HEALTH REIMBURSEMENT ARRANGEMENT

Summary Plan Description

INTRODUCTION

We are pleased to announce that we have established a medical expense reimbursement program for you and other eligible employees. Under this program, you will be able to receive reimbursement for the cost of eligible medical expenses without taxation to you individually. The purpose of this Summary Plan Description is to briefly describe the expenses that qualify for reimbursement, as well as provide an outline of other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

However, one of the most important features of our Plan is that the cost of all benefits being offered to you within this Plan are entirely paid for by us, the Employer, at no additional cost to you or your family.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Administrator. There is a Plan document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan document, the Plan document will control. Also, to the extent there are any type of insurance contracts that exist to provide any portion of benefits under this Plan, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract would control.

PART A
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information, which you may need to know about the Plan.

1. General Plan Information. Northern Michigan University Health Reimbursement Arrangement is the name of the Plan.

2. The provisions of your Plan became effective on January 1, 2012, which is called the Effective Date of the Plan.
3. Your Plan’s records are maintained on a twelve-month period of time. This is known as the Plan Year. The initial Plan begins on January 1st and ends on December 31st. Future Plan years will be based on a full twelve-month period beginning on each January 1st and ending each December 31st.

4. Your Employer has assigned Plan Number 535 to your Plan.

5. Employer Information

Your Employer’s name, address and identification number are:

Northern Michigan University  
Human Resources Department  
1401 Presque Isle Ave  
Marquette, MI 49855  
38-6029206

6. The Plan shall be governed under the laws of the State of Michigan.

7. Plan Administrator Information

The name, address and business telephone number of your Plan’s Administrator (also referred to as the “Administrator”) is:

Northern Michigan University  
Human Resources Department  
Assistant Director of Human Resources - Benefits  
1401 Presque Isle Ave  
Marquette, MI 49855  
906-227-1030

The Administrator keeps the records for the Plan and is responsible for the Plan. The administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

8. Service of Legal Process

The Administrator is the Plan’s agent for service of legal process.

9. Type of Administration

The type of Administration is Employer Administration.
10. Eligibility Requirements.

Eligible employees include those employees specified by the Employer, including but not limited to full-time Food, Maintenance and Police workers represented by AFSCME Local 1094, and non-represented employees, which includes academic deans, academic department heads, coaches, executives, senior administrators, and senior management, but only if these employees are eligible under the Employer's group medical plan. Notwithstanding the above, commissioned employees, leased employees, independent contractors, temporary or seasonal employees and non-resident aliens are not eligible for participation in the Plan.

11. Entry Date. The Entry Date for eligible Employees shall be:

☐ Same as Employer's group health medical plan.

12. Benefits. The Plan shall reimburse Eligible Employees for the cost of Eligible Medical Expenses (as defined under Internal Revenue Code Sections 105 and 213 (without regard to the limitations contained in Code Sec. 213(a)), any accompanying regulations or other applicable Treasury guidance information and as further described below), subject to the Annual Limit. (None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred).

Types of Eligible Medical Expenses. The following types of Medical Expenses qualify for reimbursement under the Plan:

☐ Prescriptions
☐ Medical Expenses subject to the deductible of your health plan
☐ Over-the-counter medicines prescribed by a physician, supplies and insulin
☐ Other IRS qualified medical, dental, vision fees and healthcare products

13. Annual Limit. The Health Reimbursement Arrangement is subject to an annual limit of the lesser of $750 or such other amount as determined by the Employer. Newly-eligible participants may have access to the Annual Limit at the time of plan entry.

14. Access to Benefits. Other than for COBRA continuees, the employer shall make all contributions for this Plan. The employer shall make access to benefits under the plan on a pro rata basis, coordinating with employee pay dates, within the Plan Year.

15. Order of Benefit Payments. If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan:

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>Pay from employer HRA dollars</th>
<th>If employee contributes to an FSA, which account pays this expense first?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>Yes ☑</td>
<td>Employer</td>
</tr>
<tr>
<td></td>
<td>No ☐</td>
<td>Employee</td>
</tr>
</tbody>
</table>
Medical expenses subject to the deductible of your health plan | Yes ☒ | ☐ Employer | ☒ Employee
--- | --- | --- | ---
Over-the-counter medicines prescribed by a physician, supplies, and insulin | Yes ☒ | ☐ Employer | ☒ Employee
--- | --- | --- | ---
Other IRS qualified medical, dental, vision fees, and healthcare products | Yes ☒ | ☐ Employer | ☒ Employee

16. Carry over amounts. The entire account balance can be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution by the employer.

17. Claims. Outstanding claims may not be considered for the next plan year.

PART B
QUESTIONS & ANSWERS

1. What is the purpose of the Plan?

   The purpose of the Plan is to provide a source of funds to reimburse you or your dependents that are covered under the Plan for uninsured medical expenses you incur in the course of each year while you are employed with the Company and the Plan remains in effect.

2. When did the Plan take effect?

   Please refer to Part A, “General Information About Our Plan,” subsection (2), of this document for a description of the “effective date” for our Plan.

3. Who can participate in the Plan?

   You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the Eligibility Requirements under this Plan. Please refer to Part A, "General Information About Our Plan," subsection (10), of this document for a description of our eligibility requirements.

4. Who shall make all of the contributions to the Plan?

   As your employer, we will make all of the contributions necessary to fund the Plan. Please refer to Part A. “General Information About Your Plan” subsection (13), of this document for a description of our contribution schedule.

5. How much of my uninsured medical expenses may be reimbursed each year?

   Please refer to Part A, “General Information About Our Plan,” subsection (13), of this document for a description of the “Annual Limit” for our Plan. To the extent provided for in Part
A, all or a portion of any unused amounts remaining at the end of the calendar year may be carried over for use in future periods in which you remain eligible under the Plan.

6. How do I become a Participant?

Before you become a member or a “participant” in the Plan, there are certain rules which you must satisfy. First, you must meet the “eligibility requirements.” Please refer to Part A, “General Information About Our Plan” of this document for a description of our eligibility requirements.

Once you have met the eligibility requirements, Please refer to Part A, “General Information About Our Plan” of this document for a description of our Entry Date.

7. How do I receive my benefits under the Plan?

When you incur an eligible medical expense, you must submit a claim reimbursement request to the Plan Administrator within the time frames specified under Part C, Section 2 set forth below. If the Plan Administrator determines that your claim is valid, you will be reimbursed for your eligible expenses as soon as is administratively feasible after it has been submitted. You may submit a claim for any eligible medical expense arising during the Plan Year at any time during the period that begins when the expense is incurred. Remember, though, you can't be reimbursed for any total expenses above the annual amount of benefit the Company has provided plus any unused carryover amounts from the previous calendar year. If your claim arises while you have COBRA continuation coverage (see Answer 16), all required premiums for the coverage (subject to a 30-day grace period for late payment of premiums) also must have been received by the Company prior to the request for reimbursement of otherwise allowable expenses.

To have your claims processed as soon as possible, please read the Claims Instructions that have been furnished to you by the Plan Administrator. Please note that it is not necessary that you have actually paid an amount due for an eligible medical expense—only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source. For purposes of the Plan, you are considered to have “incurred” an expense when the health care services are rendered for which you are seeking a reimbursement, and not when you have actually paid the bill.

8. What is an “eligible expense?”

An “eligible expense” means any expense identified as an Eligible Medical Expense that is further described under subsection 12 of Part A, “General Information About our Plan” described above. However, you may not submit a claim for an amount that has been deducted on your prior year’s personal tax return or that was incurred prior to the time that you became a participant under the Plan, nor shall you be entitled to submit a claim for any other expenses that have been paid through any other health insurance plan, Section 125 “cafeteria” plan, or other similar medical expense reimbursement arrangement. In addition, you may not submit a claim for medical expenses related to any over-the-counter (OTC) medicine or drug that is not
prescribed or is not insulin. Please review the list of any other eligible medical expenses included with the Claims Instructions for assistance in determining what is generally accepted as an “eligible expense.”

9. When must the expenses be incurred that I may be reimbursed for?

Eligible expenses must have been incurred after the date the Plan became effective. You may not be reimbursed for any expenses arising before the Plan became effective, or prior to the time you became covered under the Plan, if later.

10. Does the Plan also provide benefits for my family?

The Plan provides reimbursement for expenses incurred for you, your spouse, and any other person defined as a dependent pursuant to the terms of the Plan.

11. What happens if my claim for benefits is denied?

You will be notified in writing by the Plan's Administrator within 30 days of the date you submitted your claim if the claim is denied. The notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 180-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review. See Part C, subsection (3), below for more information regarding your rights to appeal any adverse claim determination.

12. Does my coverage under this Plan end when my employment terminates?

Generally yes. Your normal participation will cease at the end of the last day before your employment with the Company terminates. However, you may still receive reimbursement of any eligible expenses, as otherwise provided for under the Plan, as long as such reimbursement requests are made prior to the expiration of the earlier of: (1) 30 days following the date that you ceased your employment or eligibility; or (2) the end of the 60-day period following the close of the Plan Year in which the expense arose. In addition, you and your family will also have the opportunity to continue to be covered under the Plan under the terms of the Continuation Coverage provisions described in Answer 16, below. Under all circumstances, coverage ends on the date the Plan terminates.

13. Will my coverage end if I go on a family or medical leave under the FMLA?

Subject to certain conditions, the Family and Medical Leave Act (“FMLA”) entitles you to take unpaid leaves of absence totaling 12 weeks per year for specific personal or family health and child care needs. Your coverage under the Plan will continue while you are on an FMLA leave as long as you opt to continue your coverage under the Plan and continue to make any
applicable premium contributions that would otherwise be paid by your employer. Upon your return you will be permitted to re-enter the Plan on the same basis that you were participating in prior to taking FMLA leave. However, you will lose coverage when you fail to return to work at the end of the leave or give earlier notice that you will not be returning to active employment.

14. Does my coverage continue while I am absent on duty in the uniformed services?

The Plan will continue to reimburse you or your family for eligible medical expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 30 days of your absence. However, coverage after that period will be suspended while you are on approved military service leave, unless you opt to continue coverage under the Plan in accordance with the procedures set forth in Answer 16. No re-entry requirements will be imposed if you return to active employment within 30 days of taking leave of employment for duty in the uniformed services.

The “uniformed services” are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

15. Which Plan pays first if I am already enrolled in a Flexible Spending Account?

Please refer to Part A, “General Information About Our Plan” subsection (15) of this document to determine the Order of Benefit Payments option, if we provide the capability for you to participate in a Section 125 “Cafeteria” Flexible Spending Arrangement, in addition to this Plan.

16. What is “Continuation Coverage” and how does it work?

“Continuation Coverage” means your right, or your spouse and dependents’ right, to continue to be covered under this Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a “Qualifying Event.” A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below what is required for participation under this Plan.
- your death or retirement
- divorce or legal separation from your spouse.
- your becoming eligible to receive Medicare benefits.
- when a dependent of yours ceases to be a dependent.
It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs. The notice of these rights that you will receive will explain all the rest of the terms and conditions of the continued coverage.

If you or any of your Eligible Dependents elect to continue coverage under the Plan, you or they will be required to pay premiums for the coverage. The Plan Administrator will inform you of the cost of continued coverage and the schedule for premium payments in the notice that will be sent to you and your Dependents after a Qualifying Event has occurred.

17. How long will the Plan remain in effect?

Although the Company expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time.

PART C
ADDITIONAL PLAN INFORMATION

1. Plan Accounting

The Plan Administrator may periodically furnish you with a statement of your medical expense reimbursement account for you to use in determining how much additional benefits remain in your account prior to the end of the Plan Year, which will also assist in budgeting for expense reimbursement needs in future Plan Years. You may also make a written request to receive a copy of your medical expense reimbursement account from the Plan Administrator at any time.

2. Claims Instructions

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits to the Plan Administrator on a form specified by the Plan Administrator, or as otherwise set out below. Upon receipt of a properly documented claim, the Plan Administrator shall pay the Participant the benefits provided under this Plan as soon as is administratively feasible. A Participant may submit a claim for reimbursement for an Eligible Medical Expense arising during the Plan Year at any time during the period that begins when the expense is incurred.

The Participant may not submit a claim that is attributable any prior taxable year or any claim that was incurred before the individual became eligible for coverage under this Plan, or which has already been paid through any other health insurance plan, Section 125 “cafeteria” plan, or other similar medical expense reimbursement arrangement.

Two types of documentation are usually acceptable to the Plan Administrator as substantiation of any claim request:
First, you must submit your claims under any medical plan under which the person receiving the medical service is covered - your own, your spouse’s, and/or your dependent’s health or Medicare, etc. plans. This will result in the medical plan sending an Explanation of Benefits (EOB). You may send the EOB as documentation of an unreimbursed out-of-pocket medical expense. Second, for unreimbursed out-of-pocket medical expense not covered by a medical plan and not documented by an EOB, you may submit a provider statement of the expenses, including: name of the recipient of the service; date of the service; description of the service; cost of the service; and name, address of the provider. You must also fill out a form provided to you by the Plan Administrator.

a) The Plan Administrator will process your claim, deduct the money from your Account, and send you a check in payment of your claim. The Plan Administrator issues checks as soon as reasonably practicable, but no less than monthly. If your claim request is denied, you will be notified of this denial under procedures further discussed and set forth below.

b) As an alternative to the method of payment referenced in subsection a) above, if an Eligible Employee agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of Eligible Medical Expenses through use of a debit card, credit card, other stored value card or other similar electronic media (hereinafter the “Debit Card”), payments under this Plan shall be made directly to the service provider, authorized merchant or other independent third party that provides products or services that are eligible for payment of Eligible Medical Expenses as otherwise set forth herein.

(i) Within the cardholder agreement, the Eligible Employee agrees that payment for Eligible Medical Expenses can only be made on behalf of the Employee, the Employee’s spouse or other qualifying dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer’s signed Adoption Agreement or as otherwise specified by the Employee’s signed Election. The Employee also certifies that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the card is used. The cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate or as required by law. The cardholder also understands that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.

(ii) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Administrator
agrees that it shall adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to a requirement to maintain the program in compliance with applicable standards under the Internal Revenue Code and any mandates that payments for Eligible Medical Expenses only be made to authorized merchants and service providers. The Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the card has been used for Eligible Medical Expense payments that are in accordance with applicable provisions of the Code, any underlying Regulations and other applicable guidance thereunder.

(iii) If any claim reimbursement request is being submitted in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator may make a conditional payment of an allowable Eligible Medical Expense reimbursement item to the authorized service provider, merchant, or approved independent third party, but shall also require the cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which shall be subject to further review and substantiation.

(iv) If any conditional payment has been made but is subsequently deemed not to be an Eligible Medical Expenses reimbursement, the Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):

(A) Upon identification of any improper payment, the Administrator shall require the Employee to pay back to the Plan an amount equal to the improper payment;

(B) If the Employee does not immediately repay the Plan, the Administrator shall ensure that the proper amount is withheld from the Employee’s wages or other compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;

(C) To the extent that neither (A) or (B) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to the Employee-cardholder as part of his Employee cardholder agreement.

(D) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the debit or credit card until the indebtedness is repaid by the Employee. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately
remitted to the Plan as required by the Plan or Employee
cardholder agreement.

(v) If a cardholder attempts to utilize the Debit Card for any improper or non-
allowable purpose, the Participant/cardholder shall be responsible for any
and all fees or other expenses, including restitution or other similar penalty
amounts, charged inappropriately by the Participant/cardholder.

c) Reimbursement payments under this Plan shall be made directly to the
Participant. However, in the Administrator’s discretion, payments may be made
directly to the service provider.

3. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than
60 days after the end of a Plan Year. Outstanding claims will not be considered for the next Plan
Year. For a terminated employee or any Participant who is no longer eligible under the terms of
this Plan, claims will still be reimbursed but only if such reimbursement requests are made by the
earlier of (1) 30 days following the date that you ceased your employment or eligibility; or (2)
the end of the 60-day period following the close of the Plan Year in which the expense arose.
Any claims submitted after that time will not be considered.

Claims for health benefits under the Plan must be made in writing by you or your authorized
representative on forms supplied by the Plan Administrator (or other designated claims
representative) and in accordance with the claims submission deadline as set forth in the Plan.
The claims administrator has sole and exclusive discretionary authority to construe and interpret
the terms of the Plan, make factual determinations and decide all questions of eligibility and the
amount, manner and time of any benefit payment as described below.

If your initial claim is denied in whole or in part, the denial will:

- be sent to you by written or electronic notice;
- set forth the specific reasons for the denial;
- reference the pertinent Plan provisions on which the denial is based;
- describe any additional material or information necessary for you to
  complete the claim and explain why such information is necessary;
- contain a description of the Plan's appeal procedures and time limits
  applicable to the procedures; and
- provide the following free of charge upon request:

- a copy of any internal rule, guideline, protocol, or other similar
criterion relied upon in making the denial; and
- an explanation of the scientific or clinical judgment used for a
denial of a case involving medical necessity or that is based on an
experimental treatment or a similar exclusion or limit.
The denial will also:

- identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable));
- provide notification that you may request the claims diagnosis code and its corresponding meaning, and the claims treatment code and its corresponding meaning, and that such information will be provided to you, free of charge, upon your request. Any request for a claims diagnosis or treatment code will not be considered to be a request for an internal appeal or external review;
- include the denial code and its corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim;
- contain a description of available internal appeal processes, including information on how to initiate an appeal; and
- disclose the availability of and contact information for any office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals.

You may request a full and fair review of the initial decision denying the claim. The review will not be conducted by the person who made the initial adverse benefit determination or that person’s subordinate and will not give deference to the initial adverse benefit determination. The Plan will ensure that all claims and appeals are decided in a manner designed to ensure the independence and impartiality of the persons involved in making the decision, and decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support a denial of benefits.

An appeal for review of a denied claim must be requested in writing and filed with the claims administrator within 180 calendar days after the initial denial of the claim.

On appeal you may:

- submit written comments, documents, records, and other information relating to the claim for benefits;
- submit testimony;
- review the claim file;
- have reasonable access (free of charge upon request) to copies of all documents, records and other information relevant to your claim for benefits; and
- require that the review take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, even if such information was submitted or considered in the initial benefit determination.

On appeal the claims administrator will:
• consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment if the adverse benefit determination was based in whole or in part on a medical judgment. The health care professional will not be the person who was consulted in connection with the adverse benefit determination that is the subject of the appeal or that person’s subordinate;
• identify the medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination;
• provide you, free of charge, with any new or additional information considered, relied upon, or generated by the Plan in connection with your claim, as soon as possible but sufficiently in advance of the date in which the final determination is made so you have time to respond prior to that final determination; and
• provide you, free of charge, with any new or additional rationale, as soon as possible but sufficiently in advance of the date in which the final determination is made so you have time to respond prior to that final determination.

The time frame for determining your appeal is described below. You will be given a full description of the appeals procedure if your initial claim is denied. The claims administrator will make a decision involving your appeal as follows:

• urgent care - not later than 72 hours after receipt of your request for review of an adverse benefit determination.
• pre-service claim - not later than 30 calendar days after receipt of your request for review of an adverse benefit determination.
• post-service claim - not later than 60 calendar days after receipt of your request for review of an adverse benefit determination.

If you are denied a benefit on review, the claims administrator will provide you written or electronic notice of the following:

• the specific reason for the denial;
• a reference to the pertinent Plan provisions on which the denial is based; and
• a statement of the following:
  o that you will be provided reasonable access (free of charge upon request) to copies of all documents, records and other information relevant to your claim for benefits;
  o that a copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the denial on review is available free of charge upon request;
  o an explanation of the scientific or clinical judgment used for making the denial on review of a case involving medical necessity or that is based on an experimental treatment or a similar exclusion or limit is available free of charge upon request; and
of your right to bring a civil action under applicable law following a final adverse benefit determination.

The claims administrator will also provide you with written or electronic notice of the following:

- a discussion of the decision to deny the claim, including the denial code and its meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
- identification of the claim involved (including the date of service, the health care provider, the claim amount (if applicable));
- provide notification that you may request the claims diagnosis code and its corresponding meaning, and the claims treatment code and its corresponding meaning, and that such information will be provided to you, free of charge, upon your request. Any request for a claims diagnosis or treatment code will not be considered to be a request for an internal appeal or external review;
- a description of available external review processes, including information on how to initiate such a review;
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist with the external review process;

If the Plan fails to substantially comply with the requirements of this claims procedure with respect to your claim, then you may immediately initiate an external review or pursue remedies under applicable law, unless the violation was:

- de minimis;
- non-prejudicial;
- attributable to good causes or matters beyond the Plan's or issuer's control;
- in the context of an ongoing good-faith exchange of information; and
- not reflective of a pattern or practice of non-compliance.

You will also be entitled, upon written request, to an explanation of the Plan's basis for asserting that it substantially complied with the requirements of this claims procedure.

You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office, the Employee Benefits Security Administration, or your State insurance regulatory agency.
4. Non-Discrimination Requirements

To the extent that the Plan is treated as a self-insured medical expense Plan under Reg. Section 1.105-11, it must comply with the non-discrimination requirements as set forth under Section 105(h).

5. Highly Compensated Employees

Under the Internal Revenue Code, if you are deemed to be a “highly compensated employee”, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Your own circumstances will dictate whether contribution limitations on “highly compensated employees” will apply. You will be notified of these limitations if you are affected.

6. No Employment Rights Conferred

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

7. HIPAA Privacy

The Plan is subject to the HIPAA privacy rules. The Plan document has incorporated the HIPAA administrative provisions regarding your privacy rights. The HIPAA rules describe the permitted and required uses and disclosures of your protected health information (PHI). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. There will be separation between the Employer and the Plan to limit the Employer’s access to your PHI. Procedures will be implemented to ensure that PHI is not improperly used or disclosed and for resolving issues of noncompliance.

8. Continuation Coverage

A federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. This provision is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law.
CONTINUATION COVERAGE FOR EMPLOYEE (COBRA)

1.1 QUALIFYING EVENTS

If your employer is subject to COBRA, you, as an employee of that employer, have the right to continue coverage under your current Plan if your coverage is lost due to any of the following qualifying events:

1. Termination of employment (for reasons other than gross misconduct.)

2. Involuntary termination of employee.

3. Reduction in hours of employment.

As a spouse of a covered employee, you have the right to continue coverage under your current health plan(s) if your coverage is lost due to any of the following qualifying events:

1. A termination of your spouse’s employment (for reasons other than gross misconduct).

2. Reduction in your spouse’s hours of employment.

3. The death of your spouse.

4. Divorce or legal separation from your spouse.

5. Your spouse becomes entitled to Medicare.

As a dependent child of a covered employee, you have the right to continue your current coverage if your coverage is lost due to any of the following qualifying events:

1. The termination of an employee parent’s employment (for reasons other than gross misconduct).

2. Reduction in an employee parent’s hours of employment with his/her current employer.

3. The death of your employee parent.

4. Parent’s divorce or legal separation.

5. Employee parent becoming entitled to Medicare.

6. You cease to be a “dependent child” under the current health plan(s).
1.2 NOTIFICATION AND PREMIUMS

Under this law, it is your responsibility to inform us of a divorce, legal separation, or a child losing dependent status under the plan(s) within 60 days of the occurrence of the event. You must also notify us within 60 days of receiving a disability determination letter from the Social Security Administration. Upon the occurrence of a qualifying event, you will be notified of your right to continue coverage under your current health plan(s). If you elect continuation coverage you must do so, in writing, within 60 days from the later of the notice or the date of the qualifying event/loss of coverage.

The recipient of coverage may have to pay part or all of the cost of coverage, which cannot exceed 102 percent of the cost under the group plan. If, during the continuation period, rates change for the employer group, persons under COBRA are subject to that increase.

You will have a 45-day period from the date you elect continuation coverage to pay the initial premium. This premium must include the entire amount due from the date you would have lost coverage to the date of the election. Thereafter, you will be given a grace period of not less than 30 days to pay premiums.

If you choose continuation coverage, your employer is required to give you coverage that is identical to the coverage provided under the plan to similarly situated employees or family members.

You do not have to show that you are insurable to choose continuation coverage.

If you do not choose continuation coverage, your group health coverage will end as of the date of the qualifying event.

If a qualified beneficiary dies or becomes incapacitated during the election period, he or she may not be able to elect coverage timely. A legally appointed guardian can make the election and act for the qualified beneficiary. However, there may not be adequate time during the 60-day election period. Therefore, the election period can be extended until a legally appointed guardian is designated. This extension of the time period is referred to as “tolling”.

1.3 TERMINATION OF RIGHTS

If you do choose continuation coverage, the law provides that coverage may be terminated for any of the following reasons:

1. Your employer terminates all group health coverage provided to its employees.

2. The premium for your continuation coverage is not paid in full the time prescribed under the Notifications and Premiums section of this provision.
3. You become covered under another group health plan other than the plan of the employer providing continuation as long as no exclusionary period will be imposed on a preexisting condition.

4. You become entitled to Medicare. However, if it is determined that Medicare is to be the secondary payor, your continuation coverage under your current health plan(s) is primary until Medicare becomes primary, or continuation coverage is otherwise terminated, whichever is earlier.

5. If, during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

1.4 ADDITIONAL INFORMATION

If you have questions about your right to continue coverage under your current health plan(s), please contact your Plan Administrator.

If you change your address, marital status, or become entitled to Medicare or another group health plan while you are covered under the plan, please notify your Plan Administrator. It is important to keep the Plan Administrator informed of any changes in your addresses or in the addresses of your family members.

1.5 QUALIFIED BENEFICIARIES

The term Qualified Beneficiary (Q.B.) refers to individuals who are covered under the employee’s group health plan the day before a COBRA qualifying event takes place. According to the COBRA statutes, a Qualified Beneficiary is the covered employee, covered spouse of the employee, covered dependent child of the employee OR any child born to, or placed for adoption with the covered employee during the period of continuation coverage.

1.6 DURATION OF COVERAGE

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the covered employee’s divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage can last for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee who loses coverage as a result of the qualifying event can last until up to 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children who lose coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28
months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally can last for only up to a total of 18 months. However, an 11-month extension may be available if a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion. In addition, if your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children receiving COBRA coverage 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 Plan Administrator.

For more information about the COBRA continuation coverage available pursuant to the NMU Health Reimbursement Arrangement, please contact the Northern Michigan University Plan Administrator at 1401 Presque Isle Avenue, Marquette, MI 49855, or (906) 227-1030.