitting an Eligible Employee to make or change an Election, the last day of the month following the effective date of the Status Change. The Election will be effective no later than thirty (30) days after receipt of the notice of Status Change.

Section 4.4.2 Change in Cost or Coverage. If there is a change in the cost of coverage for a benefits plan (including a self-insured plan) other than the Medical Reimbursement Plan described in Article VI, and Eligible Employees are required to make a corresponding change in their contributions, the Employer may, on a reasonable and consistent basis, automatically make a prospective increase or decrease, as appropriate, in all affected Participants’ Salary Reduction Contributions. If, during a Period of Coverage, there is a significant increase or decrease in the cost charged to Eligible Employees for one of the benefits listed in Section 5.2, other than the Medical Reimbursement Plan described in Article VI, or an option for coverage under an accident or health plan, policy or program, the Employer may, to the extent permitted under applicable law and on a uniform basis, allow Eligible Employees to commence participation in the Plan for the limited purpose of electing the reduced cost benefit or option, revoke their elections under such benefit or option and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit plan or option with similar coverage, or drop coverage under the benefit or option if there is no benefit plan or option with similar coverage.

To the extent permitted by the Employer on a uniform basis, if coverage under a benefits plan (including a self-insured plan) other than coverage under the Medical Reimbursement Plan described in Article VI, is significantly curtailed or ceases during a Period of Coverage, affected Participants may revoke their elections under such plan, and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage. In the case of a cessation of coverage, to the extent permitted under

applicable law, if no other benefit or option provides similar coverage, affected Participants may drop coverage with respect to the benefits plan.

If a significant increase or decrease in cost is imposed by a Participant's dependent care provider (other than a relative of the Participant as defined in Code Section 152) or the Participant has a change in either his or her dependent care provider or the coverage provided by such a provider, the Employer may, to the extent permitted under applicable law and on a uniform basis, allow the Participant to make a corresponding prospective change in his or her dependent care reimbursement coverage election in accordance with this Section 4.4 and applicable law.

If, during a Period of Coverage, the Plan is amended to add a new benefit option other than health care reimbursement coverage or a coverage option is added to an existing benefit or an existing benefit or coverage option is significantly improved, the Employer may, to the extent permitted under applicable law and on a uniform basis, allow affected Participants to elect the newly added or improved benefit or other coverage option on a prospective basis.

The Employer may, to the extent permitted under applicable law and on a uniform basis, allow affected Eligible Employees to make a prospective election change that is on account of and corresponds with a change made under the plan of another employer or under one of its own plans if such plan permits election changes that would be permitted under Section 4.4, or the Plan permits Participants to make an election for a Period of Coverage that is different from the period of coverage under the other plan.

An Eligible Employee must provide written notice to the Employer of his or her desire to make, revoke or change an election as permitted under this paragraph 4.4.2, on a form prescribed by the Employer, either prior to or after the change in cost or coverage, but not later than thirty (30) days after the occurrence of the change in cost or coverage. Any such change shall be effective for the first pay period for which the Employer can process the change, but not later than thirty (30) days after the date such Eligible Employee's written notice is received by the Employer.

Section 4.5 Limitations on Elections. A Participant's Election shall be subject to limitations of applicable law or this Plan, including but not limited to the following:

- (a) A Participant may not make any change in Election that would reduce the Participant's level of Medical Reimbursement coverage under the Medical Reimbursement Plan described in Article VI to an amount that would be less than the amount of benefits claimed under such coverage as of the date the change would become effective.
- (b) If a Participant increases the amount deferred by the Participant for the Plan Year due to a Status Change as defined in this Plan or other change which would allow the Participant to change his Election, such increase shall apply only to claims made by the Participant on or after the date on which such increase becomes effective.

- (c) The Employer may, in its sole discretion, limit a Participant's contributions as permitted under Section 4.8 in order to prevent the Plan from failing to meet nondiscrimination requirements under applicable law.

Section 4.6 Termination of Employment. In the event of the termination of a Participant's employment, the Participant's Salary Reduction Contributions will cease at such time as the Participant ceases to receive Compensation for employment services. To the extent permitted under Section 3.5 or Section 3.6, such a Participant may elect to continue to make contributions for benefits under this Plan other than through Salary Reduction Contributions. A Participant who elects to continue coverage as permitted by Sections 3.5 or 3.6 and who returns to service with the Employer during the Plan Year, may not make a new benefit election for the remaining portion of the Plan Year unless it is consistent with a Status Change.

Section 4.7 Cessation of Required Contributions. A Participant's election to receive a benefit under this Plan shall be automatically revoked effective the first day of any period for which such Participant fails to make a contribution required by the Employer for such benefit for such period. A Participant whose Election has been revoked for a Plan Year pursuant to this paragraph shall not be entitled to make a new benefit Election for such Plan Year.

Section 4.8 Adjustments to Prevent Discrimination. If the Employer believes that the benefits selected by Participants for any Plan Year put the Plan at risk of failing to comply with nondiscrimination rules described in Section 3.8 or other applicable law, then the Employer may, in its sole discretion, limit or reduce the amount of contributions or benefits selected by Key Employees and highly compensated employees so that the Plan meets all nondiscrimination rules for the Plan Year. Any such reduction imposed by the Employer shall apply on a uniform basis pursuant to rules applicable equally to all Participants who are members of the group of highly compensated or key employees that must not be favored under the nondiscrimination rules described in Section 3.8 or other applicable law. The Employer may also take any other steps that may be necessary to comply with the nondiscrimination requirements of the Code and applicable regulations. A Participant whose benefit Election for a Plan Year has been revoked pursuant to this paragraph shall not be entitled to make a new Election for such Plan Year.

Section 4.9 List of Benefits. The Employer shall maintain and make available to Participants accurate information regarding the respective types, amounts, and costs of benefits available through the Plan. Each Participant shall be notified in writing if there is a change in the cost of a benefit or a change in the type, nature, or amount of any benefit.

Section 4.10 Maximum Amount of Contributions. The maximum amount of Salary Reduction Contributions under the Plan for any Participant is the maximum amount that may be designated by the Participant for benefits described in Section 5.2 of the Plan.

## **Article V. Plan Benefits**

Section 5.1 Available Benefits. Except as otherwise provided in this Article, and subject to any open enrollment or other provisions of contracts with third party benefit providers, a Participant may use available Salary Reduction Contributions to pay for the benefits described

in Section 5.2 that the Participant has elected to receive. Benefits shall be provided under such insurance policies, plans, programs or other arrangements as are obtained by or established by the Employer. All benefits are subject to the terms and conditions of the plans, policies, programs or other arrangements obtained or established by the Employer to fund or provide those benefits.

Section 5.2 Benefits. Each Participant shall elect, pursuant to Section 4.1, to apply his Salary Reduction Contributions, in such amounts as the Participant chooses, to any or all of the following:

(a) Medical Coverage. An amount equal to the employee cost of single only, single plus one other individual, or family coverage under the Minneapolis College of Art & Design Medical Plan and coverage under such other health care policies or programs as the Employer elects to make available to the Participant.

(b) Medical Reimbursement. An amount up to Five Thousand Dollars (\$5,000), and Two Thousand Five Hundred Dollars (\$2,500) for Plan Years beginning on or after January 1, 2013), to increase the Participant's Medical Reimbursement Account as established in the Medical Reimbursement Plan set forth in Article VI of this Plan.

(c) Dependent Care Reimbursement. An amount up to Five Thousand Dollars (\$5,000), (Two Thousand Five Hundred Dollars (\$2,500) for married participants filing separately), or if less, the amount of the Participant's or the Participant's spouse's earned income (provided that a Participant's spouse who is a student or who is incapable of self-care shall be deemed to have earned income as provided under Section 21(d)(2) of the Code), to increase the Participant's Dependent Care Account as established in the Dependent Care Reimbursement Plan set forth in Article VII of this Plan.

(d) Supplemental Life Insurance. An amount equal to the employee cost of supplemental employee life insurance coverage under the Minneapolis College of Art & Design Group Life and Accidental Death and Dismemberment Insurance Plan, not to exceed Fifty Thousand Dollars (\$50,000), including coverage under the basic life plan.

(e) Supplemental Short-Term Disability Insurance. An amount equal to the employee cost of coverage under the Self-Funded Supplemental Short-Term Disability Income Plan of Minneapolis College of Art and Design.

(f) Dental Coverage. An amount equal to the employee cost of single only, single plus one other individual, or family coverage under the Dental Benefit Plan of Minneapolis College of Art & Design.

Section 5.3 Limitation on Benefits. Except as permitted under the provisions relating to the Grace Period for purposes of a Participant's Medical Reimbursement Account, and as otherwise permitted by law or regulation, a Participant may not carry over unused Salary Reduction Contributions from one Plan Year to a subsequent Plan Year, nor may a Participant use Salary Reduction Contributions from one Plan Year to purchase a qualified benefit coverage in a subsequent Plan Year.

Section 5.4 Incorporation of Other Plans. Provisions of the Minneapolis College of

Art and Design Medical Plan, the Minneapolis College of Art and Design Elective Life Insurance Plan, the Minneapolis College of Art and Design Supplemental Short-Term Disability Plan, and the Minneapolis College of Art and Design Dental Plan, and other applicable employee benefit plans of the Employer that describe benefits and eligibility, and other provisions of such plans relevant to this Plan, are hereby incorporated by reference and are and shall be considered a part of this Plan.

## **Article VI. Medical Reimbursement Plan**

6.1 Medical Reimbursement Coverage. Participants may elect to receive medical reimbursement coverage of up to a maximum coverage of Five Thousand Dollars (\$5,000) per Plan Year, except that for the short Plan Year of December 1-31, 2010, the maximum coverage shall be Four Hundred Sixteen Dollars (\$416). Effective for Plan Years beginning on or after January 1, 2013, the maximum coverage shall be Two Thousand Five Hundred Dollars (\$2,500) per Plan Year. The Employer shall establish for each Participant who elects to participate in the Medical Reimbursement Plan a Medical Reimbursement Account, which shall initially contain Zero Dollars (\$0).

6.2 Medical Reimbursement Account. Subject to the annual maximum, a Participant's Medical Reimbursement Account for a Plan Year shall be increased by the portion of the Participant's Salary Reduction Contributions that he or she has elected to apply toward his or her Medical Reimbursement Account pursuant to Article IV. A Participant's Medical Reimbursement Account shall be reduced by the amount of any benefits paid to or on behalf of a Participant pursuant to Section 6.3.

6.3 Health Care Reimbursement Benefits. Subject to limitations contained in other provisions of this Plan, a Participant who incurs expenses for Medical Care attributable to the Participant or the Participant's spouse or Dependents during the Participant's Period of Coverage for a Plan Year shall be entitled to receive from Plan full reimbursement for the entire amount of such expenses to the extent of the amount of coverage elected by the Participant for that Plan Year, reduced by any reimbursements already made. An expense is deemed incurred when the health care giving rise to the expense is provided, regardless of the date of billing or payment.

Effective the Plan Year beginning on December 1, 2004, and thereafter, except during the short Plan Year of December 1-31, 2010, the Participant shall have a Grace Period of two and a half (2 ½) months following the end of the Plan Year in which to incur expenses eligible for reimbursement up to any amount remaining in the Participant's Health Care Reimbursement Account. Eligible expenses incurred during the Grace Period will be paid first from the Participant's Health Care Reimbursement Account for the preceding Plan Year, and then, if such Account is exhausted, from the Participant's Health Care Reimbursement Account for the current Plan Year.

The Employer shall pay all such expenses to the Participant upon the presentation of documentation of such expenses in a form prescribed by the Employer, which shall include satisfactory third party evidence of the amount of the expense and the date(s) incurred. In addition, upon presentation of a claim, a Participant shall

expressly represent that the item for which a claim is made is not subject to reimbursement under any policy described in Section 6.4 of this Plan or from any other source. In its discretion, the Employer may pay any of such expenses directly, in which event it shall be relieved of all further responsibility with respect to that particular expense. These expenses shall be paid periodically during the Plan Year in accordance with uniform policies adopted by the Employer and upon receipt of a claim complying with Plan requirements.

6.4 Limitations on Health Care Reimbursement Benefits. Anything in the Plan to the contrary notwithstanding, no Participant shall be entitled to benefits under this Article VI:

(a) In the event and to the extent that the reimbursement or payment is covered under any insurance policy or policies, whether paid for by the Employer or the Participant, or under any other health and accident plan by whomever maintained. If there is such a policy or plan in effect providing for reimbursement or payment, in whole or in part, then to the extent of the coverage under that policy or plan, the Plan shall be relieved of any liability; or

(b) To the extent that the expense has been submitted for reimbursement from the Participant's Dependent Care Reimbursement Account or under any similar program or plan maintained by some other person or entity.

6.5 Forfeiture of Unused Benefits. If, following the final payment of reimbursement benefits for eligible expenses incurred during the Period of Coverage and the Grace Period for any Plan Year, any amount remains in a Participant's Health Care Reimbursement Account for that Plan Year, the Participant shall forfeit such amount to the Employer, and shall have no further claim to that amount. Forfeitures shall be used to offset any losses to the Medical Reimbursement Plan due to one or more Participants receiving reimbursements exceeding their Salary Reduction Contributions to the Medical Reimbursement Plan. If such forfeitures are greater than such losses, the remainder may be used to defray reasonable expenses of administering the Medical Reimbursement Plan or carried forward to the following Plan Year to offset losses to or defray reasonable expenses of the Medical Reimbursement Plan.

6.6 Qualified Reservist Distributions. A Participant who is a reservist is eligible to receive a "qualified reservist distribution" (QRD) of all or a portion of the remaining balance in his or her Medical Reimbursement Account if he or she is called to active duty of 180 days or more. QRDs may be requested at any time from the date of the call to active duty through the last day of the Grace Period for the Plan Year including the date of the call to active duty. The distribution for a Participant shall be the amount contributed to the Medical Reimbursement Account as of the date of the QRD request minus reimbursements received as of the date of the request. A Participant who takes a QRD shall not participate in the Medical Reimbursement Plan for the remainder of the Plan Year for which the QRD was taken.

6.7 Health Insurance Portability and Accountability Act of 1996 (HIPAA). Notwithstanding any other provision of this Plan to the contrary, the Medical Reimbursement Plan shall be operated and maintained in a manner consistent with HIPAA and applicable corresponding regulations, effective as of the date such compliance is required by law or

regulation.

(a) *Definitions.* The following definitions will apply to this Section 6.7.

1) “Health Information” is any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to the individuals; or the past, present, or future payment for the provision of health care to the individual.

2) “Health Care Operations” means activities related to Medical Reimbursement Plan operations and administration, as defined at 45 C.F.R. Section 164.501.

3) “Individually Identifiable Health Information” is Health Information, including demographic information, collected from an individual, that is created or received by the Employer or the Medical Reimbursement Plan and that:

(i) relates to any of the following: 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

(ii) identifies the individual, or

(iii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

4) “Payment” means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Medical Reimbursement Plan, or to obtain or provide reimbursement for health care expenses.

5) “Medical Reimbursement Plan Administration Functions” are administration functions performed by the Plan Administrator, as defined in 45 C.F.R. Section 504.

6) “Protected Health Information” or “PHI” means Individually Identifiable Health Information that is transmitted or maintained in electronic form or any other form or medium by the Plan.

(b) *Use and Disclosure of Protected Health Information.*

1) The Plan Administrator may use or disclose PHI without authorization of the Participant or other appropriate individual for Payment or Health Care Operations or for other reasons permitted by or required by HIPAA. All other uses or disclosures of PHI will be pursuant to authorization of the Participant or other individual, or his or her personal representative.

2) The Plan Administrator will only use PHI for Medical Reimbursement Plan Administration Functions.

3) The Plan Administrator will not use or further disclose PHI other than as permitted or required by the Medical Reimbursement Plan documents or as required by law.

4) The Plan Administrator will ensure that any agents, including a subcontractor, to whom it provides PHI received from the Medical Reimbursement Plan, agree to the same restrictions and conditions that apply to the Plan Administrator, with

respect to such information.

5) The Plan Administrator will not use or disclose PHI for employment-related actions and decisions or in connection with any other Employer-sponsored benefit or employee benefit plan of the Employer.

6) The Plan Administrator will report to the Medical Reimbursement Plan any use or disclosure of PHI that is inconsistent with HIPAA's permitted uses or disclosures, of which it becomes aware.

7) The Medical Reimbursement Plan will disclose PHI to the Employer only upon receipt of a certification by the Employer that the Medical Reimbursement Plan documents have been amended as required by HIPAA.

8) The Plan Administrator will make PHI available to Participants or other individuals only as follows:

(i) in accordance with 45 C.F.R. Section 164.524, upon written request of the individual;

(ii) for amendment of such PHI, incorporating any amendments to PHI in accordance with 45 C.F.R. Section 164.526; and

(iii) as an accounting of disclosures of the individual's PHI in accordance with 45 C.F.R. Section 164.528.

9) The Plan Administrator will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Medical Reimbursement Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Medical Reimbursement Plan with HIPAA.

10) In accordance with HIPAA, the Medical Reimbursement Plan may disclose summary Health Information to the Employer as Plan Sponsor, if the Employer requests the summary Health Information for the purposes of modifying, amending or terminating the Medical Reimbursement Plan. Summary Health Information may be Individually Identifiable Health Information which summarizes the claims history, claims expenses, or the type of claims experienced by individuals in the Medical Reimbursement Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by zip codes of at least five digits.

11) When any PHI received from the Medical Reimbursement Plan ceases to be needed for the purpose for which it was disclosed, the Plan Administrator will return or destroy such information maintained in any form and retain no copies of such information, except that, if return or destruction is not feasible, the Plan Administrator will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

12) The Employer as Plan Sponsor will provide adequate separation between the Medical Reimbursement Plan and itself when it serves in any capacity other than as Plan Administrator.

13) Only those employees or other persons under the control of the Plan Administrator whose duties involve Payment under, Health Care Operations of, or other matters pertaining to the Medical Reimbursement Plan in the ordinary course of business may have access to PHI. Access to, and use of, PHI by the employees and other persons described in this paragraph will be limited to the Medical Reimbursement Plan Administration Functions.

14) Any individual who fails to comply with this Section 6.6 will be subject to discipline by the Employer, in accordance with its disciplinary policy.

6.8 Separate Written Plan. For purposes of the Code, Article VI shall constitute a separate written plan providing for the reimbursement of Medical Care expenses. To the extent necessary, other provisions of the Plan are incorporated by reference in Article VI.

## **Article VII. Dependent Care Reimbursement Plan**

7.1 Dependent Care Reimbursement Accounts. A Dependent Care Reimbursement Account shall be established for each electing Participant for each Plan Year. Each Dependent Care Reimbursement Account shall initially contain Zero Dollars (\$0.00).

7.2 Increases in Dependent Care Reimbursement Accounts. A Participant's Dependent Care Reimbursement Account shall be increased each relevant pay period by such whole dollar amount of the Participant's Salary Reduction Contributions as the Participant has elected to apply toward the Participant's Dependent Care Reimbursement Account. The maximum for a Plan Year shall be Five Thousand Dollars (\$5,000), (or Two Thousand Five Hundred Dollars (\$2,500) for married participants filing separately), or if less, the amount of the Participant's or the Participant's spouse's earned income, provided that a Participant's spouse who is a student or who is incapable of self-care shall be deemed to have earned income as provided under Code Section 21(d)(2). For the short plan year of December 1-31, 2010, the maximum coverage shall be Four Hundred Sixteen Dollars (\$416) (or Two Hundred Eight Dollars (\$208) for married participants filing separately).

7.3 Decreases in Dependent Care Reimbursement Account. A Participant's Dependent Care Reimbursement Account shall be reduced by the amount of any benefits paid to or on behalf of a Participant pursuant to Section 7.4.

7.4 Dependent Care Reimbursement Benefits. Subject to limitations contained in other provisions of this Plan, a Participant who incurs Employment Related Dependent Care Expenses during his/her Period of Coverage shall be entitled to receive from the Plan reimbursement for the amount of such incurred expenses to the extent of the amount then contained in the Participant's Dependent Care Reimbursement Account. An expense is deemed incurred when the care giving rise to the expense is provided, regardless of the date of billing or payment. No reimbursement shall be paid pursuant to this Article VII to the extent that an expense has been submitted for reimbursement from a Participant's Medical Reimbursement Account under Article VI or under any other program or plan for the reimbursement or coverage of Health Care Expenses or Employment Related Dependent Care Expenses maintained by the Employer or some other person or entity. The Employer, as administrator of the Plan, shall pay all such expenses to the Participant upon the presentation to the Employer of documentation of these expenses in a form prescribed by the Employer. However, in its discretion, the Employer may pay any of these expenses directly, in which event it shall be relieved of all further responsibility with respect to that particular expense. These

expenses shall be paid periodically during the Plan Year in accordance with uniform policies adopted by the Employer and upon receipt of a claim complying with Plan requirements. No reimbursement will be made in excess of contributions actually made by the Participant.

7.5 Forfeiture of Unused Benefits. If, following the final payment of reimbursement benefits for eligible expenses incurred during the Period of Coverage for any Plan Year, any amount remains in a Participant's Dependent Care Reimbursement Account for that Plan Year, the Participant shall forfeit such amount to the Employer, and shall have no further claim to such amount. Forfeitures shall be used to defray reasonable expenses of administering the Dependent Care Reimbursement Plan in the same or subsequent Plan Years.

7.6 Statement of Benefits. The third-party administrator shall provide each Participant that receives benefits under Article VII during the prior or current calendar year with a statement of benefits, updated upon each contribution or reimbursement, available through the Participant's online account.

7.7 Separate Written Plan. For purposes of the Code, this Article VII shall constitute a separate written plan providing a program of dependent care assistance. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in Article VII.

### **Article VIII. Claims Procedure**

Section 8.1 Written Claim for Benefits. Benefit payments shall not be made under this Plan until the Plan Administrator has received a claim for benefits that satisfies all requirements of the separate benefit plan under which such benefit is claimed to be due.

Section 8.2 Claims Procedure. The Plan Administrator shall notify a person within ninety (90) days (thirty (30) days for claims under the Medical Reimbursement Plan) of receipt of a written claim for benefits of that person's eligibility or noneligibility for benefits under the Plan.

If the claim for benefits is allowed, the payment of benefits will occur within the time limits set forth in the Employer's regular policies governing payment of claims, but no later than the end of the month following the month in which the claim for benefits is made. Payment of the claim for benefits shall be considered notice of approval of the claim.

If it is determined that a person is not eligible for benefits or for full benefits, the written notice of denial shall set forth

- (1) the specific reasons for the denial,
- (2) a specific reference to the provision of the Plan on which the denial is based,
- (3) a description of any additional information or material necessary for the claimant to perfect the claim and an explanation of why it is needed,
- (4) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken if the Participant wishes to have the claim

- reviewed, including a statement of any right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; and
- (5) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

If the Employer determines that there are special circumstances requiring additional time to make a decision, the Employer shall notify the Participant of the special circumstances and the date by which a decision is expected to be made, and may extend the time for up to an additional ninety (90) days (fifteen (15) days for claims under the Medical Reimbursement Plan).

**Section 8.3 Review Procedure.** If a Participant is determined by the Employer not to be eligible for benefits, or if the Participant believes that he is entitled to greater or different benefits, the Participant shall have the opportunity to have the claim reviewed by the Employer by filing a petition for review within sixty (60) days (one hundred eighty (180) days for claims under the Medical Reimbursement Plan) after receipt by the Participant of the notice issued by the Employer. That petition shall state the specific reasons the Participant believes he is entitled to benefits or greater or different benefits. After receipt of that petition, the Employer shall afford the Participant (and the Participant's counsel, if any) an opportunity to present the Participant's position to the Employer orally or in writing, and the Participant (or the Participant's counsel) shall have the right to review the pertinent documents. The Employer shall notify the Participant of its decision in writing within sixty (60) days of receipt of the petition, stating specifically the basis of said decision written in a manner calculated to be understood by the Participant and the specific provisions of the Plan on which the decision is based. If, because of the need for a hearing, the sixty (60)-day period is not sufficient, the decision may be deferred for up to another sixty (60)-day period at the election of the Employer, but notice of this deferral shall be given to the Participant.

**Section 8.4 Review of Claims under Medical Reimbursement Plan.** The following additional rules apply to review of a claim under the Medical Reimbursement Plan.

(a) The review must not afford deference to the initial adverse benefit determination and must be conducted by an appropriate fiduciary of the Plan, who is neither an individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(b) In deciding an appeal of any denial of benefits based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(c) Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with a claimant's denial of benefits must be identified, and such individual must not have been consulted in connection with the adverse benefit

determination that is the subject of the appeal, nor the subordinate of any such individual.

## **Article IX. Administration and Finances**

Section 9.1 **Administration**. The Employer shall be the administrator of the Plan, and, as such, has total and complete discretionary authority to determine conclusively for all parties all questions arising in the administration of the Plan. The Employer shall have all powers necessary to administer the Plan, including, without limitation, powers:

- (a) to interpret the provisions of the Plan;
- (b) to establish and revise the method of accounting for the Plan and to maintain the accounts;
- (c) to establish rules for the administration of the Plan and to prescribe any forms required to administer the Plan; and
- (d) to change plans, contracts or policies and/or insurers or other providers or benefits described in Sections 5.2 of the Plan.

Section 9.2 **Delegation**. The Employer shall have the power, by resolution of its Board of Directors, to delegate specific duties and responsibilities. Such delegations may be to officers or other employees of the Employer or to other individuals or entities. Any delegation by the Employer, if specifically stated, may allow further delegations by the individual or entity to whom the delegation has been made. Any delegation may be rescinded by the Employer at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for the exercise of those duties or responsibilities and shall not be responsible for the acts or failure to act of any other individual or entity.

Section 9.3 **Reports and Records**. The Employer and those to whom the Employer has delegated duties and authority under the Plan shall keep records of all their proceedings and actions, and shall maintain all books of account, records, and other data necessary for the proper administration of the Plan and to comply with applicable laws.

Section 9.4 **Actions of the Employer**. Subject to the claims procedures of Article VII, all determinations, interpretations, rules, and decisions of the Employer shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

Section 9.5 **Funding**. The costs of the Plan shall be borne as provided herein. For purposes of the Plan, Salary Reduction Contributions shall be deemed contributions by the Employer. All amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein shall be construed to require the Employer to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made.

Section 9.6 **Indemnification**. To the extent permitted by law, the Employer shall indemnify the members of the Employer's Board of Directors, and others to whom the Employer has delegated duties and authority pursuant to Section 9.2 who are either employees, officers, or directors of the Employer against any and all claims, losses, damages, expenses, and liabilities, arising from their responsibilities in connection with the Plan which are not covered by insurance

(without recourse) paid for by the Employer, unless due to gross negligence or intentional misconduct.

### **Article X. Amendments and Termination**

Section 10.1 Amendments. The Employer shall have the right to amend the Plan at any time and from time to time, by resolution of its Board of Directors, or action of such other person(s) to whom such authority has been delegated by the Board of Directors pursuant to Section 9.2. Any such amendment shall be filed with the Plan documents.

Section 10.2 Benefits Provided through Third Parties. In the case of any benefit provided pursuant to an insurance policy or other contract with a third party, the Employer may amend the Plan by changing insurers, policies, or contracts without changing the language of the Plan, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are informed of the effects of any material changes.

Section 10.3 Termination. The Employer expects the Plan to be permanent, but necessarily must, and hereby does, reserve the right to terminate the Plan at any time. Any such termination shall be by resolution of the Board of Directors of the Employer or by action of such other person(s) to whom such authority has been delegated by the Board of Directors pursuant to Section 9.2. Neither the Employer nor any Affiliate nor any of their respective officers, directors, or employees shall have any further financial obligations under the Plan from and after termination of the Plan except those that have accrued up to the date of termination and have not been satisfied.

### **Article XI. Miscellaneous**

Section 11.1 No Guaranty of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Employer and any Employee. Nothing contained in the Plan shall give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, nor shall it give the Employer the right to require any Employee to remain in its employ or to interfere with the Employee's right to terminate employment at any time.

Section 11.2 Limitation on Liability. The Employer does not guarantee benefits payable under any insurance or health maintenance organization policy or contract described in the Plan, and any benefits payable thereunder shall be the exclusive responsibility of the insurer or health maintenance organization that is obligated under the contract or policy.

Section 11.3 Non-Alienation. No benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Section 11.4 Applicable Law. The Plan and all rights under it shall be governed by and construed according to the laws of the State of Minnesota, except to the extent those laws are preempted by the laws of the United States of America.

Section 11.5 Benefits Provided Through Third Parties. In the case of any benefit provided through a third party, such as an insurance company, pursuant to a contract or policy with that third party, if there is any conflict or inconsistency between the description of benefits contained in the Plan and the contract or policy, the terms of the contract or policy shall control.

Section 11.6 Tax Consequences Not Guaranteed. Neither the Board of Directors, the Employer, the Plan, nor any other person connected with any of these makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excluded from the Participant's gross income for federal, state or local tax purposes.

Section 11.7 Effect of Mistakes. In the event of a mistake which causes an incorrect Plan contribution from or distribution to a Participant, the Employer shall, to the extent it deems possible, make such adjustments and take such action as appropriate to accord to the Participant the contributions and distributions to which he or she is properly entitled under the Plan. Such action by the Employer may include withholding of any amounts due the Plan or Employer from the Participant's Compensation, and such other actions authorized by law.

**MINNEAPOLIS COLLEGE OF ART & DESIGN**

Date: \_\_\_\_\_

By: \_\_\_\_\_  
Pamela Newsome

Its: Vice President of Administration