CMU CHOICES

THE CENTRAL MICHIGAN UNIVERSITY FLEXIBLE BENEFITS PLAN

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION

Amended and Restated as of July 1, 2024

CENTRAL MICHIGAN UNIVERSITY
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INTRODUCTION

CENTRAL MICHIGAN UNIVERSITY (the "**University**" or "**CMU**") sponsors CMU CHOICES: THE CENTRAL MICHIGAN UNIVERSITY FLEXIBLE BENEFITS PLAN (the "**Plan**") for the benefit of eligible employees of the University and their eligible family members. The Plan is amended and restated as of July 1,2024.

The Plan allows you to choose benefits from among the following benefit programs (the "**Benefit Programs**"):

- a **Medical Program** that provides comprehensive major medical, hospitalization, and prescription drug benefits (unless your drug benefits are provided through the separate prescription program listed below);

- a **Prescription Drug Program** that provides coverage for prescription drugs if drug benefits are not provided through the Medical Program;

- a **Dental Program** that provides benefits to pay for maintenance and treatment services for teeth and gums;

- a **Vision Program** that provides routine eye exams, eyeglasses and contact lenses;

- A Diabetes, Pre-diabetes, and Weight Management Program that provides a personalized nutrition program with an app, dietician and health guide.

- A Chronic Care Solutions Program that offers coaching, advocacy and gaps in care for nine chronic conditions.

- a **Short-Term Disability Program** ("**STD Program**") that provides income replacement benefits for a limited period of time if you become disabled;

- an **Employee Assistance Program** ("**EAP**") that provides you with resources to help with work, family and other personal matters;

- a **Long-Term Disability Program** ("**LTD Program**") that offers income replacement benefits if you become totally disabled;

- a **Life Insurance/Accidental Death and Dismemberment Program** ("**Life/AD&D Program**") that provides benefits for you or your beneficiary in the event of your death, paralysis or loss of limb due to an accident. Dependent life insurance to cover your spouse, OEI and/or child(ren) is also available on a voluntary basis at your expense on an after-tax (not pre-tax) basis;

- a **Wellness Rewards Program** ("**Wellness Program**") as described on Schedule K that provides a rewards for participating in a variety of wellness initiatives;

- a **Dependent Care Flexible Spending Account Program** ("**Dependent Care FSA Program**") that allows you to pay for Eligible Dependent Care Expenses on a *pre-tax* basis up to an annual maximum of $5,000 ($2,500 if married filing separately);

- a **Health Care Flexible Spending Account Program** ("**Health Care FSA Program**") that allows you to pay for unreimbursed medical expenses on a *pre-tax* basis up to an annual maximum $2,850 (which may be adjusted annually for inflation as permitted by law), plus a Carry Over of unused funds from a previous Plan Year of up to 20% of the IRS maximum of the Plan Year% (provided that the Carry Over amount is at least $25);

- a **Health Savings Account Contributions Program** ("**HSA Contributions Program**") that is integrated with the Medical Program and allows you to pay for certain unreimbursed medical benefits if you participate in a high deductible health plan ("**HDHP**"); and

- a **Pre-Tax Payment Program** that allows you to pay your share of the cost of certain Benefit Programs with pre-tax dollars.

Some of the benefits are "**Insured**," which means the University pays premiums to insurance companies that, in turn, pay for the benefits under insurance policies or contracts. Other Benefit Programs are "**Self-funded**," which means the benefits are paid from the University's general assets and not through an insurance contract. The Benefit Program Information Chart provided on **Schedule A-2** at the end of this document indicates each Benefit Program's type of funding. The Benefit Programs may be offered separately or may be grouped with other Benefit Programs at the University's discretion.

For each Insured Benefit Program:

- This document and the insurance contract or policy prepared by the insurer ("**Insurance Contract**") serve as the official Plan document. If a conflict arises between the terms of this document and the Insurance Contract, the terms of the Insurance Contract will control.

- The insurer-prepared booklets, summaries, and/or certificates that describe the benefits available under the Benefit Program ("**Booklets**"), together with this document, make up the summary plan description ("**SPD**"). If a conflict arises

between the terms of this document and a Booklet, the terms of the Booklet will control.

- If a conflict arises between the terms of the SPD and the Plan document, the terms of the Plan document will control.

For each Self-Funded Benefit Program:

- This document, along with applicable benefit certificates, booklets and/or summaries ("**Booklets**"), serve as the Plan document and summary plan description ("**SPD**").

- If a conflict arises between the terms of this document and a Booklet, the Booklet will control.

The provisions of this Plan apply uniformly to all Participants, except as otherwise specifically stated herein. Please read these documents carefully and keep them with your personal records for future reference. Throughout this document, capitalized words have specific meanings and are defined terms. Where a term is defined, it also appears in bold print and in quotes. For your convenience, an Index of Defined Terms appears at the beginning of this document with page references to each defined term.

This Plan is intended to qualify under Sections 105, 106, 129 and 179 of the Internal Revenue Code ("**Code**") and also as a cafeteria plan under Section 125 of the Code, except that life insurance coverage on any Eligible Dependent (as defined in the next section) is not a qualifying benefit under Section 125, is not available under the cafeteria plan and must be paid by you on an after-tax, not pre-tax, basis.

If you have any questions about a Benefit Program or the Plan in general, please contact the University's **Benefits and Wellness Office** at 989-774-3661 or benefits@cmich.edu.

OBTAINING AND CHANGING COVERAGE

ELIGIBILITY

Employee Eligibility

To be eligible to participate in the Plan, you must meet the requirements set forth below. However, you are not eligible to participate in the Plan if you are classified by the University as one of the following, even if it is later determined that the classification is incorrect: (i) a leased employee; (ii) an individual who performs services for the University but who is paid by a temporary or other employment or staffing agency; (iii) an individual considered by the University to be providing services as an independent contractor; (iv)

an employee covered under a collective bargaining agreement, unless the collective bargaining agreement provides for participation in the Plan; (v) an individual classified by the University as a relief staff employee; (vi) employed as a less-than-half-time fixed-term faculty; or (vii) classified by the University as a Global Campus Adjunct Faculty, graduate assistant or student employee.

Full-time and part-time employees of the University in one of the employee groups listed below ("**Benefit Eligible Employees**") are eligible to participate in the Plan on the first day of employment as a Benefit Eligible Employee.

- **Staff** - "**Staff**" means only employees classified by the University as one of the following: (i) Professional & Administrative (previously referred to as Confidential Clericals and off Campus); (ii) Public Broadcasting; (iii) Police Officers; (iv) Police Sergeants and Lieutenants; (v) Supervisory Technical; (vi) Service Maintenance; (vii) Office Professional (previously referred to as Clerical); (viii) Senior Officer; and (ix) Dispatchers.

- **Medical Faculty -** "**Medical Faculty**" means only employees classified by the University as medical faculty.

- **Regular Faculty -** "**Regular Faculty**" means only employees classified by the University as regular faculty.

- **Fixed-Term Faculty -** "**Fixed-Term Faculty**" means only employees classified by the University as fixed-term faculty with at least a half time or greater appointment for a minimum of a full semester.

- **Postdoctoral Research Fellow -** "**Postdoctoral Research Fellow**" means only employees classified by the University as postdoctoral research fellows who have a half-time (1/2) or greater appointment.

The Benefit Programs available to each of the above employee groups are listed on **Schedule A-1**.

You are a full-time or part-time employee if you meet the definition provided in your employment handbook or union contract and you are not classified by the University in a position that is excluded from participation in the Plan.

Change In Eligibility Based On Reclassification Of Employment

If you have been working in a position not qualified for benefits and you are reclassified as a Benefit Eligible Employee, you will be eligible to participate in each Benefit Program on the first day of your employment as a Benefit Eligible Employee.

If you have been participating in the Plan but you are reclassified to a position not eligible for benefits, your participation in the Plan will end on the date you are reclassified. To the extent it is available, you may elect COBRA Continuation Coverage.

Medical Program Eligibility
To be eligible for coverage under the Plan, you must be classified by the University as an benefits-eligible employee. If the University has not classified you as benefits-eligible employee, you are not eligible to participate in the Plan, even if it is later determined that the classification is incorrect.

DEPENDENT ELIGIBILITY

Your Spouse or Other Eligible Individual, and your Child(ren) (as defined below) are eligible for coverage under some of the Benefit Programs as shown in the chart below. They are "**Eligible Dependents**" with respect to those Benefit Programs.

Benefit Program	**Eligible Dependents You May Cover**
Medical Program	Your Spouse or Other Eligible Individual* and your Children If your Spouse or Other Eligible Individual* is eligible for other medical coverage through his or her employment, he or she is not an Eligible Dependent under the Medical Program unless (i) he or she is charged 100% of the cost of coverage through his or her employer or (ii) he or she enrolls in his or her employer's medical coverage before enrolling in this Plan.**
Prescription Drug Program	Your Spouse or Other Eligible Individual* and your Children If your Spouse or Other Eligible Individual* is eligible for other prescription drug coverage through his or her employment, he or she is not an Eligible Dependent under the Prescription Drug Program unless (i) he or she is charged 100% of the cost of coverage through his or her employer or (ii) he or she enrolls in his or her employer's prescription drug coverage before enrolling in this Plan.**
Dental Program	Your Spouse or Other Eligible Individual and your Children

	If your Spouse or Other Eligible Individual is eligible for other dental coverage through his or her employment, he or she is not an Eligible Dependent under the Dental Program unless (i) he or she is charged 100% of the cost of coverage through his or her employer or (ii) he or she enrolls in his or her employer's dental coverage before enrolling in this Plan.**
Vision Program	Your Spouse or Other Eligible Individual and your Children
Life Insurance Program (Dependent Coverage Options)	Your Spouse or Other Eligible Individual and your Children
Wellness Program	Your Spouse or Other Eligible Individual enrolled in CMU's PPO 2, Advantage HDHP/HSA or Advantage Plus HDHP/HSA medical plans

* Coverage for Other Eligible Individuals is not permitted under the MESSA Medical and Prescription Drug Programs.

**This rule does not apply to regular faculty.

All other Benefit Programs under the Plan are available to you as an eligible employee of the Employer and do not apply to your family. However, you may be eligible to receive reimbursement under the Health Care FSA Program for health care expenses incurred by your family members (see "Health Care FSA Program" beginning on page 32), and you may be eligible to receive reimbursement under the Dependent Care FSA Program for expenses incurred for the care of a family member (see "Dependent Care FSA Program" beginning on page 26).

The Plan Administrator may require you to show proof that a dependent or Other Eligible Individual meets the eligibility criteria. You must notify the Plan Administrator on or before the 30th calendar day following the date of any change in status that would result in a dependent or Other Eligible Individual no longer being an Eligible Dependent (e.g., your Spouse in the event of a divorce). The Plan has a right to recover from you any payments made by the Plan on behalf of an individual who is not an Eligible Dependent (see "Overpayments" beginning on page 58).

Definitions

"**Spouse**" means your legally married spouse, unless you are legally separated under a court order of separation or separate maintenance. A spouse by common law marriage is not an eligible spouse.

"**Other Eligible Individual**," or "**OEI**," means an individual described below, provided the employee is not currently married and has not designated a Spouse or other OEI to receive benefits in the past 18 months:

- the individual currently lives in the same residence as the employee (not as the employee's tenant) and has done so continuously for the last 18 months;

- the individual and employee are jointly responsible for each other's common welfare and shared financial obligations, and can provide at least two pieces of supporting documentation;

- the individual is not (i) a spouse under Michigan law, (ii) a dependent as defined by the IRS, (iii) an in-law or step-relative of the employee, or (iv) eligible to inherit from the employee under the laws of intestate succession in the State of Michigan in the event the employee dies intestate.

To cover your OEI, you must complete and submit to the **Benefits and Wellness Office** an "Other Eligible Individual Designation" form in order to add coverage for your OEI. You may only cover one OEI at a time. If your OEI no longer meets the University's OEI criteria, you must immediately notify the **Benefits and Wellness Office** and file a "Declaration of Termination of Other Eligible Individual Status" form. Coverage terminates on the date the criteria are no longer met.

"**Child**" means an individual who meets the eligibility criteria listed on **Schedule B**. Your eligible unmarried Child, regardless of age, who is mentally or physically disabled and is covered under the Plan may continue to be covered beyond the age limits on **Schedule B**. The Child must be incapable of self-support, the disability must have occurred before the Child's coverage under the Plan would otherwise have ended, and the disability must be expected to continue indefinitely. Satisfactory proof of disability must be provided to the **Benefits and Wellness Office** within 30 calendar days after the date coverage would otherwise end and from time to time thereafter as requested by the Plan Administrator. Coverage ends when the Child is no longer disabled or if satisfactory proof of the disability is not provided.

The child of an OEI is eligible for coverage if the child meets the eligibility requirements for a Child on **Schedule B**.

Imputed Income

The value of any benefits provided under the Plan to an individual who does not meet the requirements for being a dependent under Code Section 105(b) (including your Other Eligible Individual and, possibly, your OEI's children) will be taxable income to you.

Special Rule Regarding Double Eligibility

Except for dependent coverage under the Life Insurance Program, your dependent cannot be your Eligible Dependent under a Benefit Program if he or she has coverage under that Benefit Program as an employee of the University. Also, if you and your Spouse or Other Eligible Individual are both Participants in that Benefit Program as an employee of the University, your Child cannot be enrolled by both of you. If both of you attempt to enroll the Child, the Plan Administrator will request an employee to determine which of you will cover the Child.

Retirees And Dependents Of Retirees

If you retired prior to July 1, 2011, you were eligible to enroll in medical and prescription drug coverage under the Plan for yourself and your dependents if you were a former full-time or part-time Staff or Faculty employee of the University and you met the following criteria:

- You were hired before July 1, 2008 (before July 1, 2009 for Office Professionals) and you retired before July 1, 2011 either:
    - at or after age 55 with at least 10 years of benefit eligible service; or
    - at any age with at least 25 years of benefit eligible service; or
    - on account of disability (within the meaning of Title II or XVI of the Social Security Act) with at least 10 years of benefit eligible service); and
- You were a participant in the University's 403(b) Basic Retirement Plan.

If you were an eligible retiree, you were required to enroll in retiree coverage at the time of your retirement; you may not enroll at a later date.

You may not add new dependents to your retiree coverage except in the following circumstances: (i) if you gain a new dependent as a result of marriage, birth, adoption or placement for adoption as provided under "Special Enrollment for Newly Eligible Dependents"; or (ii) your spouse was covered through his or her own employer's health plan and lost coverage because of termination of employment.

ENROLLMENT AND PARTICIPATION

New Employee Enrollment Period

As a newly hired Benefit Eligible Employee, the Plan Administrator will enroll you in the Plan as soon as administratively practicable upon your completion of the enrollment process. You must complete the enrollment process within 30 calendar days following the date you become a Benefit Eligible Employee ("**Initial Enrollment Period**").

The electronic enrollment materials will describe the amount of any Employee Contributions required for the available options under each Benefit Program. To participate in the Plan, you must enroll using the University's CentralLink online enrollment portal at www.cmich.edu/benefits. You must elect the Benefit Programs in which you wish to participate and authorize the University to reduce your pay based on the contribution that is required or available for each Benefit Program you elect.

Your elections will be effective from the date you begin participating in the Plan, but Employee Contributions will be taken only from income you have not yet received. Elections during your Initial Enrollment Period are irrevocable for the remainder of the Plan Year, unless you become eligible to change elections under a Special Enrollment Period or a Change Event occurs.

If you are not receiving a paycheck from the University, you agree to timely pay your Employee Contributions as directed by the Plan Administrator.

Only you, and not your Eligible Dependents, may make Benefit Program elections. If you have properly enrolled in any Benefit Program, you are a "**Participant**" in the Plan. Any Eligible Dependents properly enrolled in the Plan are "**Covered Dependents**."

Open Enrollment Period

Each year the University establishes an "**Open Enrollment Period**," which is usually toward the end of the Plan Year. During the Open Enrollment Period, you can make new benefit choices and elections for the upcoming Plan Year. Regular Faculty may have the opportunity to make elections toward the end of the calendar year to change elections under the Medical and Prescription Drug Programs. The University will notify Regular Faculty if this separate enrollment period applies.

To change your elections, or enroll in a Benefit Program for the first time during an Open Enrollment Period (if you failed to do so during your Initial Enrollment Period or during prior Open Enrollment Periods), you must complete your enrollment electronically through the University's online portal at www.cmich.edu/benefits prior to the end of the Open Enrollment Period. The period of coverage under the Plan is a 12-month period, beginning on the first day of the Plan Year. The choices you make during the Open Enrollment Period will be effective on the first day of the upcoming Plan Year, and will remain in effect without any changes permitted through the remainder of the Plan Year unless you experience a Special Enrollment Period or Change Event. You may, however, change your Employee Contributions under the HSA Contributions Program on a prospective basis at any time.

If the Open Enrollment Period occurs while you are on an Employer-approved leave during which your benefits continue, you will be contacted and required to make an election during the Open Enrollment Period. If the Open Enrollment Period occurs while you are on an Employer-approved leave during which your benefits do <u>not</u> continue, you

will be allowed to make limited changes to your elections for the new Plan Year when you return from your leave as long as you are eligible to participate upon your return.

If you enroll in the Medical, Prescription Drug, Dental, Vision, STD, Dependent Care FSA, or Health Care FSA Programs, you will be simultaneously enrolled in the Pre-Tax Payment Program for purposes of making Employee Contributions to those Benefit Programs.

Failure To Timely Enroll

Initial Enrollment Period

If you are a Benefit Eligible Employee and you fail to properly enroll in the Plan during your Initial Enrollment Period, you will be enrolled automatically for coverage in the following Benefit Programs:

All Staff, Regular Faculty and Medical Faculty

- Medical (employee-only coverage)
- Prescription Drug (employee-only coverage)
- Long-Term Disability Insurance
- Life Insurance/AD&D (University-paid (basic) coverage)

Fixed-Term Faculty

- Life Insurance/AD&D (University-paid (basic) coverage)
- Long-Term Disability Insurance

Postdoctoral Research Fellows

- Life Insurance/AD&D (University-paid (basic) coverage)

Required Employee Contributions under the Medical and Prescription Drug Programs will be taken from your pay.

If you are automatically enrolled in a Benefit Program that requires Employee Contributions, you will have a period of time in which you can elect to drop coverage under that Benefit Program. The Plan Administrator will communicate the exact dates of the window to you in the enrollment materials. Otherwise, your elections are irrevocable for the remainder of the Plan Year unless you become eligible to change elections under a Special Enrollment Period or a Change Event occurs.

Open Enrollment Period

If you fail to properly enroll during any Open Enrollment Period, you will be deemed to have elected to participate in the same Benefit Programs under the Plan for the upcoming Plan Year as you elected for the current Plan Year, except that you will not be enrolled in the HSA Contributions, Health Care FSA, Dependent Care FSA.

Any required Employee Contributions will be taken from your pay. Your elections for the upcoming Plan Year will be irrevocable unless you become eligible to change elections under a Special Enrollment Period or a Change Event occurs.

Participation Upon Change In Employee Group

If you become ineligible to participate in a Benefit Program because you move from one employee group to another, your participation in that Benefit Program will end on the date your employee group changes.

If you are enrolled in a Benefit Program on the date your employee group changes, you will remain enrolled in that Benefit Program so long as it is available to employees in your new employee group. However, for purposes of the Medical Program, if you move from the Regular Faculty employee group to any other employee group, or from any other employee group to the Regular Faculty group, you will be automatically transitioned to an available option under that Program as follows:

Currently Enrolled In	Transitioned To
Choices 10/20 (MESSA)	PPO 2 (BCBS)
Choices Saver 200/400 (MESSA)	PPO 2 (BCBS)
Choices Saver 500/1000 (MESSA)	PPO 2 (BCBS)
ABC HSA Saver (MESSA)	Advantage HDHP/HSA (BCBS)
PPO 2 (BCBS)	Choices Saver 500/1000 (MESSA)
Advantage HDHP/HSA (BCBS)	ABC HSA Saver (MESSA)
Advantage PLUS HDHP/HSA (BCBS)	ABC HSA Saver (MESSA)

The change in options under the Medical Program will be effective as of the date of your change in employee group.

If you are moving from the Postdoctoral Research Fellows group to any other employee group, you will be automatically enrolled in the Long-Term Disability Program as of the date of your change in employee group. You will also be given the opportunity to enroll in the Vision Program and, as long as you are not moving to the Fixed-Term Faculty group, the Short-Term Disability Program. You will have 30 days from the date of your employee group change to elect enrollment in those Benefit Programs.

If you are moving from the Fixed-Term Faculty Group to any group other than the Postdoctoral Research Fellows group, you will be given the opportunity to enroll in the

Short-Term Disability Program. You will have 30 days from the date of your employee group change to elect enrollment.

Special Enrollment Period

A Special Enrollment Period is a period of enrollment other than the Initial Enrollment Period or the annual Open Enrollment Period during which you may elect to enroll yourself and your Eligible Dependents in the Medical and Prescription Drug Programs as described below.

Special Enrollment for Newly Acquired Eligible Dependents

If you gain an Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, the following individuals may be enrolled in the Plan if they are not currently enrolled: (1) you; (2) your Spouse; and (3) any eligible Children. You must notify the **Benefits and Wellness Office** and request enrollment within 30 calendar days after the date of the marriage, birth, adoption, or placement for adoption. If the 30th day falls on a weekend or a University recognized holiday, your enrollment will be accepted if submitted via fax or email before 8:00am on the next immediate business day.

Coverage will begin on the date of the birth, adoption, or placement for adoption. In the case of marriage, coverage will begin on the later of the date of your marriage or the first day of the next available pay period after the date of your request for Special Enrollment.

If you have an individual who is within 30 days of qualifying as your OEI (as defined above), you may request enrollment of that individual and his or her Children as of the effective on the first day of the next available pay period after you submit the Status Change Request Form, so long as you promptly provide any requested follow-up documents.

Special Enrollment for Loss of Other Coverage

If you and/or your Eligible Dependents were eligible but did not enroll in this Plan previously because you were covered under another group health plan or had other health insurance coverage, and eligibility for that other coverage is lost, you and your Eligible Dependents may enroll in the Plan during a Special Enrollment Period if the following requirements are met:

- You declined coverage (in writing if the Plan required a written statement at the time) when it was previously offered because you or your dependents were covered under another group health plan or had other health insurance coverage; and
    - The other coverage was COBRA continuation coverage and it was exhausted; or
    - The other was not COBRA continuation coverage and it ended because:

- you or your dependents lost eligibility (including as a result of divorce, legal separation, loss of dependent status, death, termination or reduction in hours of employment, or because you or your dependents no longer live or work in the other health plan service area);

- the other coverage no longer offers any benefits to a class of similarly situated individuals; or

- employer contributions to the other coverage were terminated.

An individual who loses coverage under another plan for the following reasons is not eligible for a Special Enrollment Period:

- did not pay premiums on a timely basis.

- chose to drop coverage for any reason, including an increase in premium or change in benefits.

- coverage was terminated for cause, such as a fraudulent claim or intentional misrepresentation of a material fact in connection with the Plan.

If you (the Employee) lose other coverage, you may enroll yourself and any of your Eligible Dependents. If one of your Eligible Dependents loses other coverage, you many only enroll yourself (if you are not already covered) and that Eligible Dependent.

Enrollment due to loss of other coverage will be effective on the first day of the next available pay period after you submit the Status Change Request Form so long as you promptly provide any requested follow-up document.

Special Enrollment for Medicaid/Children's Health Insurance Program Changes

If you or an Eligible Dependent are eligible, but not enrolled in this Plan's medical or prescription drug coverage, you are entitled to a Special Enrollment Period if:

- Your coverage or the coverage of your Eligible Dependent under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 calendar days after the date the Medicaid or CHIP coverage terminates; or

- You, your spouse or a dependent become eligible for a premium assistance subsidy in this Plan under Medicaid or a state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 calendar days after the date you are determined to be eligible for such assistance.

Special Enrollment Request

You must request enrollment by completing and returning a Status Change Request Form to the **Benefits and Wellness Office** within 30 calendar days after the special enrollment event (or within 60 calendar days if the special enrollment event is due to Medicaid/CHIP changes). The Status Change Request Form is available online at www.cmich.edu/benefits or from the **Benefits and Wellness Office**. You must provide satisfactory proof of the special enrollment event if requested. If the 30th day (or 60th day in the event of a Medicaid/CHIP change) falls on a weekend or a University recognized holiday, your enrollment will be accepted if submitted via fax or email by 8:00am on the next immediate business day.

If your status change request is received more than 30 calendar days after the date of the Change Event (or more than 60 days in the event of a Medicaid/CHIP change), you must wait until the next Open Enrollment Period, a Special Enrollment Period, or until you experience another Change Event. If your status change request regarding a birth is received more than 30 calendar days after the date of the birth, you may enroll your newborn in the Plan on a prospective basis from the time notification is received by the Plan Administrator. If the enrollment of your newborn child causes a change to your coverage tier and cost (for example, single to two-person or two-person to family), you will be required to pay for the Child's coverage on an after-tax basis until the next Open Enrollment Period.

You should contact the **Benefits and Wellness Office** if you have any status change questions: 989-774-3661 or benefits@cmich.edu.

QUALIFYING STATUS CHANGE EVENTS

Your Benefit Program elections generally remain in effect for the full plan year. However, you may change your benefit elections during the Plan Year outside an enrollment period if you experience a qualifying status change event ("**Change Event**") and the change you want to make is consistent with the Change Event.

Change Events For All Benefit Programs

You may change your Benefit Program selections if you or a dependent becomes eligible or ineligible for coverage under either this Plan or another plan on account of:

- change in legal marital status (for example, marriage, divorce, legal separation, annulment);

- change in number of dependents (for example, birth, death, adoption, placement for adoption);

- change in employment status (for example, termination or commencement of employment, strike or lock-out, leave of absence or a new collective bargaining contract that affects eligibility for some or all benefits);

- change in work schedule (for example, full-time to part-time); or

- change in a dependent's eligibility status (that is, a dependent becomes eligible or ineligible for benefits under the Plan).

In addition, you may change your selections on account of the following:

- coverage change under another employer's health plan (for example, your Spouse's employer-provided health coverage or your Spouse's employer's contribution to health coverage ends or is significantly reduced) ***(not available for the Dependent Care FSA or Health Care FSA Programs);***

- change in the availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO option is added to or deleted from the Medical Program) ***(not available for the Dependent Care FSA or Health Care FSA Programs)***;

- change in an election under another employer's health plan that relates to a period that is different from the Plan Year for this Plan (for example, your Spouse's open enrollment period is in December, your open enrollment is in May, and your Spouse desires to drop dependent coverage under his/her plan and enroll eligible dependents in this Plan) ***(not available for the Dependent Care FSA or Health Care FSA Programs)***;

- significant change in the cost of health coverage during the Plan Year if it is a significant increase or decrease ***(not available for the Dependent Care FSA or Health Care FSA Programs)***;

- significant curtailment of health coverage during the Plan year ***(not available for the Dependent Care FSA or Health Care FSA Programs)***; or

- change in your dependent care provider or a significant change in the cost of your dependent care ***(available for the Dependent Care FSA Program only)***.

Additional Change Events For Health Care Options

In addition to the above Change Events, you may also change elections for the Medical, Prescription Drug, Dental, Vision and Health Care FSA Programs if:

- you, your spouse, or other Covered Dependent become eligible for continuation coverage under COBRA or USERRA;

- a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires or eliminates accident or health coverage for your Child;

- you, your Spouse, or other Covered Dependent become enrolled in Medicare; or

- you, your Spouse, or other Covered Dependent become eligible for a Special Enrollment Period (described previously).

Additional Change Events For the Medical Program
In addition to the above Change Events, you may also change your elections under the Medical Program if you become eligible to enroll in a health plan offered through the Health Insurance Marketplace, either because of a special enrollment right or during the Marketplace's annual open enrollment period, and your new coverage under such a plan will become effective no later than the day after your coverage under this Plan ends. You will be required to certify your intent to enroll in other coverage.

Consistency Rule
Your election change must be consistent with the Change Event that affects your coverage under a Benefit Program. Examples:

- If your dependent care provider changes, you cannot change your Medical Program elections, but you can change your elections relating to the Dependent Care FSA Program.

- If one of your dependents no longer qualifies as a Covered Dependent, you can cancel coverage for that dependent, but you cannot cancel coverage for your other Covered Dependents.

- If you have single coverage and you marry, you may elect two-person or family coverage.

Some of the Change Events may allow you the option of either increasing or decreasing coverage, for example, your spouse changing an election under his or her employer's plan allows you to increase or decrease your benefits under the Plan so long as your choice is consistent with your spouse's election. If you are not sure the election change you would like to make is consistent with the Change Event, you should contact the **Benefits and Wellness Office**.

Special Rule For Election Changes For HSAs
If you are making contributions to your HSA through the HSA Contributions Program, you may at any time elect to increase, decrease or entirely stop making your contributions.

The change will be effective as of the next payroll period that begins after your submission of the completed HSA Enrollment/Change form, or as soon thereafter as administratively feasible. The change will not affect your prior HSA contributions, but only contributions that you make going forward.

When you make a change to your HSA contributions, you will not be permitted to make any mid-year election changes to your other elected benefits unless you independently meet the other requirements in this section that would permit a mid-year election change.

Procedures For Changing Elections Mid-Year

If you want to change an election because of a Change Event, you must submit a Status Change Request Form to the **Benefits and Wellness Office** and identify the event that resulted in the change. The Status Change Request Form must be filed on or before 30 calendar days after the date of the Change Event. If the 30th day falls on a weekend or a University recognized holiday, your enrollment will be accepted if submitted via fax or email by 8:00am on the next immediate business day.

The change in coverage generally will be effective as of the first payroll period following notification or as soon as administratively practical thereafter, but if the Change Event is the birth or adoption of a Child, the change in coverage will be retroactively effective to the date of the birth or adoption. If one or more payroll periods have passed since the birth or adoption, additional Employee Contributions will be withheld from subsequent paychecks to place you in the position you would have been in had your new election been in effect at the date of the birth or adoption.

If your Status Change Request Form is received more than 30 calendar days after the date of the Change Event, you must wait until the next Open Enrollment Period, a Special Enrollment Period, or until you experience another consistent Change Event to make the change. If your Status Change Request Form regarding a birth is received more than 30 calendar days after the date of the birth, you may enroll your newborn in the Plan on a prospective basis from the time notification is received by the Plan Administrator, but you may only do so on an after-tax basis until the next Open Enrollment Period.

You should contact the **Benefits and Wellness Office** if you have any status change questions: 989-774-3661 or benefits@cmich.edu.

PARTICIPATION DURING A LEAVE OF ABSENCE

If your leave is a paid leave, your Employee Contributions will continue to be deducted from your pay during your paid leave. If your leave is unpaid, you must make arrangements with the **Benefits and Wellness Office** to pay any required contributions during your leave.

For any unpaid leave, including unpaid leave that qualifies under the Family and Medical Leave Act ("**FMLA**"), the University intends to allow you to continue Plan benefits, to the extent possible if permitted by the specific coverage.

- If you do not wish to continue the same coverage during your leave that you were receiving prior to your leave, you must notify the **Benefits and Wellness Office** before the start of your leave, or as close to the beginning of your leave as possible. When you return from your leave, you will be entitled to receive the same benefits as you were receiving immediately before the start of your leave, without having to complete any waiting period.

- If you do wish to continue in the Plan during your leave, you must make arrangements with the **Benefits and Wellness Office** to pay any required contributions.

- Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not make the required contributions during the period of your leave, unless you have made other arrangements with the **Benefits and Wellness Office**.

- If the University advances contribution payments for you, in whole or in part, it can recoup any amounts advanced through payroll deductions when you return to employment or from any other amounts owed to you by the University.

Special rules for the Dependent Care FSA and Health Care FSA Programs are described in those sections.

TERMINATION OF COVERAGE

End Of Plan Participation

Your participation (and your Covered Dependents' participation) in the Plan will end on the earliest of the following dates:

- your termination of employment or, if later, the date your benefits terminate pursuant to a 10-month faculty appointment;

- a Change Event (as defined above) that leads you to revoke your participation;

- your (or your Covered Dependent's) failure to meet the eligibility requirements or conditions described in the Plan;

- for the Insured Benefit Programs, the date the group insurance policy or contract between the University and the insurer ends;

- for Covered Dependents, pursuant to the terms of a Qualified Medical Child Support Order under which he or she participates in the Plan;

- you or a Covered Dependent commits, or attempts to commit, fraud against the Plan or has been dishonest about a material matter affecting eligibility for benefits. In the case of fraud or intentional misrepresentation of a material fact, ***coverage may be retroactively terminated***;

- modification or termination of the Plan or a Benefit Program by the University; or

- your coverage is terminated by the University for cause; for example, if you commit or attempt to commit fraud against the Plan or you have been dishonest about a material matter affecting eligibility or benefits.

Also, if you fail to timely make any required contributions, the Plan may terminate coverage retroactive to the last day of the coverage period for which you have paid.

If eligible, you and your dependents may elect to continue health coverage under COBRA. Special rules apply to the timing of any required payments for COBRA Continuation Coverage (see the section titled "COBRA Continuation Coverage" for more information).

Participation Upon Return From a Leave of Absence

If your benefits under a Benefit Program end while you are on leave and you return to a position eligible for benefits, you may participate again immediately upon return from leave. Benefits will be reinstated automatically with the same elections in effect at the time your leave began. If you return from leave after 30 days, you qualify for a status change event, which allows a change in benefit elections consistent with the change event.

Rules regarding your Health Care FSA and Dependent Care FSA elections upon return from a leave are contained in the section of this Plan entitled Health Care FSA Program and Dependent Care FSA Program, respectively.

Participation Upon Rehire

If you terminate employment but are rehired by the University within the same Plan Year, your benefit elections under the Plan before your termination of employment will be reinstated automatically and you will not be allowed to make a new election. If you terminate employment and are rehired in a later Plan Year, you will be treated as a new hire and will be required to make new benefit elections.

FUNDING

The benefits provided under the Plan are paid either from the general assets of the University or through insurance.

The University pays its share of the cost of the Benefit Programs for which Employee Contributions are required through a credit amount allocated to each employee. This is referred to as the CMU Contribution ("**CMU Contribution**"). You may direct your CMU Contribution to the purchase of Medical Program and other Benefit Program coverages. If the total cost of the coverage you elect each year is more than the amount of CMU Contribution to which you are entitled, you are required to pay the difference. The additional amounts you must pay for the coverage you elect are referred to in this Plan as Employee Contributions ("**Employee Contributions**") and do not include any co-payments, co-insurance or deductibles that may be required under the terms of the Benefit Programs.

You will be informed of the amount of the CMU Contribution and any Employee Contributions at the time of your Initial Enrollment Period and again at each Open Enrollment Period. The amount, or the formula for calculating the amount, of the CMU Contribution will be the same for all similarly situated members of the same employee group. The amount, or formula, of the CMU Contribution may differ for different employee groups. The amount of CMU Contribution may be zero for some categories of employees or for certain Benefit Programs.

If you and your Spouse or Other Eligible Individual are both employed by CMU, you may not combine your CMU Contribution with the CMU Contribution for your Spouse or Other Eligible Individual for purposes of selecting and paying for any Benefit Program.

Staff, Fixed-Term Faculty, Medical Faculty and Postdoctoral Research Fellows whose CMU Contribution exceeds the amount required for the Benefit Programs elected will have the difference added to his or her pay as additional cash compensation.

Regular Faculty may apply CMU Contributions toward the cost of Benefit Programs elected. Regular Faculty whose CMU Contributions exceed the amount required for the Benefit Programs elected will not receive the difference as cash compensation.

Nothing in this Plan will be construed to require the University to maintain any fund for its own contributions or segregate any amount that it is obligated to contribute for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the University from which any payment under the Plan may be made.

BENEFIT PROGRAMS

The Plan provides the following component Benefit Programs:

MEDICAL PROGRAM

For a description of the Medical Program benefits, see **Schedule C** of this document.

PRESCRIPTION DRUG PROGRAM

For a description of the Prescription Drug Program benefits, see **Schedule D** of this document.

DENTAL PROGRAM

For a description of the Dental Program benefits, see **Schedule E** of this document.

VISION PROGRAM

For a description of the Vision Program benefits, see **Schedule F** of this document.

SHORT-TERM DISABILITY PROGRAM

For a description of the Short-Term Disability Program benefits, see **Schedule G** of this document.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Under the EAP, counselors are available to you 24 hours a day, 7 days a week either on-line, on-site or on-call at (866) 799-2691. These benefits are provided to you at no cost and provide confidential support for issues that may impact your work or personal life. Professional confidential support is available to you to assist with any life difficulties that you may encounter. For more information on how to obtain these benefits go to: https://www.cmich.edu/about/human-resources/benefits-wellness/wellness-benefits/health-advocate

LONG-TERM DISABILITY PROGRAM

For a description of the LTD Program benefits, see **Schedule H** of this document.

LIFE INSURANCE/ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PROGRAM

For a description of the Life/AD&D Program benefits, see **Schedule I** of this document.

HEALTH SAVINGS ACCOUNT CONTRIBUTIONS PROGRAM

The Health Savings Account Contributions Program allows you to reduce your taxable compensation by making pre-tax contributions to a Health Savings Account ("**HSA**") established in your name. Although you can use the funds in your HSA for any purpose, these funds will be tax free when you use them to reimburse medical expenses consistent with federal tax code requirements. For more information on qualifying medical expenses, you should obtain and read the most current version of IRS Publication 969.

You are the owner of your HSA, and the University has no authority or control over the funds deposited in your HSA. Even though this plan allows you to make pre-tax contributions to your HSA, your HSA is not an ERISA benefit plan sponsored or maintained by the University. It will be up to you to decide when and how to use the funds in your HSA.

Eligibility

In order to contribute to an HSA through the Health Savings Account Contributions Program, you: (1) must be eligible for and participating in a HDHP offered under this Plan; (2) may not be claimed as a dependent on anyone else's tax return; and (3) may not be covered by any other medical plan that provides coverage below the deductible threshold established under the federal tax code. See the most current version of IRS Publication 969 for the current deductible threshold. You must be eligible during each month that you contribute to your HSA. You are considered eligible for a particular month if you are eligible on the first day of that month.

A General-Purpose Health Care FSA under this Plan is considered disqualifying medical coverage for purposes of determining eligibility for HSA contributions. Other coverage that will disqualify you from contributing to an HSA includes: Medicare Parts A, B or D; a Medicare Advantage plan; Veterans Administration medical benefits received during the preceding three months, unless you have been determined to have a service-related disability; coverage under a spouse's medical plan that is not a HDHP, coverage under a Spouse's or other family member's health FSA (unless it is a limited-purpose or post-deductible FSA); Indian Health Service medical benefits received during the preceding three months; and any other coverage that covers all or even a portion of medical expenses that you incur before you have satisfied the deductible threshold.

Effect Of General-Purpose Health Care FSA Carry-Over On HSA Eligibility

Because Carry-Over Amounts under the Health Care FSA Program effectively extend your coverage under the Health Care FSA Program through the next Plan Year, a positive balance in a General-Purpose Health Care FSA at the end of one Plan Year will make you, your Spouse, and other Covered Dependents ineligible to make HSA contributions, or accept any employer HSA contributions, for the next Plan Year. To assist in maintaining your HSA eligibility in the following Plan Year, if you enroll in an HDHP option under the Medical Program for the following Plan Year, you will be automatically enrolled in the

Limited-Purpose Health Care FSA Program and any Carry-Over Amount from the prior Plan Year will be automatically transferred to your Limited-Purpose Health Care Account.

Benefits

If you are eligible to participate in the Health Savings Account Contributions Program, you may reduce your taxable income by having the University submit your elected contributions on a pre-tax basis to an HSA that you establish with the HSA trustee/custodian selected by the University.

The University, at its sole discretion, may also make contributions to your HSA. The contribution amounts may vary from year to year or may not be made at all. If a contribution is made by the University for any Plan Year, the amount and timing of any such contribution along with any requirements necessary for you to complete in order to receive the contribution to your HSA will be communicated to you in writing. The University may also adjust contributions as necessary to comply with tax code nondiscrimination requirements.

Establishing An HSA Account

If you choose to participate in the Health Savings Account Contributions Program, you must establish an HSA with the trustee/custodian selected by the University. Information on establishing your HSA is available from the Plan Administrator.

You will be the owner of any contributions deposited into the HSA. At any time you may transfer funds from the HSA to another HSA with the trustee/custodian of your choice. The University, however, will only contribute pre-tax funds to an HSA with the custodian of its choosing.

Changing Contributions

You can elect to increase, decrease, or entirely stop contributing to your HSA at any time, and such change will be effective on a prospective basis. These changes will not affect your prior contributions, but only contributions you make going forward. Your change will go into effect with the first payroll period that begins after you have successfully submitted your election change, or as soon as administratively feasible thereafter.

Maximum Contributions

General Limitations on Contributions

The maximum amount that you may contribute to your HSA may not exceed the limits established under the federal tax code, which are adjusted annually. The maximum contribution limits for single coverage and for any family coverage will be communicated in each year's enrollment materials. If you are age 55 or older, you may also elect to make an additional "catch-up" contribution of $1,000 per year through payroll deduction.

If you are married and both you and your Spouse have an HSA, the IRS has a special rule limiting your joint contributions for the year to the family deductible limit. If both

you and your Spouse are above age 55 and each of you establish an HSA, then you may both also make an additional "catch-up" contribution to each account. If only you have an HSA, then only you can make a "catch-up" contribution. For more information about the rules that apply to married couples, you should obtain and read the most current version of IRS Publication 969.

If you have family coverage and your Spouse also contributes to an HSA, then you must also reduce your maximum HSA contribution limit for family coverage by the amount that your Spouse contributes.

If the total deposits into your HSA for the year exceed your maximum contribution limit, the excess amounts will be deemed an excess contribution for federal tax purposes. You will be taxed on this excess contribution. Additionally, if you do not promptly withdraw this excess contribution (and any interest earned on the excess contribution), you will pay a 6% excise tax each year that the excess contribution (and its earned interest) remains in your HSA.

Limits for Those Not Eligible to Contribute to an HSA For the Full Year

The amount that you may contribute may also have to be pro-rated for the number of months of the year that you are eligible to contribute to an HSA (see the "Eligibility" section above). For example, if you terminate employment with the University on June 15 and are no longer covered under a HDHP for the rest of the calendar year, you will only be eligible to contribute to an HSA for the first six months of the year and your maximum contribution amount will be reduced to half of the annual limit. This pro-rata contribution rule also applies to catch-up contributions during the year you turn age 55.

If you join the Plan after the start of the year and have not been previously covered under a HDHP, the amount you may contribute without restriction is also prorated for the number of months you are covered by the HDHP option (and are otherwise eligible to contribute to an HSA). However, the IRS has a special rule that allows you to fund your HSA up to the annual contribution limit for a calendar year as long as you are covered under a HDHP by December 1 of the year. This special rule is called the "Last-Month Rule." To take advantage of this Last-Month Rule, you are required to remain covered under a HDHP (and not otherwise be disqualified from contributing to an HSA) until the end of the following calendar year. If you fail to remain HSA eligible throughout the following calendar year, you would face adverse tax consequences: you would have to pay income taxes plus an additional 10% penalty tax on the contributions above your prorated contribution limit (except if you lose your HSA eligibility based on disability or death). You do not, however, have to withdraw the contribution in excess of the pro-rated amount (and you would be subject to an additional 20% penalty if you tried to withdraw the contribution for any purpose other than paying for qualifying medical expenses).

The Last-Month Rule also applies to catch-up contributions that you make during the year you turn age 55. As long as you are age 55 by December 1 of the calendar year, you can contribute the entire $1,000 catch-up amount for the year. But if you do not remain eligible to contribute to an HSA during the entire following calendar year, you would have to pay income taxes plus an additional 10% penalty on the amount of the catch-up amount that exceeds the pro-rated amount you were otherwise allowed to contribute.

You are responsible for determining whether you are eligible to contribute to an HSA each month and for adjusting your HSA contributions accordingly. For more information about the Last-Month Rule, you should obtain and read the most current version of IRS Publication 969.

Recording Contributions

Because you are the owner of your HSA, you are responsible for keeping track of how much has been deposited into your account. The University will keep track of HSA contributions made through this Plan, but will not keep track of contributions made outside of the Plan or of amounts that your Spouse may contribute to an HSA. Nor will the University keep track of whether you maintain eligibility to contribute to an HSA throughout the year. Also, the University will not create any separate fund or otherwise segregate assets relating to the Health Savings Account Contribution Program.

Trust/Custodial Agreement

Your HSA is a personal account that you own, not an employee benefit program sponsored by the University. To establish the HSA, you must execute a custodial agreement with an HSA custodian. Additionally, your HSA is subject to terms and conditions, which the HSA custodian will provide to you. You are solely responsible for any fees assessed by the HSA custodian.

HSA Distributions

This Plan does not govern distributions from your HSA. Distributions and all other matters relating to maintenance of your HSA are subject to the trust/custodial agreement between you and the HSA custodian. You are solely responsible for complying with federal tax rules regarding distributions from your HSA and any tax consequences associated with those distributions. For more information about HSA distribution rules, you should obtain and read the most current version of IRS Publication 969.

Termination

When your participation in this Plan ends, pre-tax contributions to your HSA will also end. You will continue to be the owner of your HSA. If you terminate mid-year and are no longer eligible for HSA contributions, you may be taxed on any additional contributions as an excess contribution. You will need to promptly withdraw the excess contribution (and any interest earned on that amount) from your HSA or pay a 6% excise tax each year that the excess contribution (and interest on the excess contribution) remains in your HSA.

PRE-TAX PAYMENT PROGRAM

The Pre-Tax Payment Program is designed to help you pay Employee Contributions on a pre-tax basis for the following qualifying Benefit Programs:

- Medical
- Prescription Drug
- Dental
- Vision
- Short-Term Disability
- Long-Term Disability
- Group-Term Life Insurance/AD&D (employee coverage up to a total of $50,000)
- Health Savings Account Contributions Program
- Health FSA
- Dependent Care FSA

Employee Contributions for all other coverage (such as dependent life insurance) will be paid on an after-tax basis.

Under the Pre-Tax Payment Program your taxes will be lower because your Employee Contributions will not be subject to federal, state, most municipal, or Social Security taxes. Because your compensation is reduced, however, other benefits that are based on your compensation, such as Social Security, life insurance, and disability insurance may also be reduced. For most employees, these benefit reductions are fairly small, particularly compared to the tax savings, and in some cases, benefits may not be reduced at all. You should review your own situation carefully before making a choice.

Treatment Of Employee Contributions While On Leave

If you take an unpaid leave of absence, you will not be able to participate in the Pre-Tax Payment Program during your leave because you will not be receiving compensation during the period of your leave. If you remain eligible to continue participation in Benefit Programs during your unpaid leave, you will generally make any required contributions on an after-tax basis, unless you have made alternative arrangements with the **Benefits and Wellness Office**. This is true whether or not your leave qualifies under the FMLA.

On the other hand, if you are on a paid leave (whether or not FMLA-qualified), you will continue to have required contributions deducted on a pre-tax basis during the leave, so long as you are still eligible to participate in the Benefit Programs.

Cafeteria Plan Elections May Not Defer Compensation

No election that you make under the Health FSA, Dependent Care FSA or Pre-Tax Program can defer compensation you have earned in one Plan Year to the next. Nevertheless, the following are not treated as improperly deferring compensation under this Plan: (i) compensation reductions in the final month of a Plan Year that satisfy premium obligations for coverage in the first month of the immediately following Plan Year, (ii) reimbursement for advanced payments required for orthodontia procedures extending from one Plan Year to the next, (iii) payment or reimbursement for durable medical equipment with a useful life beyond a single Plan Year, and (iv) disability payments under a long term disability policy.

WELLNESS PROGRAM

For a description of the Wellness Program benefits, see **Schedule K** of this document.

DEPENDENT CARE FSA PROGRAM

The Dependent Care FSA Program is designed to help you pay your Eligible Dependent Care Expenses with pre-tax dollars.

Dependent Care Account

If you enroll in the Dependent Care FSA Program for a Plan Year, the Plan Administrator will establish a dependent care bookkeeping account ("**Dependent Care Account**") for the Plan Year. Your Dependent Care Account will be credited each pay period with the Benefit Contribution amount you authorized. The Dependent Care Account is for recordkeeping purposes only; the amounts credited to your Dependent Care Account are not assets that belong to you.

Annual Contribution Amount

The maximum amount you may contribute to your Dependent Care Account each Plan Year is the least of:

- $5,000 annually ($2,500 if married filing separate tax returns),
- your earned income from employment, or
- your spouse's earned income from employment.

If your Spouse has not earned any income from employment, but is a Full-time Student or is disabled and unable to care for himself or herself, your Spouse will be assumed to

have earned $250 a month if you claim reimbursement for the care of one Qualifying Individual, or $500 a month if you claim reimbursement for the care of two or more Qualifying Individuals. A "**Full-time Student**" is someone who enrolls at least five months during the taxable year for what is considered a full-time course of study, carrying a minimum of 12 credit hours, at an educational organization.

If the amount of your or your Spouse's earned income changes during the Plan Year, so that your authorized contribution amount exceeds the maximum amount as stated above, you should immediately notify the Plan Administrator so that your authorized contribution amount can be reduced.

The Plan Administrator may reduce your contribution to the extent necessary to comply with the Internal Revenue Code's nondiscrimination requirements.

Amount That Can Be Reimbursed To Participants

Unlike the Health Care FSA Program, the Dependent Care FSA Program reimburses you for a Claim only up to the balance in your Dependent Care Account. If the amount in your Dependent Care Account is insufficient to pay a Claim in full, the remainder of the Claim will be carried over and paid when the balance in your Dependent Care Account is sufficient. No reimbursement is available before an expense is Incurred. If you terminate employment or otherwise cease to be a Plan Participant before the end of the Plan Year, you may submit claims for Eligible Dependent Care Expenses incurred before your termination date up to the amount remaining in your Dependent Care Account. Claims may be submitted until 90 calendar days after the end of the Plan Year or, if earlier, 90 calendar days following termination of employment. You cannot, however, carry over amounts remaining in your Dependent Care Account at the end of the Plan Year to pay expenses Incurred in a subsequent Plan Year.

Eligible Dependent Care Expenses

The amount credited to your Dependent Care Account may only be used to pay for the Eligible Dependent Care Expenses of a Qualifying Individual. A "**Qualifying Individual**" is defined as:

- your child under the age of 13 for whom you are allowed a personal exemption deduction for federal income tax purposes; or

- your disabled spouse or tax dependent (regardless of age) who is physically or mentally incapable of self-care and resides with you for at least half the calendar year.

If you are a parent who is divorced, legally separated, separated under a written separation agreement, or who lived apart from your spouse at all times during the last six months of the calendar year, your child will be considered a Qualifying Individual if:

- the child is under the age of 13 or is physically or mentally incapable of caring for himself;

- the child is in the custody of one or both parents for more than one-half of the calendar year; and

- you have custody of the child for more of the calendar year than your spouse or former spouse, as the case may be.

"**Eligible Dependent Care Expenses**" are expenses for the care of a Qualifying Individual and for household services performed in connection with that care provided their primary function is to assure the well-being and protection of your qualifying dependent and they are incurred to enable you and your spouse, if you are married, to be gainfully employed or to actively seek employment. Eligible dependent care expenses include:

- Fees for nursery schools, day care (including day camps) or other dependent care centers. If the school or center serves more than six children, it must comply with applicable state and local licensing laws;

- Fees for before- and after-school care programs;

- Fees for care centers that provide day care–not overnight care–for qualifying dependent adults (if the dependent adult spends at least eight hours a day in your household);

- Expenses for services of individuals who provide care for your Qualifying Individual or adult in or outside of your home (but not including services provided by (i) your own child who is under age 19, (ii) an individual you or your spouse can claim as a tax dependent, (iii) your spouse, or (iv) a parent of your qualifying dependent);

- Expenses for household services provided in connection with the care of a qualifying individual in your home;

- Expenses for transportation to or from a caregiver if the transportation is provided by the caregiver;

- The cost of providing room and board to a caregiver; and

- Related expenses in connection with the care of a Qualifying Individual, such as day care application fees, agency fees and deposits required to obtain care.

Expenses for care provided outside of your home may be claimed for dependents under age 13 or for a disabled spouse or disabled dependent over age 13 who regularly spends at least eight hours each day in your home.

If a portion of an expense is for household services or for the care of a Qualifying Individual and a portion is for another purpose, a reasonable allocation must be made and only the portion attributable to household services or care is an Eligible Dependent Care Expense.

If you are temporarily absent from work for two consecutive weeks or less, dependent care expenses incurred during your absence will be eligible expenses provided the agreement with your caregiver requires payment during the absence.

If you (or your spouse) work part-time, dependent care expenses incurred on a day you (or your spouse) are not scheduled to work will be considered eligible expenses provided the agreement with your caregiver requires payment for a period that includes both working and nonworking days.

Ineligible Dependent Care Expenses

There are certain kinds of dependent care expenses that do not qualify for reimbursement. These include:

- expenses in excess of your annual elected amount or the maximum amount under the Dependent Care FSA Program;
- expenses paid to send a dependent to an overnight camp;
- expenses Incurred during a period of time you were not covered by the Dependent Care FSA Program;
- expenses Incurred for food, clothing, or education unless incidental to and inseparable from the care provided (for example, nursery school expenses are considered eligible expenses even if lunch and some educational services are provided);
- educational expenses for a child in kindergarten or a higher grade level;
- generally, expenses for transportation between your home and the place where the dependent care is provided, except that transportation to a day camp or an after-school program (not on school premises) that is furnished by a dependent care provider may be reimbursable if the expenses are otherwise Eligible Dependent Care Expenses;
- expenses for which you have not provided satisfactory proof of payment, *i.e.,* you have not provided third-party substantiation as to the nature of the expense and the amount of your payment;

- expenses for which the name and address of the dependent care provider has not been reported to the Claims Administrator;

- claims submitted later than 90 calendar days after the end of the Plan Year or 90 calendar days following termination of employment; and

- expenses Incurred under the Health Care FSA Program under this Plan.

Any reimbursement paid for an Ineligible Dependent Care Expense will be subject to applicable income taxes.

Example Of How The Dependent Care FSA Program Saves Taxes

You are married and you and your spouse each earn $30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Dependent Care Expenses will be $3,000. So, you choose to contribute $3,000 to your Dependent Care FSA. Your tax savings will be:

	Using Dependent Care FSA Program	**Not Using Dependent Care FSA Program**
Your Gross Pay (You and Your Spouse)	$60,000	$60,000
Your Pre Tax Dependent Care Expenses	3,000	N/A
Your Taxable Income	57,000	60,000
Your Income Taxes (for example, 25%)	14,250	15,000
Your Post Tax Dependent Care Expenses	0	3,000
Your Net Take Home Pay	$42,750	$42,000
Your Tax Savings	**$750**	N/A

Federal Dependent Care Tax Credit

You are not eligible to receive both the federal dependent care tax credit and reimbursement under the Dependent Care FSA Program for the same expense. Before enrolling in the Dependent Care FSA Program, you should consider whether reimbursement under the Dependent Care FSA Program is more advantageous to you than the maximum federal dependent care tax credit. See IRS Publication 503 for more information.

Provider Information

When you submit your first Claim each year, you must provide the Claims Administrator with information about your dependent care provider including the provider's name, address, and employer identification number (if applicable). If this information changes at any time, you are required to provide the new information with your next Claim. This information must also be provided to the IRS on your income tax return. You may obtain

this information from your dependent care provider on IRS Form W-10 "Dependent Care Provider's Identification and Certification."

Debit Card

You may use a debit card tied to your Dependent Care Account to pay for your Eligible Dependent Care Expenses.

You should retain for your personal records proof of all expenses paid by debit card in case of tax audit.

Before your debit card is issued, you will be asked to certify that you will not use the card to pay for expenses other than expenses eligible for reimbursement under the Dependent Care Account and that you will not seek reimbursement for the same expense under any other plan. Furthermore, this certification will be referenced on your debit card and you will be considered to have reaffirmed your certification each time you use your card.

Forfeiture Of Amounts Remaining At The End Of The Plan Year

Because of Internal Revenue Code requirements, if you do not use the total amount in your Dependent Care Account for reimbursement of Eligible Dependent Care Expenses Incurred during a Plan Year, the amount remaining will be forfeited and will not be returned to you. Claims for expenses Incurred during the Plan Year must be submitted within 90 calendar days following the end of the Plan Year or, if earlier, 90 calendar days following termination of employment. An expense is "**Incurred**" on the date the service that gives rise to the expense takes place. Forfeited amounts are retained by the University and may be used to pay the administration expenses of the Dependent Care FSA Program.

Participation During Leave Of Absence

If you take a leave of absence that is not short-term or temporary, based on the particular facts and circumstances of your leave, you may not be able to participate in the Dependent Care FSA Program during your leave. If you are not eligible to participate during your leave, you will not be entitled to receive reimbursement for Claims Incurred during the period of your leave. Upon your return to work, you may resume your participation in the Dependent Care FSA Program and make a new Employee Contribution election.

You should contact the **Benefits and Wellness Office** before taking a leave of absence to determine whether you will be eligible to participate in the Dependent Care FSA Program during your leave.

HEALTH CARE FSA PROGRAM

The Health Care FSA Program is designed to help you pay for Eligible Health Care Expenses with pre-tax dollars. **Please note that if you want to participate in the**

Health Savings Account Contributions Program, you are only eligible to participate in the Limited-Purpose Health Care Account described herein.

Health Care Account

If you enroll in the Health Care FSA Program for a Plan Year, the Plan Administrator will establish a health care spending account ("**Health Care Account**"). The Health Care Account will reimburse eligible expenses incurred by you and your dependents during the Plan Year. Your Health Care Account will be credited each pay period with the Employee Contribution amount you authorized, plus any Carry Over Amount available to you from the prior Plan Year. Your Health Care Account is for bookkeeping purposes only. The amounts credited to your Health Care Account are not assets that belong to you.

Because coverage under a health care FSA can adversely affect your eligibility to contribute to an HSA (see "Effect on HSA Eligibility" beginning on page 38), the Health Care FSA Program offers two kinds of Health Care FSAs: (1) a general-purpose Health Care FSA that is considered disqualifying medical coverage for purposes of HSA eligibility ("**General-Purpose Health Care Account**"); and (2) a limited-purpose Health Care FSA that is designed to preserve your HSA eligibility ("**Limited-Purpose Health Care Account**"). The difference is in the expenses that are reimbursable under each. (See the definition of Eligible Health Care Expenses in "Eligible Health Care Expenses" beginning on page 33.)

If you elect to participate in the Health Care FSA Program and you choose to participate in the HSA Contributions Program, you will be notified that you will be ineligible for the HSA Contributions Program unless you update your Health FSA Program election to a Limited-Purpose Health FSA or elect a non-HDHP option under the Medical Program.

If you do <u>not</u> elect to participate in the HSA Contributions Program and you elect to participate in the Health Care FSA Program, you will be enrolled in the General-Purpose Health Care FSA. As described in "Effect on HSA Eligibility" beginning on page 38, electing the General-Purpose Health Care FSA will make you and your Qualified Dependents ineligible to make HSA contributions for any month during which you are covered by the General-Purpose Health Care FSA. For example, even if your Spouse enrolls in HDHP medical coverage through his or her employer, your participation in the General-Purpose FSA under this Plan will disqualify your Spouse from contributing to an HSA.

Annual Contribution Amount

You may contribute up to $2,850 each Plan Year to your Health Care Account, plus up to an amount equal to 20% of the annual IRS maximum contribution as a Carry Over balance from a previous Plan Year. The amount of any Carry Over balance will not count toward the annual contribution limit. The annual contribution amount, at the Plan Administrator's sole discretion, may be adjusted annually for inflation as permitted by law. The annual contribution limit will be described in your Benefit Program election materials.

If the University, as a result of a reasonable mistake, erroneously allows you to elect a contribution amount above the annual limit, the University may be able to correct the mistake by reimbursing to you the excess contribution amount, when permitted by law. Any reimbursed amount will be treated as taxable income to you in the calendar year in which the correction is made.

The Plan Administrator, however, may reduce your contribution amount to the extent necessary to comply with certain nondiscrimination requirements under the Code.

Amount That Can Be Reimbursed To Participants

Immediately upon your participation in the Health Care FSA Program, the full annual amount you elected to contribute will be available to reimburse you for Eligible Health Care Expenses. For example, if you have chosen to have your wages reduced by an annual amount of $2,700 under the Health Care FSA Program, you may be reimbursed in full for a $2,700 Claim Incurred on your first day of participation in the Health Care FSA Program. Once determined by your Plan Administrator, the amount available to you will also include any Carry Over Amount from the prior Plan Year.

Eligible Health Care Expenses

The amount credited to your Health Care Account can only be used to pay for your or a Qualified Dependent's Eligible Health Care Expenses Incurred while you were covered under the Health Care FSA Program.

For the Health Care FSA Program, "**Qualified Dependent**" is:

- your legal spouse;
- any individual who is eligible for coverage as your child under a University health plan. Coverage will extend through the end of the calendar year of the child's 26th birthday; and
- any other individual whom you can claim as a dependent on your federal income tax return or who is a Code Section 105(b) dependent for health coverage purposes.

Note that this is a different definition than applies to other University health plans and may not cover an OEI or the child of an OEI. Contact your tax adviser or the **Benefits and Wellness Office** if you have questions.

General-Purpose Health Care Account

"**Eligible Health Care Expenses**" for purposes of a General-Purpose Health Care Account are expenses that qualify as medical care under Sections 213(d)(1)(A) and (B) of the Code and are for the benefit of you or a Qualified Dependent. These generally include expenses Incurred for diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for

transportation essential to obtaining these services. Eligible Health Care Expenses do not include payment for long-term care services or health insurance premiums.

For example, Eligible Health Care Expenses include amounts paid for:

- hospital expenses;
- medical, dental, or vision expenses;
- prescription drugs;
- insulin;
- Over-the-counter drugs and medications purchased for medical care, such as cold medication, antacids, allergy medicine and pain relievers;
- Menstrual care products as defined by the Internal Revenue Code Section 223(d)(2)(D) (e.g. tampons, pads, liners, cups, and sponges); and
- insurance deductibles and copayments that are not reimbursed by another insurance plan or reimbursement account.

Limited-Purpose Health Care Account
"Eligible Health Care Expenses" under the Limited-Purpose Health Care Account are dental and vision expenses that qualify as medical care under Sections 213(d)(1)(A) and (B) of the Code for the benefit of a Qualified Dependent.

Ineligible Health Care Expenses
There are certain "**Ineligible Health Care Expenses**" that do ***not*** qualify for reimbursement. These include:

- expenses incurred prior to the beginning or after the end of the current Plan Year;
- expenses paid on behalf of an individual who is not a Qualified Dependent;
- expenses that are payable under any other health insurance or group health plan (including one sponsored by the University) or that were paid under another employer's health care spending account. (At the Claims Administrator's request, you must provide additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments);
- Cosmetic surgery or similar procedures unless the surgery or procedure is necessary to ameliorate a deformity due to a congenital abnormality, an injury, or a disfiguring disease;

- Long-term care (e.g., nursing home) services and premiums for long-term care insurance;

- expenses for which you have received, or will receive, an itemized deduction on your federal tax return;

- premiums for health insurance (for example, premiums paid for your spouse's insurance);

- expenses in excess of the annual elected amount, plus any Carry Over amount;

- expenses Incurred during a time you were not covered by the Health Care FSA Program;

- expenses for which you have not provided satisfactory proof of payment;

- expenses claimed later than 90 calendar days after the end of the Plan Year or termination of employment; and

- expenses incurred under the Dependent Care FSA Program.

Additionally, for the Limited-Purpose Health Care Account, "Ineligible Health Care Expenses" also include expenses for medical care (other than dental or vision).

Amounts in your Health Care Account can only be used to pay for Eligible Health Care Expenses, and not for Eligible Dependent Care Expenses.

Any reimbursement paid for an Ineligible Expense under the Health Care FSA Program will be subject to income taxes as applicable.

Example Of How The Health Care FSA Program Saves On Taxes

You earn $30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Health Care Expenses will be $1,500. So, you choose to contribute $1,500 to your Health Care FSA. Your tax savings will be:

	Using Health Care FSA Program	**Not Using Health Care FSA Program**
Your Gross Pay	$30,000	$30,000
Your Pre Tax Health Care Expenses	1,500	N/A
Your Taxable Income	28,500	30,000
Your Income Taxes (for example, 25%)	7,125	7,500
Your Post-tax Health Care Expenses	0	1,500
Your Net Take Home Pay	$21,375	$21,000
Your Tax Savings	**$375**	N/A

Debit Card

You may use a debit card tied to your Health Care Flexible Spending Account to pay your copayment for prescription drugs and doctor's office visits and to pay for over-the-counter medications obtained with a doctor's prescription that qualify as a reimbursable expense under the plan. Your debit card will be accepted at merchants equipped with an inventory information approval system ("**IIAS**") that automatically identifies qualifying expenses. If your debit card is rejected by a merchant, you must pay for the expense out of your own funds and submit a claim for reimbursement.

If you pay for an expense with your debit card and the Plan Administrator determines that it is not an eligible expense or if you do not submit the proper proof of the expense when requested, your debit card will be deactivated and you will be asked to repay the amount to the Plan. If you do not do so promptly, CMU may deduct the amount from your paycheck and, if necessary, offset the reimbursement of future claims by the amount you still owe.

Even though, in most cases, you will not be required to submit further proof of your expense, you should retain for your personal records proof of all expenses paid by debit card in case of tax audit.

Before your debit card is issued, you will be asked to certify that you will not use the card to pay for expenses other than expenses eligible for reimbursement under the Health Care Account and that you will not seek reimbursement for the same expense under any other medical plan. Furthermore, this certification will be referenced on your debit card and you will be considered to have reaffirmed your certification each time you use your card.

Federal Itemized Deduction

You cannot receive both a federal tax deduction for medical expenses and reimbursement under the Health Care FSA Program for the same expense. Before enrolling in the Health Care FSA Program, you should determine whether reimbursement of Eligible Health Care Expenses under the Health Care FSA Program is more advantageous than the federal itemized deduction. For those employees whose Eligible Health Care Expenses never exceed 7.5% of adjusted gross income, reimbursement under the Health Care FSA Program will likely be more advantageous.

Expenses Eligible Under More Than One Health Care Spending Account Program

If a health care benefit is payable under two or more health care spending account programs, you may submit a Claim for the expense to either program, but this Health Care FSA Program will not pay an expense paid by another program. At the Claims Administrator's request, you are obligated to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments.

Forfeiture Of Amounts Remaining At The End Of The Plan Year

Except for amounts you are allowed to carry over to the next Plan Year, if you do not use the total amount in your Health Care Account for reimbursement of Eligible Health Care Expenses Incurred during a Plan Year, the amount remaining will be forfeited and cannot be returned to you because of Internal Revenue Code requirements.

You are permitted to carry over unspent funds up to an amount equal to 20% of the annual contribution limit for the Plan Year into the following Plan Year ("**Carry Over Amount**"), provided that the Carry Over Amount is at least $25. You must be a participant in the Health FSA Program on the last day of the Plan Year as an active Employee in order for your unspent funds to carry over into the following Plan Year.

If you qualify for the Carry Over Amount, any unspent amount in your account over the Carry Over Amount at the end of a Plan Year's run out period will be forfeited. If you do not qualify for the Carry Over Amount, then all unspent amounts will be forfeited at the end of the Plan Year.

Claims for expenses Incurred during the Plan Year must be submitted by September 30th, or, if earlier, within 90 calendar days following termination of employment. Any amount under $25 remaining in your Health Care Account as of the end of a Plan Year's run out period will be forfeited.

Forfeited amounts will be retained by the University and may be used to pay the administration expenses of the Health Care FSA Program.

Participation During An Unpaid Leave Of Absence
If you take an unpaid leave of absence (regardless of whether that leave qualifies under the FMLA), you have the following options under the Health Care FSA Program:

- Discontinue making contributions to your Health Care Account in which case you will not receive reimbursements for Claims Incurred during the period your Health Care FSA Program coverage is terminated. If you return from leave during the same Plan Year, you may either:

  - o resume coverage at the level in effect before your leave started and increase your salary reductions for the remaining portion of the Plan Year to make up the unpaid pre-tax contributions; or

  - o resume coverage at a reduced level (with the level of coverage pro-rated for the period during which no contributions were made) and keep your salary reductions at the same level in effect before your leave.

  In both cases, the coverage level is reduced by prior reimbursements.

- Continue your coverage under the Health Care FSA Program during your leave and make contributions on an after-tax basis (or on a pre-tax basis if your leave is paid leave or if you make arrangements with the **Benefits and Wellness Office** for a different payment method). The full annual amount you have elected to contribute to the Health Care FSA Program, less any prior reimbursements, will be available to reimburse you for Eligible Health Care Expenses Incurred during your leave. Upon your return from leave, your pre-tax Employee Contributions will resume at the same level as was in effect before your leave started.

You should contact the **Benefits and Wellness Office** before taking a leave of absence.

Qualified Reservist Distribution
If you are a military reservist ordered or called to active duty for a period of at least 180 calendar days (or for an indefinite time period), you may request a distribution from your Health Care FSA account of any unspent amounts that you have contributed for the year. If you qualify, you should submit a written request for a qualified reservist distribution to the **Benefits and Wellness Office** along with a copy of your military orders or call to duty before the last day of the plan year in which the order or call to active duty occurred. The distribution amount will be paid to you and included in your taxable income for the year.

Effect On HSA Eligibility
Coverage under a Limited-Purpose Health Care FSA will not affect your HSA eligibility or that of your Qualified Dependents. However, coverage under a General-Purpose Health Care Account is considered disqualifying medical coverage and will make you and your Qualified Dependents ineligible to make contributions to an HSA for each month during

which you are covered by the General-Purpose Health Care Account. If you have a General-Purpose Health Care Account with amounts remaining at the end of the Plan Year that are carried over to the next Plan Year, and you elect an HDHP option under the Medical Program for that next Plan Year, your Carry-Over Amount automatically will be carried over to your Limited-Purpose Health Care Account. However, if you do not elect an HDHP option under the Medical Program for that next Plan Year, your Carry-Over Amount will remain in your General-Purpose Health Care Account and you and your Qualified Dependents will be ineligible to make HSA contributions for the entire next Plan Year.

CLAIMS FILING AND REVIEW PROCEDURES

All claims under the Plan must be submitted to the appropriate Insurer or Claims Administrator listed on **Schedule A-2** using a claim form or other method required by the Insurer or Claims Administrator. The **Benefits and Wellness Office** can provide you with information on how to file a claim for benefits. Claims procedures and provisions for the review of denied claims for each Benefit Program are described in the Booklets and other benefit information prepared by the providers listed on **Schedule A-2**.

If a claim is denied, you may appeal to the Claims Administrator or Insurer for a review of the denied claim. The appeal will be decided in accordance with the Insurer's or Claims Administrator's claims and appeal procedures. You should consult the Booklets referenced above or contact the **Benefits and Wellness Office** for information on claims procedures under the applicable Benefit Program.

No legal action may be brought against the Plan before the claimant has exhausted all administrative remedies available under the Plan. Any legal action must be commenced within one year after the date you receive a notice of denial on appeal (or within such other time period required by the Insurer for any Insured Benefit Programs).

SPECIAL RULES FOR THE HEALTH CARE PROGRAMS: MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION AND HEALTH CARE FSA

Coordination Of Benefits

The Insured Benefit Programs will be coordinated in accordance with the applicable provision of the policies and Booklets provided by the insurer(s) or HMO(s).

With respect to Self-funded benefits, the Plan will coordinate with another group health plan (including any other employer-sponsored health plan that provides medical, prescription drug or dental coverage, such as insurance provided by a spouse's employer.

When the Plan coordinates benefits, one source of benefits will be "**Primary**" (that is, it will pay before the other source). The other source will be "**Secondary**" (that is, it will pay after the source of benefits that is Primary).

When this Plan is Primary, it will pay benefits as if there were no other source of benefits. But if the Plan is Secondary, it will first calculate what it would pay in the absence of any other source of benefits. Then the Plan will subtract from that amount the amount that should be paid by the other source. The Plan will pay that difference, so that the Participant will receive the full amount of benefits payable under the Plan. (The amount payable by the other source will be subtracted even if you do not apply for benefits from that other source.) This Plan will not, however, pay more than it would have paid if it were the only source of benefits.

Coordination With Other Group Health Plans

If you and/or your Covered Dependent incur an expense that would be paid by two or more group health plans, the group health plan with the highest priority is Primary and will pay first. The other group health plan is Secondary and will pay next.

Benefits will be paid as follows:

First: A group health plan without a coordination of benefits provision will pay.

Second: Then a group health plan covering the individual as an employee, rather than as a dependent, will pay.

Third: Then in the case of a group health plan covering a dependent minor Child of divorced or legally separated parents:

- if a divorce decree or separation agreement makes a parent responsible for a Child's health expenses, that parent's plan (that also covers the Child) will pay;
- then a plan that covers the Child as a dependent of a custodial parent will pay;
- then a plan that covers the Child as a dependent of the spouse of the custodial parent will pay;
- then a plan that covers the Child as a dependent of the non-custodial parent will pay.

Fourth: Then in the case of a group health plan covering a patient who is a dependent and minor child of married parents, the group health plan of the parent whose birthday occurs earlier in the year will pay.

Fifth: Then the group health plan that has covered the patient for the longer period of time will pay.

Sixth: Then any other group health plan will pay.

If two or more group health plans have the same priority, they will each pay pro-rata. There are some special rules that have precedence over the above priorities.

- COBRA coverage is always Secondary to any other group health plan,

- Coverage provided by virtue of being a retired or laid-off employee or an employee on a leave of absence is always secondary to coverage provided by virtue of that individual being an active employee.

Coordination With Medicare

The Plan will be Secondary to Medicare in all circumstances where federal law does not require the Plan to be Primary. If you are an active University employee covered under the Medical Program and you or your Spouse are age 65 or over and eligible for Medicare, coverage under this Plan will be Primary. If you are enrolled in Medicare, Medicare will be Secondary to this Plan unless you reject coverage under this Plan and rely on Medicare as your sole source of coverage in which case Medicare will be Primary and you will have no coverage under this Plan. Note that this Plan will be secondary to Medicare for an Other Eligible Individual who is eligible for Medicare. The Other Eligible Individual should enroll in Medicare when first eligible. The Other Eligible Individual may be subject to premium penalties under Medicare if he or she delays enrolling in Medicare because the or she is covered under this Plan.

Medicare is also available for certain people who have not yet reached the age of 65, but who have received Social Security disability benefits for at least 24 months. When Medicare is available in those situations, the Plan will be Primary for you and your Covered Dependents as long as you are in current employment status; otherwise the Plan will be Secondary.

Medicare is also available to individuals who have been under treatment for end-stage renal disease. The Plan will be Primary to Medicare for a covered individual who qualifies for Medicare benefits because of end-stage renal disease for the coordination period set forth in the Medicare secondary payer provisions of the Social Security Act. After the coordination period ends, the Plan will be Secondary.

If you are covered under the Medical Program as a retiree and you and/or your Spouse are age 65 or over, Medicare will be the Primary payor, whether or not you and/or your spouse have actually enrolled in Medicare. It is your responsibility to apply for Medicare benefits that are available. If you are covered as a retiree and are eligible for Medicare, the Plan will calculate the benefits it provides as if you were enrolled in Medicare Parts A

and B, regardless of whether or not you have enrolled. Therefore, you should be sure to enroll in at Medicare on a timely basis when you retire.

Third-Party Reimbursement; Subrogation

If you or your covered dependents incur medical expenses for which another party may be responsible, the Plan has a right to recover benefits paid by the Plan for such expenses. The Plan has an equitable right to seek reimbursement from any payments that you or your covered dependents receive from such party, or the Plan may "step into the shoes" of yourself or your covered dependent (or your successors in interest) to bring legal action against any third party that may be responsible for paying these costs. This right exists until the Plan has been reimbursed in full for the benefits it has paid and for the expenses and attorney fees the Plan has incurred in enforcing its rights.

For those benefits provided through an Insured Benefit Program, more information about these subrogation and reimbursement rights is explained in the various insurance policies and Booklets provided by the insurance companies and HMOs.

When you and your covered dependents accept benefits under the Self-funded Benefit Programs that are part of this Plan, you assign to the Plan, or transfer to the Plan, all rights of recovery from any other party, to the fullest extent permitted by law. The Plan will be subrogated to and may bring any claim you or your dependents may have against the other party (or its insurer). You may not assign your claims to any other person without permission of the Plan. The Plan will have a first priority lien on any recovery for the total amount it has paid, as well as for any expenses or attorneys' fees incurred in enforcing the Plan's rights. The Plan may withhold payment of benefits when it appears that another party may be liable for the expenses until the liability is legally determined.

If you or your Covered Dependents receive any funds from any person who may have a responsibility to pay expenses covered by the Plan, the Plan has the right to be reimbursed from your total recovery before any amounts, including expenses or attorneys' fees, are deducted, whether or not the recovery is specifically for medical payments, and regardless of how the proceeds are characterized or the source of the recovery. This is a right of first reimbursement, and the "make whole" rule or "common fund" rule will not apply.

Without limiting the Plan's right to reimbursement or subrogation, these rights apply to any judgment, settlement or payment made or to be made because of an accident or malpractice, including but not limited to payments made by other insurance of any kind. The Plan will not pay, offset any recovery, or in any way be responsible for any attorneys' fees or other fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

You and your Covered Dependents must cooperate fully with the Plan administrator to protect the Plan's right of reduction, recovery, reimbursement or subrogation and must

sign any reimbursement or subrogation agreement or other document that may be requested by the Plan Administrator, although the Plan may exercise its rights under this section whether or not any such agreement is requested or signed by you. You and your Covered Dependents are responsible for notifying the Plan in writing of any claim you may have against another party who may be responsible for benefits paid under this Plan.

If you, your agent, a trust, or any other person or entity receives any proceeds of settlement or judgment on behalf of you or your covered dependent, and if the Plan has a right to any portion of those proceeds, you, your agent, or the third party must hold those proceeds in trust for the Plan. The Plan may recover any expenses it incurs because you or your covered dependents failed to cooperate in enforcing the Plan's rights under this section. If you or your Covered Dependents do not comply with this section, your right to benefits under the Plan may be forfeited.

COBRA Continuation Coverage

You and your Covered Dependents have the right to continue coverage under the Medical, Prescription, Dental, Vision and Health FSA Programs beyond the time the coverage would normally end ("**COBRA Continuation Coverage**") under certain circumstances. This right is referred to under this Plan as COBRA Continuation Coverage which can become available to you and your Covered Dependents when you or they would otherwise lose coverage. This section generally explains COBRA Continuation Coverage, when it may become available to you and your Covered Dependents, and what you need to protect your right to receive it.

You may have other, more affordable options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. When deciding whether to elect COBRA Continuation Coverage, you should investigate these other options.

COBRA Continuation Coverage for the Plan is self-administered by the University's **Benefits and Wellness Office,** whose contact information can be found in the section of this Plan titled "*Other Important Provisions*."

Qualifying Events

COBRA Continuation Coverage is a continuation of coverage under the Medical, Prescription, Dental, Vision and Health FSA Programs when coverage would otherwise end on account of a "**Qualifying Event**." After a Qualifying Event, COBRA Continuation Coverage will be offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone who loses coverage under the Plan because of a Qualifying Event.

Employee Qualifying Event

You will become a Qualified Beneficiary if you will lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of work are reduced or you move to a position with the University where you are not eligible to participate in the Plan.

- Your employment ends for any reason other than your gross misconduct.

Spouse Qualifying Event

Your Spouse will become a Qualified Beneficiary if coverage is lost because any one or more of the following Qualifying Events happens:

- You die.

- You become divorced or legally separated from your spouse.

- Your hours of work are reduced or you move to a position with the University where you are not eligible to participate in the Plan.

- Your employment ends for any reason other than your gross misconduct.

- You become entitled to Medicare benefits.

Dependent Child Qualifying Event

Your Covered Dependent Child will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

- You die.

- You are divorced or legally separated from your spouse.

- Your hours of work are reduced or you move to a position with the University where you are not eligible to participate in the Plan.

- Your employment ends for any reason other than your gross misconduct.

- You become entitled to Medicare benefits.

- Your Child stops being eligible for coverage under the Plan as a dependent Child.

Retiree Qualifying Event

A bankruptcy filing with respect to the University under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed, and the bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary. The retired employee's Covered Dependents will also become Qualified Beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

Notice Of Qualifying Event Required

When the Qualifying Event is the reduction of your hours or end of your employment, your death, commencement of a proceeding in bankruptcy with respect to the University or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the University must notify the Plan Administrator of the Qualifying Event.

For the other Qualifying Events (your divorce or legal separation, or your Child's losing eligibility for coverage as a dependent Child), you must notify the Plan Administrator within 60 calendar days after the Qualifying Event occurs. You must provide written notice of the Qualifying Event to the Plan Administrator. Your notice must include: the name of the employee or former employee who is or was a Plan Participant, a description of the Qualifying Event, the date of the Qualifying Event, any documents or materials relevant to the Qualifying Event, and the name(s), address(es), and Social Security number(s) of the Covered Dependent(s) affected by the Qualifying Event. Failure to notify the Plan Administrator in a timely manner will mean that neither you nor your Covered Dependents will be able to elect COBRA Continuation Coverage for these Qualifying Events.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each Qualified Beneficiary. To elect Continuation Coverage, you must complete the election form and submit it according to the directions and the deadline set forth on the form. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, your Spouse may elect coverage even if you do not. COBRA Continuation Coverage may be elected for only one, several, or all dependent Children who are Qualified Beneficiaries. A parent may elect or reject Continuation Coverage for any minor Children. You and your Spouse may elect Continuation Coverage for each other, but cannot reject coverage for the other person. After you have submitted your election forms, if it is determined that you or a Covered Dependent is not entitled to COBRA Continuation Coverage, you will be provided with a written explanation of why the election of Continuation Coverage could not be honored.

In considering whether to elect COBRA Continuation Coverage, you should take into account other options available to you. You have the right to request special enrollment

in another group health plan for which you are otherwise eligible, such as a plan sponsored by your Spouse's employer, within 30 calendar days after your coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you elect COBRA Continuation Coverage for the maximum time available to you.

Cost Of COBRA Continuation Coverage

Generally, each Qualified Beneficiary must pay the entire cost of COBRA Continuation Coverage. The cost cannot exceed 102% (or in the case of an extension due to a disability, 150%) of the cost to the Plan for coverage of a similarly-situated Plan Participant and/or beneficiary who is not receiving COBRA Continuation Coverage. The cost for a similarly-situated Plan Participant or beneficiary includes both the employer and employee contributions for coverage. The required payment for each COBRA Continuation period for each option will be described in the notice sent to you.

Paying For COBRA Continuation Coverage

First Payment For COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with the election form. You must, however, make your first payment no later than 45 calendar days after the date of your election. (This is the date the election notice is post-marked, if mailed.) Your coverage will be reinstated retroactive to the date it ended when the first payment is received. If you miss this first payment date, you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the **Benefits and Wellness Office** to confirm the correct amount of your payment.

Periodic Payments For COBRA Continuation Coverage

After your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Each monthly payment for COBRA Continuation Coverage is due on the date stated in the COBRA election forms sent to you. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace Periods For Monthly Payments

Although monthly payments are due on the dates stated in the COBRA election forms, you will be given a grace period of 30 calendar days after the first day of each coverage period to make each monthly payment. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made

before the end of the grace period for that payment. If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan retroactive to the date payment was due. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and you will be asked to pay the shortfall. If you do not pay within 30 calendar days after the date the notice is received, COBRA Continuation Coverage will end retroactive to the date the shortfall payment was due.

Duration Of COBRA Coverage

COBRA Continuation Coverage for you and/or your Covered Dependents may continue for:

- 18 months when the Qualifying Event is the end of your employment or reduction in your hours of employment;

- 29 months when the Qualifying Event is your end of employment or reduction of your work hours and you or a Covered Dependent qualify for a disability extension (refer to "Disability" below) during the 18-month COBRA Continuation Coverage period;

- 36 months for your Covered Dependents when the Qualifying Event is your divorce or legal separation, your death, your enrollment in Medicare (Part A or Part B) or a Child's loss of Eligible Dependent status; or

- For your Covered Dependents, 36 months after the date you enrolled in Medicare when the Qualifying Event is termination of employment or reduction in your work hours, and you enrolled in Medicare fewer than 18 months before the Qualifying Event. For example, if you enrolled in Medicare eight (8) months before you terminated employment, Continuation Coverage for your Covered Dependents could last up to 36 months from the date you enrolled in Medicare, which is 28 months after the date of the Qualifying Event.

- See "Special Rule For Health Care FSA Programs" below for the duration of COBRA continuation of Health FSA coverage.

Termination Of COBRA Coverage

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- any required premium payment was due but not timely paid (within the grace period);

- after electing COBRA Continuation Coverage, a Qualified Beneficiary:

- o becomes covered under another employer's group health plan; or
- o becomes enrolled in Medicare benefits; or

- the University ceases to provide any group health plan for its employees.

COBRA Continuation Coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Continuation Coverage, such as fraud or misrepresentation of a material fact regarding your eligibility or claim for benefits. If your period of COBRA Continuation Coverage is terminated for any reason before the end of your maximum period, you will be notified of the termination and provided with an explanation of why it was terminated.

At the end of the 18-month, 29-month or 36-month COBRA Continuation Coverage period, you must be allowed to enroll for individual conversion coverage, but only if this opportunity is provided under the specific Benefit Program for which you elected COBRA Continuation Coverage.

Extending The Length Of COBRA Continuation Coverage

There are two ways in which a COBRA Continuation Coverage period of less than 36 months may be extended: (i) if a Qualified Beneficiary is disabled or (ii) a second Qualifying Event occurs. You must notify the Plan Administrator in writing of a disability or second Qualifying Event in order to extend the period of COBRA Continuation Coverage. Your failure to provide notice of a disability or second Qualifying Event may affect the right to extend the period of COBRA Continuation Coverage.

Disability

If you or any Covered Dependent is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of COBRA Continuation Coverage.

You or a Covered Dependent must notify the Plan Administrator in writing on or before the 60th day after the latest of: (a) the date of the Social Security Administration's disability determination, (b) the date on which the employment-related Qualifying Event occurred, or (c) the date on which the Qualified Beneficiary lost Plan coverage as a result of the Qualifying Event. This disability notice must include the name of the disabled person, the effective date of the Social Security Administration's disability determination, and a copy of the Social Security disability determination.

Each Qualified Beneficiary who has elected COBRA Continuation Coverage on account of your employment-related Qualifying Event (not just the disabled individual) will be

entitled to the 11-month disability extension as long as one of them qualifies for it. If the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact in writing on or before the 30th day following the Social Security Administration's determination. Coverage due to your initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for that COBRA Continuation Coverage has not expired as of the date a determination of "no longer disabled" is made.

Second Qualifying Event

If your Covered Dependents experience a 36-month Qualifying Event while receiving 18 months of COBRA Continuation Coverage, your Covered Dependents can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the COBRA Administrator. This extension may be available to your Covered Dependents receiving COBRA Continuation Coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), become divorced or legally separated from your spouse, or your dependent Child stops being eligible under the Plan as a dependent Child, but only if the event would have caused your Covered Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

You must notify the Plan Administrator within 60 calendar days after a second Qualifying Event occurs if you want to extend COBRA Continuation Coverage. Your notice must include: the name of the employee or former employee who is or was a Plan Participant; a description of the second Qualifying Event; and the name(s), address(es), and Social Security number(s) of the Covered Dependents involved in the second Qualifying Event. Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.

Special Rule For Health Care FSA Program

The COBRA Continuation Coverage available for the Health Care FSA Program is different from the COBRA Continuation Coverage for the other health Programs offered by the University (medical, prescription drug, dental, and vision).

First, COBRA Continuation Coverage for the Health Care FSA Program is only available until the end of the Plan Year in which the Qualifying Event occurs and may not be extended beyond that date.

Second, if you elect to receive COBRA Continuation Coverage under the Health Care FSA Program, you must pay the applicable COBRA premium which includes a 2% administration charge. If you will not be receiving any compensation that can be reduced under the Health Care FSA Program, you will be paying up to 102% premium on an after-

tax basis for only 100% coverage. Thus, even though COBRA Continuation Coverage is available, you must decide if it is a justifiable option for you based on its cost to you.

Third, the Plan does not have to offer you COBRA Continuation Coverage for the Health Care FSA Program if, at the time of the Qualifying Event, the contribution you must pay for this coverage exceeds the maximum coverage remaining available to you for the Plan Year under the Health Care FSA Program. For example, if you terminate employment in March after electing to contribute $1,800 to the Health Care FSA Program and you have already submitted Claims totaling $1,000, then your remaining coverage would be $800, but your cost to keep this coverage would be $1,377 ($1,800 x 102% = $1,836/12= $153/month x the 9 months remaining in the Plan Year). In this case, you would not be entitled to COBRA Continuation Coverage under the Health Care FSA Program.

Questions About COBRA Continuation Coverage

If you have questions concerning the Plan or your COBRA Continuation Coverage rights, you should contact the **Benefits and Wellness Office**.

Keep The Plan Informed Of Any Changes Of Address

In order to protect your family's rights to COBRA Continuation Coverage, you should keep the Plan Administrator informed of any changes in the addresses of family members.

Military Leave Continuation Coverage

If you are called to active duty in the United States Armed Forces, the Coast Guard, the National Guard or the Public Health Service, you will be offered, under the Uniformed Services Employment and Reemployment Act of 1994, as amended ("**USERRA**"), up to 24 months of continuation health care coverage. The maximum period for continuation coverage under USERRA is the lesser of (a) 24 months from the date your leave commences or (b) the period from the date your leave begins to the day after you fail to return to employment within the time allowed following discharge.

To be eligible for this continued coverage, you (or an appropriate officer of the uniformed service branch in which you will serve) must notify the Plan Administrator when you know that you will leave work for military service. In most cases, you must provide notice to the Plan Administrator at least 30 calendar days before you leave for military service. However, you are excused from providing prior notice of your upcoming military leave if military necessity prevents you from providing notice, or if it is otherwise impossible or unreasonable under the circumstances for you to do so.

If you decide to continue your coverage under the Plan, you must elect continued coverage within 60 calendar days from your last day of work before you left due to military service. Your election notice must be given in writing to the Plan Administrator.

Your employee contribution will be the full cost (includes both the employer and employee contributions for coverage), except that if you are absent for less than 31 days, the

employee contribution will be the same as for similarly situated active employees. Your continuation coverage will terminate if the monthly premium is not timely paid. This means that your first payment for the continuation coverage you elected under USERRA must be made within 45 calendar days from the date you elected to continue coverage. You must also make payments for any premiums due because you elected coverage retroactively within 45 calendar days from your election. After the initial (or retroactive) premiums, you must make monthly premium payments within 30 calendar days of the due date.

Whether or not you elect to continue coverage during your period of service, you may reinstate coverage under this Plan when you return to work from military service as required under the USERRA. Coverage will be reinstated without regard to any pre-existing condition exclusion or waiting period except as would have been applied if coverage had not terminated because of military service. This waiver of exclusions and waiting periods will not apply to any illness or injury that the Plan Administrator determines was incurred in, or aggravated during, the performance of military service.

HIPAA Privacy Rule

All definitions in the Health Insurance Portability and Accountability Act ("**HIPAA**") privacy regulations ("**Privacy Rules**") and security regulations ("**Security Rules**") are incorporated by reference into the Plan. If a term is not defined in the Privacy Rules or Security Rules, the term will have its generally accepted meaning.

Hybrid Entity

To the extent the Plan provides any non-health benefits (e.g., dependent care, disability, life insurance), only the health care components of the Plan are subject to these provisions.

Protected Health Information

The University will have access to protected health information ("**PHI**") only as permitted under this Plan or as otherwise required or permitted by the Privacy Rules. PHI means information that is created or received by the Plan and relates to:

- past, present, and future physical or mental health or condition of an individual;
- provision of health care to an individual; or
- past, present, or future payment for the provision of health care to an individual; and
- that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

Uses and Disclosures of PHI by the Plan

The Plan may disclose PHI to the University only if the Privacy Rules specifically permit the use or disclosure, or if the individual authorizes the Plan to use or disclose PHI to the University.

Plan Administrative Functions

Once the University receives PHI from the Plan, it may use or disclose PHI only for Plan Administration Functions. "**Plan Administration Functions**" are administrative tasks performed by the University on behalf of the Plan and exclude employment-related functions and functions performed by the University in connection with any other benefit or benefit plan of the University. Plan Administration Functions include, but are not limited to:

- Enrollment and disenrollment activities;
- Verification of participation in the Plan;
- Obtaining premium contributions;
- Determining eligibility for benefits;
- Activities to coordinate benefits with other plans and coverages;
- Final adjudication of appeals of claim denials;
- Exercise of the Plan's rights of reimbursement and subrogation;
- Assisting participants in eligibility, benefit claims matters, inquiries, and appeals;
- Obtaining premium bids;
- Evaluation of health plan design;
- Activities relating to placement, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss and excess loss insurance);
- Legal services and auditing functions (including fraud and abuse detection);
- Business planning, management and general administration;
- Making claims under stop-loss or excess loss insurance;
- Activities in connection with the transfer, merger or consolidation of the Plan, including due diligence.

Privacy Obligations of the University

With respect to PHI created by or received from the Plan, the University will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the University with respect to such PHI;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University unless authorized by the individual;

- Report to the Plan any use or disclosure of PHI that is inconsistent with the Privacy Rules of which the University becomes aware;

- Make PHI available to an individual in accordance with the access requirements of the Privacy Rules;

- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rules;

- Make available the information required to provide an accounting of disclosures;

- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services Secretary for purposes of determining compliance with the Privacy Rules;

- If feasible, return or destroy all PHI received from the Plan and retain no copies of that PHI when no longer needed by the University for the purpose for which disclosure was made, (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible); and

- Ensure that adequate separation between the Plan and the University is maintained as required by the Privacy Rules. For purposes of maintaining adequate separation between the Plan and the University, only the employees or classes of employees identified in the University's privacy policies and procedures ("**Authorized Employees**") will be given access to PHI. The section of the University's privacy policies and procedures that lists these employees is incorporated by reference into this Plan. The access to and use of PHI by Authorized Employees is restricted to the Plan Administration Functions that the University performs for the Plan. If an Authorized Employee uses or discloses PHI

in ways other than those permitted by the Plan or the Privacy Rules, the Authorized Employee will be subject to the disciplinary procedures described in the University's employee handbook. The University may impose, at its discretion, reasonable sanctions as necessary to ensure that no further non-compliance with the Plan or the Privacy Rules occurs.

Electronic Data Security Obligations of the University

To the extent the University maintains electronic PHI, the University will:

- Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the University on behalf of the Plan as required by the HIPAA Security Rules;

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the University creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the required separation between the Plan and the University is supported by reasonable and appropriate security measures;

- Ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and

- Report to the Plan any security incident involving PHI of which it becomes aware.

Qualified Medical Child Support Orders

The Plan Administrator will honor a National Medical Support Notice or an order that is a "**Qualified Medical Child Support Order**" within the meaning of ERISA Section 609(a)(2)(A) ("**QMCSO**"). The Plan Administrator, or its delegate, has full discretionary authority to determine whether a medical child support order is "qualified" and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency. Upon receipt of a Medical Child Support Order or a National Medical Support Notice issued under applicable state or federal law, the Plan Administrator will take the following steps:

- Reply to the issuing court or agency if the individual is no longer employed, falls into a class of employees who are ineligible for coverage or if the dependent is already covered.

- Determine if the Order or Notice contains sufficient information for the Plan Administration to be able to respond.

- Notify the issuing court or agency if the Order or Notice is determined not to contain sufficient information.

- Notify the issuing court or agency of the coverage options available under the Plan and any waiting period that exists for coverage under the Plan, if applicable.

- Determine if federal withholding limits or prioritization rules permit the withholding from the Participant's income of the amount required to obtain coverage for the child(ren) specified.

- Notify the Participant of any contributions to be withheld from future pay.

- If appropriate, withhold from the Participant's income any required contributions.

- Notify the Claim and/or COBRA Administrators, if applicable, about enrollment of the child(ren).

- Notify the issuing court or agency of the date of enrollment and the date coverage under the Plan will begin.

The Participant and each affected child have the right to request in writing, within 60 calendar days after being notified of the Plan Administrator's decision, that the Plan Administrator again review the status of the Order or Notice. The Participant and each affected child may present additional materials to the Plan Administrator for review. The Plan Administrator may request additional information or material from the Participant and/or affected child(ren).

Medicaid Eligibility And Assignment Of Rights

The Plan will not take into account that an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("**State Medicaid Plan**") either in enrolling that individual as a Participant or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits in accordance with any assignment of rights made by or on behalf of that individual as required under a State Medicaid Plan pursuant to Section 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to the individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law that provides that the State has acquired the rights with respect to the individual to payment for those items and services under this Plan.

Maternity And Childbirth Benefits

Pursuant to federal law, the Plan, or any insurance issuer providing coverage for maternity benefits under the Plan, will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following

a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's treating physician, after consultation with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as the case may be). The Plan will not require a medical provider to obtain authorization from the Plan (or the insurance issuer) for prescribing a length of stay not in excess of the above periods. Nothing in this provision, however, requires that a woman covered under this Plan give birth in a hospital or stay in the hospital a fixed period of time following the birth of her Child.

Women's Health And Cancer Rights Act Post-Mastectomy Benefits

To the extent the Plan (or any insurance issuer) provides benefits for mastectomies, it will also provide coverage for reconstructive surgery of either or both breasts following the mastectomy (including for the purpose of attaining a symmetrical appearance) and for the treatment of physical complications at all stages of the mastectomy and the recovery period, including lymphedemas.

PLAN ADMINISTRATION

Plan Administrator

The University is the Plan Administrator and has sole responsibility for the administration of the Plan. The Plan Administrator has full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of Participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by the Internal Revenue Code of 1986, as amended (the "**Code**") with respect to the Plan; employ or appoint persons to help or advise in any administrative functions; to appoint investment managers and trustees; and generally do anything needed to operate, manage and administer the Plan. The discretionary authority of the Plan Administrator extends to its factual determinations, as well as its construction of Plan terms and its determination of benefit entitlements. The Plan Administrator has the necessary discretionary authority and control over the Plan to require deferential judicial review pursuant to the U.S. Supreme Court decision in Firestone Tire and Rubber Co. v. Bruch (1980).

The Plan has other fiduciaries, advisors, and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. A person or persons to whom an allocation or delegation is made has the same amount of discretion as the Plan Administrator for matters covered by the allocation or delegation. The Claims Administrators are the fiduciaries with respect to Claims processing and benefit determinations. The insurer is the fiduciary for Claims processing for any Insured Benefit Program. Refer to the Benefit Program Information Chart for additional information relating to the Claims Administrators. The Plan Administrator retains all fiduciary obligations with respect to the Pre-Tax Payment,

Dependent Care FSA and Health Care FSA Programs, except to the extent delegated in writing.

Each fiduciary is solely responsible for its own improper acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary.

Indemnification

The University will indemnify each employee to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the employee. The University may choose, at its own expense, to purchase and keep in effect sufficient liability insurance to cover any claim, loss, damage, expense, or liability arising from any employee's action or failure to act.

Payment Obligations And Role Of Claims Administrator

For those health care Benefit Programs that are Self-funded, if you are covered by the Plan and either the Plan or the University does not ultimately pay the medical expenses that are eligible for payment under the Plan for any reason, you and your Covered Dependents may be responsible for those expenses.

The Claims Administrators under the Self-funded Benefit Programs merely process claims and do not ensure that any of your medical expenses will be paid. Complete and proper claims for benefits made by you will be promptly processed; but if there are delays in processing claims, you will have no greater rights against the Claims Administrators than are otherwise afforded you by law.

Amendment Or Termination Of The Plan

The University, acting through its President or other individual authorized by the Board of Trustees may amend, modify, or terminate the Plan at any time in any manner or with respect to any individual in its sole discretion. Any amendment may be made retroactively effective to the extent not prohibited by applicable law. If the Plan is terminated or partially terminated for any reason, the benefits to which you became entitled prior to the effective date for the Plan's termination will be covered. Termination of the Plan will not reduce or eliminate your right to reduce your compensation earned before the date of termination.

For Insured Benefit Programs, the University may request that the insurance company amend or modify its policy, and if the insurance company agrees, it will provide a copy of such an amendment to the University for its review and approval. Approval of the proposed amendment by the University according to procedures set forth by the insurance company will serve to amend the policy. An amendment of the insurance policy

may change the benefits available under the applicable Benefit Program. The University may also amend or modify an Insured Benefit Program by changing policies or insurance companies.

Nondiscrimination Rules

If the University determines at any time that the Plan may not satisfy any applicable nondiscrimination rule in the Code, the University may take whatever action it deems appropriate to assure compliance with the rule. Any action will be taken uniformly with respect to similarly-situated Participants. The action may include, without limitation, the modification of enrollment choices for a highly compensated employees, with or without consent. If your Plan benefits are affected, you will be notified of the action to be taken.

Compliance With Tax Law

The Plan is intended to comply with all applicable laws, including Section 125 of the Code. It will be considered amended to the extent necessary to comply. However, neither the Plan, the Plan Sponsor, the Plan Administrator, nor any Plan fiduciary represents or guarantees that this Plan in fact meets the requirements of any provision of the Code. Any other provision of this Plan notwithstanding, individuals who are not treated as employees for purposes of the tax treatment of any contribution to any Benefit Program are not eligible to participate in the Plan. The Plan cannot be operated so as to defer the receipt of compensation in a manner that violates Section 125.

Limitation Of Rights

The Plan does not constitute a contract of employment between you and the University. Nothing contained in the Plan gives you the right to be retained in the service of the University or to interfere with the right of the University to discharge you at any time regardless of the effect that the discharge will have upon you as a Participant in the Plan.

Overpayments

An "**Overpayment**" occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense or benefit more than once, or if an expense or benefit is paid by both the Plan and a third party. An expense or benefit is considered paid if it is paid to you or to someone else (for example, a health care provider) on your or your Covered Dependent's behalf.

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a health care provider, the Plan may request a refund of the overpayment from either you or the provider. If the refund is not received from either you or the provider, the Overpayment will be deducted from future Plan benefits available to you or your Covered Dependents or from your wages, but the amounts withheld may not reduce your pay below the applicable state minimum wage law to the extent permitted by law. Any Overpayment you owe due to your or your Covered Dependent's ineligibility for Plan benefits will be offset by the amount of any Employee Contributions you paid for coverage for the person while ineligible.

Insurance Rebates
If the University or Plan receives an insurance rebate or other distribution from an insurance company in connection with the medical loss ratio standards as set forth in Section 2718 of the Public Health Service Act, the portion of such rebate or distribution attributable to participant contributions shall be utilized, at the sole discretion of the Plan Administrator, for any permissible plan purpose. Such purposes shall include, but not be limited to, the payment of future participant premium payments, benefit enhancements, or any other use permitted by law.

Forfeitures
Failure to claim any amount or cash any check that becomes payable to you or is paid on your behalf under this Plan within two years after such amount first becomes payable, will result in such amount being forfeited. Such amounts shall cease to be a liability of the Plan, provided due and proper care has been exercised by the Plan Administrator in attempting to make such payment.

Entire Description
This document, along with any summary, schedule of benefits, or Booklets describing any Benefit Program, are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral).

Acceptance And Cooperation
If you accept benefits under this Plan, you are considered to have accepted its terms, and agree to perform any act and to execute any documents that may be necessary or desirable to carry out this Plan or any of its provisions.

Governing Law
The Plan is to be construed and enforced in accordance with the laws of the State of Michigan, to the extent not preempted by federal law.

Construction
Words used in the masculine apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural should be read as the singular, and the singular as the plural.

Non-Assignability Of Rights
No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest will be void.

Errors
An error cannot give a benefit to you if you are not actually entitled to the benefit.

Severability
The enforceability of any provision of the Plan will not affect the enforceability of the remaining provisions of the Plan.

OTHER IMPORTANT PROVISIONS

Plan Name
CMU CHOICES: THE CENTRAL MICHIGAN UNIVERSITY FLEXIBLE BENEFITS PLAN

Employer Identification Number
38-6004447

Plan Year
July 1 - June 30

Plan Sponsor And Plan Administrator
Central Michigan University
108 Rowe Hall
Mt. Pleasant, Michigan 48859
989-774-3661
Attention: **Benefits and Wellness Office**

COBRA Administrator
Benefits and Wellness Office
Central Michigan University
989-774-3661
email: benefits@cmich.edu

HIPAA Privacy
Privacy Representative
Benefits and Wellness Office
Central Michigan University
989-774-3661
e-mail: benefits@cmich.edu

See https://www.cmich.edu/offices-departments/general-counsel/Office-of-HIPAA-Compliancefor additional details regarding the University's HIPAA privacy resources.

Type Of Plan
The Plan is a wrap-around welfare benefit plan and includes a cafeteria plan intended to satisfy the requirements of Section 125 of the Code.

EXECUTION

IN WITNESS WHEREOF, CENTRAL MICHIGAN UNIVERSITY has caused this amendment and restatement of the CENTRAL MICHIGAN UNIVERSITY FLEXIBLE BENEFITS PLAN to be executed by its duly authorized officer this _____ day _____, _____, to be effective July 1, 2024.

CENTRAL MICHIGAN UNIVERSITY

By: _____

Its: _____

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE A-1

BENEFIT ELIGIBLE EMPLOYEES AND AVAILABLE BENEFIT PROGRAMS

Employee Group	Effective Date	Benefit Programs
Staff including: • Professional & Administrative • Senior Officer • Police Officers • Police Sergeants & Lieutenants • Public Broadcasting • Supervisory Technical • Office Professional • Service Maintenance • Dispatchers	 07/01/1994 07/01/1994 10/01/1994 03/08/2012 01/01/1995 09/01/1995 04/01/1996 07/01/1999 02/24/2020	All Benefit Programs
Fixed-Term Faculty	10/01/1994	All Benefit Programs except STD Program
Regular Faculty	10/01/1997	All Benefit Programs except: • Wellness Program • Diabetes • Pre-Diabetes • Weight Management Program • Chronic Care Solutions Program
Medical Faculty	07/01/2012	All Benefit Programs
Postdoctoral Research Fellows	07/01/2014	All Benefit Programs except: • Vision Program • STD Program • LTD Program

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE A-2

BENEFIT PROGRAM INFORMATION CHART

Benefit Program	Funding Type	Insurance Company or Claims Administrator Contact Information
Medical Program • PPO 2 • Advantage HDHP/HSA • Advantage PLUS HDHP/HSA	 Self-funded Self-funded Self-funded	Blue Cross Blue Shield of Michigan 1-877-354-2583 www.bcbsm.com
• Choices 10/20 • Choices Saver 200/400 • Choices Saver 500/1000 • ABC HSA Saver	Insured Insured Insured Insured	MESSA 800-336-0013 www.messa.org
Prescription Drug Program	Self-funded	CVS Caremark 888-796-8687 www.caremark.com
Dental Program - Core Plan - Buy Up Plan	Self-funded	Guardian 888-541-7846 www.guardiananytime.com
Vision Program - Standard Plan - Premium Plan	Insured	VSP 800-877-7195 www.vsp.com
EAP	Self-funded	Health Advocate 866-799-2691 answers@HealthAdvocate.com www.HealthAdvocate.com/CMU
STD Program	Insured	Unum 866-679-3054 www.unum.com/support/employees

LTD Program	Insured	Unum 866-679-3054 www.unum.com/support/employees
Life/AD&D Program	Insured	Unum 866-679-3054 www.unum.com/support/employees
Pre-Tax Payment Program	Not applicable	Self-administered by the University 989-774-3661 benefits@cmich.edu
Wellness Program	Self-funded	Health Advocate 866-799-2691 www.healthadvocate.com/CMU
Dependent Care FSA Program	Self-funded	WEX, Inc. 866-451-3399 customerservice@wexhealth.com www.benefitslogin.wexhealth.com
Health Care FSA Program	Self-funded	WEX, Inc. 866-451-3399 customerservice@wexhealth.com www.benefitslogin.wexhealth.com
Health Savings Account Contributions Program (Designated HSA Custodian)	Self-funded	Health Equity 877-284-9840 www.healthequity.com
Diabetes, Pre-Diabetes and Weight Management Program	Self-funded	DayTwo Daytwo.com/cmu 833-833-2149
Chronic Care Solutions Program	Self-funded	Health Advocate 866-799-2691

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE B

DEPENDENT ELIGIBILITY CRITERIA

*DISCLAIMER – This document is for ILLUSTRATIVE PURPOSES ONLY. Changes made by any vendor will supersede this document. Contact the **Benefits and Wellness Office** at 989.774.3661 with questions.*

	Medical, Prescription Drug, Dental and Vision Plans (MESSA***, BCBS of Michigan, CVS Caremark, Guardian and VSP)	**Child Life Insurance*** (UNUM)	**Health Care Flexible Spending Account** (WEX)	**Dependent Care Flexible Spending Account** (WEX)
Employee's legal spouse, unless you are separated under an order of separate maintenance (spouse by common law marriage is not eligible)	Eligible for coverage, however, if spouse is offered coverage from their employer they must enroll in their coverage as primary first, unless their employer charges 100% of the cost for coverage.****	Eligible for coverage.	Eligible health care expenses are reimbursable.	Eligible dependent care expenses are reimbursable for a spouse who is disabled and unable to care for their self.
Employee's Other Eligible Individual (OEI)* **	Eligible for coverage, however, if OEI is offered coverage from their employer they must enroll in their coverage as primary first, unless their employer charges 100% of the cost for coverage.**** IRS regulations require the University to tax the fair market value of University-provided benefits for OEI's. This means that the employee will be taxed on the full premium for the OEI.	Eligible for coverage.	Not eligible for any health care expense reimbursements per IRS regulations.	Not eligible for any dependent care expense reimbursements per IRS regulations.

	Medical, Prescription Drug, Dental and Vision Plans (MESSA***, BCBS of Michigan, CVS Caremark, Guardian and VSP)	**Child Life Insurance*** (UNUM)	**Health Care Flexible Spending Account** (WEX)	**Dependent Care Flexible Spending Account** (WEX)
Employee's child (through birth, adoption or placement for adoption) or step-child (if employee is legally married to the child's parent)	Eligible for coverage from birth through the end of the calendar year of the child's 26th birthday** regardless of the child's residency, marital, student or financial dependency status.	Eligible for coverage from age 14 days through the end of the calendar year of the child's 26th birthday.	Eligible health care expenses are reimbursable through the end of the calendar year of the child's 26th birthday regardless of the child's residency, marital, student or financial dependency status.	Eligible dependent care expenses are reimbursable until the child turns age 13. The child must be a dependent for federal income tax purposes.
Child of an Other Eligible Individual (OEI)* **	Eligible for coverage from birth through the end of the calendar year of the child's 26th birthday regardless of the child's residency, marital status, student or financial dependency status. IRS regulations require the University to tax the fair market value of University-provided benefits for Other Eligible Individuals and, in some cases, their children. This means that the employee will be taxed on the full premium for the OEI and any children of an OEI who are not the employee's Tax Code dependents for health plan purposes.	Eligible for coverage from age 14 days through the end of the calendar year of the child's 26th birthday.	Eligible health care expenses are reimbursable through the end of the calendar year of the child's 26th birthday if the child is the employee's Tax Code dependent for health plan purposes.	Eligible dependent care expenses are reimbursable until the child turns age 13. The child must be the employee's dependent for federal income tax purposes.
Child for whom the employee has legal guardianship	Eligible for coverage until the termination of legal guardianship (typically at age 18). Coverage may continue beyond termination of legal guardianship until the end of the calendar year of the child's 26th birthday if the child: • lives with the employee, and • is the employee's Tax Code dependent for health plan purposes.	Not eligible for coverage at any age.	Eligible health care expenses are reimbursable while the guardianship is in effect. Thereafter expenses are reimbursable through the end of the calendar year of the child's 26th birthday if the child is the employee's Tax Code dependent for health plan purposes.	Eligible dependent care expenses are reimbursable until the child turns age 13. The child must be the employee's dependent for federal income tax purposes.

	Medical, Prescription Drug, Dental and Vision Plans (MESSA***, BCBS of Michigan, CVS Caremark, Guardian and VSP)	**Child Life Insurance*** (UNUM)	**Health Care Flexible Spending Account** (WEX)	**Dependent Care Flexible Spending Account** (WEX)
Employee's child over age 26 who is mentally or physically disabled prior to the end of the calendar year of the child's 26th birthday	Employee's child (through birth, adoption or placement for adoption), step-child, child of an OEI, and a child for whom the employee had legal guardianship may be covered beyond the end of the calendar year of the child's 26th birthday if the child is: • covered under the plan at the end of the calendar year of 26th birthday and continuously thereafter; • physically or mentally disabled prior to the end of calendar year of 26th birthday and incapable of self-sustaining employment by reason of the mental or physical disability; • unmarried; and • dependent on the employee for more than half of his/her support.	Employee's child (through birth or adoption), step-child, and child of an OEI may be covered beyond the end of the calendar year of the child's 26th birthday if child is: • covered under the plan at the end of the calendar year of 26th birthday and continuously thereafter; • physically or mentally disabled prior to end of calendar year of 26th birthday and incapable of self-sustaining employment by reason of their mental or physical disability.	Eligible health care expenses are reimbursable if the child is the employee's Tax Code dependent for health plan purposes.	Eligible day care expenses are reimbursable if the child is the employee's dependent for federal income tax purposes and the child lives with the employee for more than half of the year.

* An employee may elect child life insurance for foster children placed in the employee's home.

** Coverage for children beyond age 26 under MESSA (Regular Faculty only) may continue if the child remains a full-time student at an educational institution with full-time faculty and is dependent upon the employee for more than half of his/her support. MESSA will send a letter directly to the member near the end of the year of the child's 26th birthday. You will need to show proof that the dependent is a full-time student and sign a form certifying you contribute the majority of the child's support.

*** Effective July 1, 2019, Other Eligible Individuals and children of Other Eligible Individuals are not eligible for coverage under MESSA.

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CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE C

MEDICAL PLANS

DESCRIPTION OF BENEFITS AVAILABLE

1. **Eligible Regular Faculty** may choose among the following four options designated by the Collective Bargaining Unit and approved by the University:

   * Choices 10/20: $100/$200; CoP: $20/$25/$50; $10/$20 Rx;

   * Choices Saver 500/1000: $500/$1000; CoP: $20/$25/$50; Saver Rx;

   * Choices Saver 200/400: $200/$400; CoP: $20/$25/$50; Saver Rx; and

   * ABC HSA Saver: $1,250/$2,500; CoP: None; Saver Rx.

2. **Eligible Staff, Fixed-Term Faculty**, **Medical Faculty and Postdoctoral Research Fellows** may choose from two medical plans. The medical plans are known as:

   * PPO 2
   * Advantage HDHP/HSA
   * Advantage PLUS HDHP/HSA

   Employees selecting the PPO 2, Advantage HDHP/HSA or Advantage PLUS HDHP/HSA medical plan must elect the same level of coverage in one of the prescription drug plans.

3. **All Benefit Eligible Employees** may choose, for each medical plan, Single Coverage (employee only), Two Person Coverage (employee and one other family member), or Family Coverage (employee's entire immediate family). Employees are eligible to purchase medical coverage for individuals they enroll as an Other Eligible Individual and their dependents as provided for in employee group handbooks or collective bargaining agreements and as allowed by the carrier. Other Eligible Individuals and their dependents are not eligible for coverage under MESSA.

4. An employee choosing "No Coverage" in the PPO 2, Advantage HDHP/HSA or Advantage PLUS HDHP/HSA plans cannot elect prescription drug coverage through the University plan.

5. Deductibles and out-of-pocket maximum payments for medical plans are calculated on a Plan Year basis.

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE D

PRESCRIPTION DRUG PLANS

DESCRIPTION OF BENEFITS AVAILABLE

1. Employees enrolled in the Choices 10/20, Choices Saver 200/400, Choices Saver 500/1000, and ABC HSA Saver plans have drug coverage through the MESSA medical plans and are not eligible for the separate prescription drug plans described below.

2. Benefit Eligible Employees may participate in a self-insured prescription drug plan.

   The third party administrators for these plans is CVS Caremark.

3. Benefit Eligible Employees may choose Single Coverage (employee only), Two Person Coverage (employee and one other family member), or Family Coverage (employee's entire immediate family). Eligible Employees selecting a prescription drug plan must elect the same level of coverage in a medical plan. The dependents covered by the prescription drug plan, if any, must be the same as the dependents covered by the medical plan. Employees are eligible to purchase prescription drug coverage for an Other Eligible as provided for in employee group handbooks or collective bargaining agreements and as allowed by the carrier. Other Eligible Individuals and their dependents are not eligible for coverage under MESSA.

4. An Eligible Employee choosing "No Medical Coverage" may not select prescription drug coverage.

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE E

DENTAL PLANS

DESCRIPTION OF BENEFITS AVAILABLE

1. Eligible Employees may choose from two dental plans. The two plans are known as:

   * Core 100/50/50
   * Buy-Up 100/75/50/50

   The University is self-insured for these dental plans, and they are administered by Guardian.

2. Eligible Employees may choose, for either of the two dental plans, Single Coverage (employee only), Two Person Coverage (employee and one other family member), or Family Coverage (employee's entire immediate family). Eligible Employees may purchase dental coverage for Other Eligible Individual and dependents as provided for in employee group handbooks or collective bargaining agreements.

3. Eligible Employees are not required to elect dental coverage, whether or not they are covered by another source.

4. An Eligible Employee's Child is eligible to be included in dental plan coverage if he or she meets the criteria on **Schedule B**. If the selected coverage option includes orthodontic services, orthodontia coverage is available for an Eligible Employee's Child for services that begin before the Child's 19th birthday. The services will be covered until the treatment plan submitted prior to the start of treatment is completed or the lifetime maximum is exhausted.

5. Deductibles for dental plans and maximum annual benefits are calculated on the July 1 through June 30 Plan Year.

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE F

VISION PLANS

DESCRIPTION OF BENEFITS AVAILABLE

1. Eligible Employees may choose from two vision plans. The two plans are known as:

   * Standard
   * Premium

   The vision plan is an insured plan through VSP.

2. Eligible Employees may choose, for either of the two vision plans, Single Coverage (employee only), Two Person Coverage (employee and one other family member), or Family Coverage (employee's entire immediate family). Eligible Employees may purchase vision insurance coverage for Other Eligible Individuals as provided for in employee group handbooks or collective bargaining agreements and as allowed by the carrier.

3. An Eligible Employee may choose "No Vision Coverage".

4. There is no CMU Contribution for the Vision Program.

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE G

SHORT-TERM DISABILITY COVERAGE

DESCRIPTION OF BENEFITS AVAILABLE

1. Eligible Employees may choose from two short-term disability plans. The two plans are:

   * 50% of monthly salary starting at 45 days
   * 67% of monthly salary starting at 45 days

   The insurance policies are issued by Unum.

2. There is no CMU Contribution for the Short Term Disability Program.

3. The amount an Eligible Employee collects under these policies, if disabled, is considered taxable income upon receipt because the short-term disability benefit coverage is being purchased with pre-tax dollars. The amount of disability benefit paid will be offset by income from certain other sources, such as social security, workers' compensation, and other retirement disability programs.

4. If an Eligible Employee's salary changes during the Plan Year, the cost and the actual benefit payable will be changed also.

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE H

LONG-TERM DISABILITY COVERAGE

DESCRIPTION OF BENEFITS AVAILABLE

1. The long-term disability plan provides 67% of monthly salary up to a maximum benefit of $10,000 per month.

   The insurance policies are issued by Unum.

2. Eligible Employees are required to carry long-term disability coverage.

3. The amount an Eligible Employee collects under these policies, if disabled, is considered taxable income upon receipt because the long-term disability benefit coverage is being purchased with either employer or pre-tax dollars. The amount of disability benefit paid will be offset by income from certain other sources, such as social security, workers' compensation, and other retirement disability programs.

4. The long-term disability plans continue to make contributions to a retirement annuity, based on the Eligible Employee's annual base salary at the start of the total disability for as long as the Eligible Employee remains disabled and continues to receive a monthly disability benefit under the insurance policy. If the Eligible Employee is a participant in the Michigan Public School Employees Retirement System (MPSERS), the contributions will be credited to an annuity.

5. If an Eligible Employee's salary changes during the Plan Year, the cost and the actual benefit payable will be changed also.

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE I

LIFE INSURANCE/AD&D

DESCRIPTION OF BENEFITS AVAILABLE

1. Eligible Employees may choose life insurance at:

   * 1 times current salary
   * 1.5 times current salary
   * 2 times current salary
   * 3 times current salary
   * 4 times current salary

   The Eligible Employee's current annual salary is multiplied by the factor the Eligible Employee selects and that amount is then rounded up to the next higher thousand dollars.

   These options contain an equal amount of additional benefits in the form of accidental death and dismemberment.

   The maximum amount of employee life insurance coverage is $750,000, subject to evidence of insurability for coverage over $575,000. For Eligible Employees hired after July 1, 1994, the life insurance coverage is reduced by 50 percent of the core amount of coverage in force when the Eligible Employee reaches age 70. Core amount is defined as up to 1.5 times earnings.

   The life insurance is a Group Term Life Insurance Plan. The insurance policies are issued by Unum.

2. Eligible Employees are required to carry life insurance for at least one times salary.

3. No proof of insurability was required for the 1994-95 enrollment period or for the initial enrollment period for an employee group entering the Plan for the first time. If an Eligible Employee increases coverage after the 1994-95 enrollment period, or after initial enrollment as stated above**,** the Eligible Employee will be asked to provide satisfactory proof of insurability and may be denied increased coverage. If an Eligible Employee elects coverage at the 4x salary level, the Eligible Employee will be asked to provide satisfactory proof of insurability and may be denied coverage at this level.

6. Because an Eligible Employee is purchasing life insurance with pre-tax dollars, the imputed value of all coverage purchased over $50,000 must be claimed as additional income and the Eligible Employee must pay income taxes on that imputed value. The additional imputed income on which the Eligible Employee pays taxes is based on the Eligible Employee's age, the amount of life insurance selected, and the rates provided by the IRS.

7. If an Eligible Employee's base salary changes during the Plan Year, the coverage amount and cost of the benefit will change also; provide, however, if an Eligible Employee's base salary increases beyond the guaranteed issue amount ($575,000), changes will only be made after an annual review during the Plan Year.

8. The age banded rates for life insurance will be fixed according to the age of each Eligible Employee as of July 1 of each Plan Year. For persons who become Participants in the Plan at a time other than the start of the Plan Year, age at the time of entry into the Plan will be used.

9. Dependent life insurance is offered through the University's annual benefit enrollment system but is not part of this Plan's cafeteria plan pre-tax benefits.

CENTRAL MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN 2024

SCHEDULE J

PLAN WORKFORCE
(Employees with Access to PHI)

Employee Class	Department	Information	Permitted Purposes			
AVP	Human Resources	PHI	HIPAA compliance issues	Claims Assistance	Breach/complaint Investigations and Employee Discipline	Claims Appeals
Director Employee Relations	Employee Relations	PHI		Claims Assistance	Breach/complaint Investigations and Employee Discipline	
Director Benefits & Wellness	Benefits/Wellness	PHI	HIPAA compliance issues	Claims Assistance	Breach/complaint Investigations and Employee Discipline	Claims Appeals
Assistant Director, Benefits	Benefits/Wellness	PHI	HIPAA compliance issues	Claims Assistance	Breach/complaint Investigations and Employee Discipline	Claims Data Analysis
HR Consultant	Employment Services	PHI			Breach/complaint Investigations and Employee Discipline	
Benefits Specialist	Benefits/Wellness	PHI	Claims Appeals	Claims Assistance	Individual Rights Requests	Medicare Secondary Payer Issues
Administrative Secretary	Benefits/Wellness	PHI	Claims Appeals	Claims Assistance	Ancillary services in relation to Breach/complaint	

					Investigations and Employee Discipline	
Senior Specialist Clerk	Employment/ Compensation	PHI		Claims Assistance		
HR Technician	SAP/HR Information Systems	PHI		PHI data entry and management		
Student Assistants	Benefits/Wellness	PHI		Claims Assistance		
Director Internal Audit	Internal Audit	PHI			Breach/complaint Investigations and Employee Discipline	Work-flow Analysis
Senior Auditor	Internal Audit	PHI			Breach/complaint Investigations and Employee Discipline	Work-flow Analysis
Administrative Secretary	Internal Audit	PHI			Breach/complaint Investigations and Employee Discipline	Work-flow Analysis
Student Assistants	Internal Audit	PHI			Breach/complaint Investigations and Employee Discipline	Work-flow Analysis
General Counsel	University Counsel	PHI	HIPAA compliance issues	Benefit claims legal issues	Breach/complaint Investigations and Employee Discipline	Responding to legal requests for documents
Assistant General Counsel	University Counsel	PHI	HIPAA compliance issues	Benefit claims legal issues	Breach/complaint Investigations and Employee Discipline	Responding to legal requests for documents
Legal Secretary	University Counsel	PHI	HIPAA compliance issues	Benefit claims legal issues	Breach/complaint Investigations and Employee Discipline	Responding to legal requests for documents

Office Manager/Administrative Assistant	University Counsel	PHI	HIPAA compliance issues	Benefit claims legal issues	Breach/complaint Investigations and Employee Discipline	Responding to legal requests for documents
Legal Assistant	University Counsel	PHI	HIPAA compliance issues	Benefit claims legal issues	Breach/complaint Investigations and Employee Discipline	Responding to legal requests for documents
Director/Faculty Employment & Comp	Faculty Personnel	PHI		Claims Assistance	Breach/complaint Investigations and Employee Discipline	
Administrative Clerk	Faculty Personnel	PHI		Claims Assistance	Ancillary services in relation to Breach/complaint Investigations and Employee Discipline	
Director, Faculty Employee Relations	Faculty Personnel	PHI			Breach/complaint Investigations and Employee Discipline	
Executive Secretary	Faculty Personnel	PHI		Claims Assistance	Ancillary services in relation to Breach/complaint Investigations and Employee Discipline	
Coordinator/Systems Technology	SAP/HR and OIT			IT Support to systems using PHI		

Director/ Infrastucture & Security	Information Technology/ Infrastructure & Security		HIPAA compliance issues	IT Support to systems using PHI	Breach/complaint Investigations and Employee Discipline	
Senior Systems Administrator	Information Technology/ Infrastructure & Security			IT Support to systems using PHI	Breach/complaint Investigations	
Systems Administrator II	Information Technology/ Infrastructure & Security			IT Support to systems using PHI		
Student Assistants	Information Technology/ Infrastructure & Security			IT Support to systems using PHI		
Help Desk Technicians	Information Technology/ Infrastructure & Security			IT Support to systems using PHI		
Director/SAP Information Systems	Human Resources	PHI		IT Support to systems using PHI		
HR/SAP Systems Analyst	Human Resources	PHI		IT Support to systems using PHI		

CENTRAL MICHIGAN UNIVERSITY
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SCHEDULE K

HEALTH ADVOCATE WELLNESS AND COACHING REWARDS PROGRAM

DESCRIPTION OF BENEFITS AVAILABLE

1. To encourage wellness and self-care, CMU sponsors a Wellness and Coaching program through Health Advocate.

   The Health Advocate Wellness and Coaching Program is designed to help you achieve your best health and provides eligible employees with an opportunity to earn a reward for participating in the Wellness and Coaching Program and other offerings through Health Advocate. The University reserves the right to modify, amend, or terminate this program at any time.

   If you think you might be unable to meet a standard for a reward under this Wellness Program, you might qualify for an opportunity to earn the same reward by different means. Contact the Plan Administrator, and we will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

2. **Healthy Change Rewards Program**

   Eligible Staff, Fixed-Term Faculty, Medical Faculty and Postdoctoral Research Fellows may participate in this program. Spouses and Other Eligible individuals are eligible to participate in the program activities; however, they are not eligible for Rewards.

   The program, administered by Health Advocate:

   * allows you to sync a compatible fitness device to the Health Advocate website or app to:
     - log and monitor physical activity, nutrition and sleep;
     - engage in programs and tools that support and drive healthy behavior change;
     - compete in personal and group challenges;
     - interact and receive support from others in a social networking environment; and
     - track and redeem Healthy Change Rewards.
   * use medical claims data to reward preventive care and flu vaccine reward points.

You may earn points for efforts that make you healthier, such as drinking water, sleeping more and managing stress. You may even earn points for logging in every day to check your progress and set personal goals.

Accumulating points will help you earn rewards each quarter. Eligible Employees may earn up to $100 each level for a total of $400 per quarter.

Rewards are redeemable as gift cards through the Healthy Change Rewards Mall. The value of rewards redeemed by the Eligible Employee will be added to the employee's income and taxed, as reported on the employee's pay statement and annual W-2.