

LANSING COMMUNITY COLLEGE BENEFIT AND WELFARE PLAN

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION
(For the Self-Funded Benefit Programs)

SUMMARY PLAN DESCRIPTION
(For the Insured Benefit Programs)

Amended and Restated as of November 1, 2008

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INTRODUCTION

Lansing Community College (the "**College**") sponsors the Lansing Community College Benefit and Welfare Plan (the "**Plan**") for your benefit and the benefit of your family, if you are an eligible employee of the College. The Plan allows you to participate in a range of benefit programs (the "**Benefit Programs**"):

- a "**Medical Program**" that provides comprehensive major medical, hospitalization, and prescription drug benefits. There are three "**Program Options**" under the Medical Program. All three Program Options are insured and are administered by the Claims Administrator listed in the Benefit Program Information Chart;
- 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 for you and your Covered Dependents;
- a "**Long-Term Disability Program** (the "**LTD Program**") that offers income replacement benefits if you become totally disabled;
- a "**Life/Accidental Death and Dismemberment Program** (the "**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;
- an "**Employee Assistance Program**" (the "**EAP**") that provides you with counseling to help with work, family, and other personal matters;
- a "**Pre-Tax Payment Program**" that allows you to pay with *pre-tax* dollars your share of the cost of the Benefit Programs;
- an "**Opt-Out Program**" that pays you a cash bonus of \$2,400 for the Plan Year if you do not need coverage under the Medical Program because you are already covered under another Group Health Plan.
- a "**Dependent Care Flexible Spending Account Program**" (the "**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 and filing separately); and
- a "**Health Care Flexible Spending Account Program**" (the "**Health Care FSA Program**") that allows you to pay for unreimbursed medical expenses on a *pre-tax basis* up to an annual maximum of \$3,000.

Some of the benefits are insured. That means the College pays premiums to insurance companies that then pay for the benefits under insurance policies or contracts. Other Benefit Programs are Self-funded. "**Self-funded**" means the benefits are paid from the College's

general assets and are not provided through an insurance contract. The Benefit Program Information Chart at the end of this document indicates each Benefit Program's type of funding.

For each insured Benefit Program there is an insurance contract or policy that serves as the official Plan document for that Benefit Program. The insurer or Claims Administrator also prepares one or more booklets, summaries, and/or certificates that describe the benefits available ("**Booklets**"). Those Booklets, together with this document, are the Summary Plan Description ("**SPD**") for the insured Benefit Programs. If a conflict arises between the terms of this document, the Booklet, and the insurance policy or contract for a Benefit Program, the terms of the insurance policy or contract will control.

You may also receive Booklets from the third party Claims Administrators describing your benefits under one or more of the Self-funded Benefit Programs. This document, along with those Booklets and/or summaries, serve as the Plan document and SPD for the Self-funded Benefit Programs.

This document and the accompanying Benefit Program Booklets describe the provisions of the Plan as of April 1, 2009. The provisions of this Plan apply uniformly to all Participants. 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 end of this SPD with page references to where each term is defined. Some terms, not defined in this document, may also have specific meanings where they are defined in other Booklets that are part of the SPD.

If you have any questions about a Benefit Program or the Plan in general, please call the Human Resources Department at (517) 483-1875.

OBTAINING AND CHANGING COVERAGES

ELIGIBILITY

Employee Eligibility

If you are a regular Full-time employee of the College, you are eligible to participate in each Benefit Program on the first day of the month following your date of hire as a Full-time employee. For Part-time employees, your participation date in the Benefit Programs in which you are eligible to participate is the date you complete your probationary period. Each of these time periods are referred to as a **"Waiting Period."**

You are a **"Full-time"** employee if you are regularly scheduled to work at least 40 hours per week for the College. A **"Part-time"** employee is a regular employee who is scheduled to work less than 40 hours per week, and who is not a student employee.

If you are a Part-time employee, you are only eligible to participate in the following Benefit Programs; Medical (the "Limited" Program Option only), Dental and Vision.

You are ***not*** eligible to participate in this Plan if you are a leased employee, a student employee, an independent contractor, or a person who has been reclassified as an employee by a court or governmental agency.

Dependent Eligibility

Certain members of your family who are dependent on you may also be eligible for coverage under the Plan. The Plan Administrator may require you to show proof that a dependent meets the eligibility criteria. You must notify the Plan Administrator on or before the 30th day following the date of any status change that would result in a dependent no longer being an Eligible Dependent (for example, 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 (*Refer to Overpayments*).

An **"Eligible Dependent"** is:

- your legal spouse;
- your Child who is not currently married and who has not reached the end of the calendar year in which he or she turns 19;
- your step-Child who is in your custody, legally dependent on your spouse, and resides with you;
- a Child who must be provided health coverage under the Plan as required by a Qualified Medical Child Support Order;
- your unmarried Child who, before age 19, is totally and permanently disabled by a medically determined physical or mental condition that prevents him or her from being self-supporting,

and who is dependent on you for support and care (*you must notify the Plan Administrator in writing of the condition by the time your Child turns 19 years old*); and

- your Child who:
 - has not yet reached the end of the calendar year in which he or she turns 25,
 - is enrolled as a Full-time Student,
 - is not currently married,
 - is a member of your household, and
 - is dependent on you for more than half of his or her support.

A "**Full-time Student**" is someone who enrolls during each of 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 ongoing educational organization.

"**Child**" includes your natural child, step child, legally adopted child, child placed with you in anticipation of the child's being adopted, or child by virtue of legal guardianship. In connection with any adoption or placement for adoption, Child means an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

Your Child will be eligible for coverage even if the Child is born out of wedlock, is not claimed by you as a dependent for federal income tax purposes, or does not reside with you. For your step-Child or your Child over the age of 19 to be eligible for coverage, however, he or she would have to be eligible to be declared as your dependent for federal income tax purposes.

This Plan allows your dependents to be covered under this Plan, even if they may not be "qualified children" or "qualified relatives" under IRC § 152, and, thus, could not be declared as a dependent on your federal income tax returns. If coverage is provided for your children who cannot be claimed as your dependent on your federal income tax returns, the value of the benefits provided under the Plan's Benefit Programs may be additional taxable income to you. Any of your dependents who do not meet the criteria for being either your "qualified child" or "qualified relative" under IRC § 152 are not eligible to be covered under the Health Care FSA Program.

PARTICIPATION

To start participating in the Plan, you need to fill out and submit the Enrollment Forms contained in your enrollment package ("**Enrollment Forms**") to the Human Resources Department. On the Enrollment Forms, you elect the Benefit Programs (and Program Options, if applicable) in which you wish to participate and authorize the College to reduce your pay in accordance with those elections. When you have properly enrolled in the Plan, you are a "**Participant.**"

An Eligible Dependent who is properly enrolled in a Benefit Program is a "**Covered Dependent.**"

Newly acquired Eligible Dependents, for example, a new spouse or a newborn child, must be enrolled on or before the 30th day following the date of the event by which they become your Eligible Dependent. If not enrolled by that 30th day, they cannot be enrolled until the next Open or Special Enrollment Period or until you experience a Change Event.

Initial Enrollment Period

As a newly hired Full-time or Part-time employee, you will participate in the Benefit Programs on the date you complete the Waiting Period, as long as you complete and return the Enrollment Forms to the Human Resources Department on or before the 30th day following that date ("**Initial Enrollment Period**").

Open Enrollment Period

Each year the College 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.

To change your elections under the Plan or enroll 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 fill out the Enrollment Forms and return them to the Human Resources Department before the Open Enrollment Period ends. The choices you make during the Open Enrollment Period will be effective on the first day of the upcoming Plan Year. Once your payroll reductions have started, your choices remain in effect without any changes permitted through the remainder of the Plan Year or Special Enrollment Period, or unless you experience a Change Event.

Special rules apply if you are on a leave of absence during an Open Enrollment Period. If the Open Enrollment Period occurs while you are on a leave that is either paid or qualified under the Family and Medical Leave Act of 1993 (the "**FMLA**"), you will be contacted and allowed to make an election during the Open Enrollment Period. If you are eligible to participate in the Plan, and the Open Enrollment Period occurs while you are on an unpaid leave of absence *not* qualifying under the FMLA, you will be presumed to have elected to continue your elections from the prior year. Your elections for the Dependent Care FSA and the Health Care FSA Programs, however, will be terminated as of the last day of the Plan Year in which your leave began, although you may seek reimbursement, up to the reimbursement deadline for that Plan Year, of eligible expenses Incurred during your period of participation. You may make new elections and participate in the Plan after you return from your leave of absence under the Change Event rules.

Special Enrollment Period

You may enroll in the Medical, Dental, Vision, Pre-Tax Payment, and Health Care FSA Programs other than during the annual Open Enrollment Period in four different circumstances ("**Special Enrollment Period**"). The third and fourth circumstances will be effective on or after April 1, 2009.

First, you declined coverage under any one of these Benefit Programs when first available because you and/or your Eligible Dependents were enrolled in other health coverage, but have since lost that coverage on account of:

- having exhausted COBRA Continuation Coverage;
- having lost eligibility for the other coverage; or
- termination of employer contributions towards the other coverage.

In this circumstance, you may enroll yourself and your Eligible Dependents in the Plan on or before the 30th calendar day following the date the other coverage was exhausted or terminated. If you or your Eligible Dependents were not provided with a Certificate of Creditable Coverage on or before the date the other coverage was exhausted or terminated, the Special Enrollment Period will end 30 days after the earlier of the date a Certificate of Creditable Coverage is provided for the previous exhausted or terminated coverage or the date that is 44 days after that coverage ceases.

Second, you initially declined enrollment and you later have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption. You may then enroll yourself and your Eligible Dependents in the Plan on or before the 30th calendar day following the date of the marriage, birth, adoption, or placement for adoption. Any oral or written request to the Plan or Claims Administrator will be treated as a request for Special Enrollment. Election changes related to a birth, adoption, or placement for adoption will take effect as of the date of the birth, adoption, or placement for adoption. Election changes related to your marriage will take effect as of the first day of the month following receipt of a written notice of the marriage. Benefit Contributions will take effect accordingly.

In this second circumstance, the Special Enrollment Period may be extended if you are making reasonable efforts to obtain the necessary enrollment information. For example, if you are in the process of obtaining a Social Security number for your newborn Child, and receipt is delayed beyond the 30 day period, the Special Enrollment Period is extended.

Third, you or your dependent may enroll if you were not covered under the Plan, but had coverage under a State Medicaid program or a state children's health insurance program ("**CHIP**"), and you or your dependent are terminated from coverage under either of those programs because you or they are no longer eligible. You must enroll in the Plan on or before the 60th calendar day immediately following your loss of such coverage.

Fourth, you or your dependent may enroll if you were not covered under the Plan, but had coverage under a state Medicaid or a state CHIP program, and the state determines that you are eligible for a premium assistance subsidy with respect to coverage under the Plan, and you enroll in the Plan on or before the 60th calendar day immediately following the date you or your dependent is determined to be eligible for the premium assistance subsidy.

Coverage will only be available under the Plan through a premium assistance subsidy so long as the Plan is "**Qualified Employer-Sponsored Coverage**," which means that (i) the Plan constitutes Creditable Coverage for HIPAA purposes, (ii) the College contribution toward the cost of any premium is at least 40%, and (iii) the coverage under the Plan is available on a non-discriminatory basis under IRC § 105(h).

Failure To Timely Enroll

If you do not deliver completed Enrollment Forms to the Human Resources Department during your Initial Enrollment Period, an Open Enrollment Period, or a Special Enrollment Period, you will be deemed to have elected to receive your full compensation during the following Plan Year through the College's normal payroll system, except as described below.

Participation During A Leave Of Absence

Paid And FMLA Leaves

For any paid leave, and for any leave, paid or unpaid, that qualifies under the FMLA, the College intends to allow you to continue all Plan benefits, to the extent 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 not wish to receive some or all of the coverage during your leave that you were receiving just prior to your leave, you must inform the Human Resources Department before the start of your leave, or as close to the beginning of your leave as possible.
- If you wish to continue your participation in the Plan during your leave, and you are currently required to make Benefit Contributions, you must make arrangements with the Human Resources Department to pay for the coverage you wish to maintain during the course of your leave. If your leave is a paid leave, you may continue having your compensation reduced as it was before your leave. If your leave is unpaid, you can pay your Benefit Contributions:
 - in advance of your leave;
 - during your leave by sending a check monthly to the Human Resources Department; or
- Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not make the required Benefit Contributions during the period of your leave, unless you have made other arrangements with the Human Resources Department.
- If the College advances money by making these payments for you, in whole or in part, it can recoup the amounts advanced through payroll deductions upon your return to employment following your leave.

Special rules apply to the Dependent Care FSA and Health Care FSA Programs, which are described in those sections.

Special Leave of Absence Rule for Full-Time Students

Effective as of January 1, 2010, a dependent Child who is covered under the Plan as a Full-time Student and who is certified in writing by his or her treating physician as suffering from a serious illness or injury that requires a medically necessary leave of absence that would necessitate the loss of status as a Full-time Student at the educational institution at which the dependent Child is enrolled, the coverage of such dependent Child shall continue under the Plan until the earlier of the date that is: (a) one year from the date the medically necessary leave of absence began, or (b) the date on which Plan coverage would have otherwise terminated under the "End of Plan Participation" provision. The loss of coverage under the Plan for purposes of

determining a COBRA Qualifying Event with respect to such dependent Child will be the date coverage under the Plan is lost under this special rule.

Other Leaves

If you take an unpaid leave of absence that does not qualify under the FMLA, or extends beyond the FMLA leave period, your benefits under the Plan will end, but for those Benefit Programs for which COBRA continuation coverage is available, you may continue to be covered, if you elect COBRA and pay the required premiums. You should consult with the Human Resources Department before taking an unpaid leave.

End Of Plan Participation

Your participation (and your Covered Dependents' participation) in the Plan and your pay period reductions will end on the earliest of:

- your termination of employment (unless you have elected COBRA Continuation Coverage for a Benefit Program for which COBRA is available);
- a Change Event (as defined below) that leads you to revoke your participation;
- your (or your dependent's) failure to meet the eligibility requirements or conditions described in the Plan (unless you have elected COBRA Continuation Coverage for a Benefit Program for which COBRA is available);
- for the insured Benefit Programs, the effective date on which coverage terminates upon the termination of the group insurance policy or contract between the College and the insurer;
- for Covered Dependents, pursuant to the terms of the Qualified Medical Child Support Order under which he or she participates in the Plan; or
- the termination of the Plan by the College.

Participation Upon Rehire

If, during the same Plan Year, you terminate employment and you are rehired, you will be treated as a new hire.

CHANGE IN STATUS EVENTS

You cannot change your benefit elections during the Plan Year outside an enrollment period, unless you experience a "**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 your Covered Dependent becomes eligible or ineligible for coverage under either this Plan or another plan on account of a change in:

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

- number of dependents (for example, birth, death, adoption, placement for adoption);
- employment status (for example, strike or lock out, termination, commencement, leave of absence, including those protected under the FMLA);
- work schedule (for example, Full-time, Part-time);
- residence or worksite;
- a Covered Dependent's status (that is, a dependent becomes eligible or ineligible for benefits under the Plan);
- coverage made by your spouse or other Covered Dependent permitted under the spouse's or Covered Dependent's employer's benefit plan due to a Change Event;
- the availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO is added to or deleted from the Medical Program) (***not available for the Dependent Care FSA or Health Care FSA Programs***);
- an election made by your spouse or other Covered Dependent during an open enrollment period under your spouse's or other Covered Dependent's employer's benefit 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 July and your spouse changes coverage) (***not available for the Health Care FSA Program***);
- the cost of coverage during the Plan Year, but only if it is a significant increase or decrease (***not available for the Health Care FSA Program***); or
- your dependent care provider or cost of dependent care (a significant increase or decrease) (***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, 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 accident or health coverage for your child;
- you, your spouse, or other Covered Dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- you, your spouse, or other Covered Dependent become eligible for a Special Open Enrollment Period.

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 could not change your Medical Program elections, but you could change your elections relating to the Dependent Care FSA Program.
- If one of your dependents no longer qualifies as a Covered Dependent, you could cancel coverage for that dependent, but you could **not** cancel coverage for your other Covered Dependents.
- If you have single coverage and you marry, you may elect two-person or family coverage, as applicable.

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 Human Resources Department.

Procedures For Changing Elections Mid-Year

If you want to change an election because of a Change Event, you must submit a written request to the Human Resources Department and identify the event that resulted in the change. The change request must be filed on or before the date that is 30 calendar days after the date of the Change Event. The change in coverage generally will be effective as of the first payroll period following notification. If the Change Event is the birth or adoption of an Eligible Dependent Child, for example, 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 Benefit 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 you file a request for a change in coverage more than 30 days after the date of the Change Event, the requested change will not take effect, and you will have to wait until the next Open Enrollment Period, a Special Enrollment Period, or until you experience another consistent Change Event to make the change.

BENEFIT PROGRAMS

MEDICAL PROGRAM

For a description of the Medical Program benefits, please refer to the Booklet(s) provided for each Program Option by the Claims Administrator listed in the Benefit Program Information Chart.

DENTAL PROGRAM

For a description of the Dental Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program's Information Chart.

VISION PROGRAM

For a description of the Vision Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program's Information Chart.

LTD PROGRAM

For a description of the LTD Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program Information Chart.

LIFE/AD&D PROGRAM

For a description of the Life/AD&D Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program Information Chart.

EMPLOYEE ASSISTANCE PROGRAM

For a description of the EAP benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program Information Chart.

PRE-TAX PAYMENT PROGRAM

The Pre-Tax Payment Program is designed to help you pay your Benefit Contributions, on a pre-tax basis, for any Benefit Program. Your coverage under the Benefit Programs will be the same whether or not you participate in the Pre-Tax Payment Program, but if you participate, your taxes will be lower because your Benefit Contributions will not be subject to federal, state, most municipal, or Social Security taxes. Because your compensation is reduced, however, choosing this option may reduce other benefits that are based on your compensation, such as Social Security, life insurance, and disability insurance. For most employees, these benefit reductions are fairly small, particularly compared to the tax savings. In some cases, benefits might not be reduced at all. You should review your own situation carefully before making a choice.

If, for any reason, you are eligible for a Benefit Program at a time when you are not eligible to participate in the Pre-Tax Payment Program, you may enroll in that Benefit Program and pay any Benefit Contributions on an after-tax basis until you can begin to participate in the Pre-Tax Payment Program.

Benefit Options

Under the Pre-Tax Payment Program, you have a choice under the Plan to either:

- receive your full taxable compensation for a Plan Year through the College's normal payroll system and make your Benefit Contributions to the Benefit Programs on an after-tax basis through payroll deduction; or
- have a portion of your taxable compensation reduced, and have the College apply that amount to pay for your Benefit Contributions to the Plan *on a pre-tax basis*. If you choose to have your compensation reduced, this will, under current law, reduce your federal, state, most municipal, and Social Security taxes.

Reduction Of Compensation

The amount by which the College will reduce your compensation to make the Benefit Contributions will be stated in the Enrollment Forms. The College will set the Benefit Contributions and communicate them to you during the Open Enrollment Period for the Plan Year.

Treatment Of Benefit 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 as you will not be receiving compensation that can be reduced. If you remain eligible to continue your participation in the other Benefit Programs during the period of your unpaid leave, you will have to make your Benefit Contributions on an after-tax basis. 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 can continue to participate in the Pre-Tax Payment Program by having the compensation you receive be reduced during the leave as you elected in your Enrollment Forms, so long as you are still eligible to participate in the Benefit Programs.

OPT-OUT PROGRAM

General

The Opt-Out Program allows you to waive medical coverage for a Plan Year and receive instead a bonus of \$200 a month up to \$2,400 a year. This option is only available, however, if you have coverage under another medical plan, including Medicare or Medicaid. You will be asked to prove that you have other medical coverage when you sign up for the Opt-Out Program bonus during Open Enrollment. The \$2,400 bonus will be added to your second paycheck each month in equal payments throughout the Plan Year. Of course, money received directly in your paycheck as a cash bonus will be taxable income to you.

Loss Of Other Coverage

If, during the course of the Plan Year you lose your other coverage (for example, you chose to opt-out because you were covered under your husband's medical plan but your husband subsequently is laid-off and loses coverage under his employer's medical plan), you will be able to elect coverage under any College-provided medical coverage for which you are otherwise eligible if you enroll within 30 days of the event that caused you to lose that other coverage. If you do not enroll within this timeframe, you may not enroll until the next Open Enrollment Period. Your loss of coverage also will qualify as a Change Event, so that if you timely enroll in for medical coverage, you can make any Benefit Contributions on a pre-tax basis.

DEPENDENT CARE FSA PROGRAM

The Dependent Care FSA Program is designed to help you pay your Eligible Dependent Care Expenses with pre-tax dollars. This lowers your income that is subject to federal, state, most municipal, and Social Security taxes. In effect, the money saved on taxes helps pay part of the Eligible Dependent Care Expenses normally paid with after-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 Spending 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 bookkeeping 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:

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

If your spouse has not earned any income from employment, but is a Full-Time Student or 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.

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 also reduce your contribution to the extent necessary to comply with the Code's nondiscrimination requirements.

Amount That Can Be Reimbursed To Participants

The Dependent Care FSA Program reimburses you for a Claim only to the extent of the balance in your Dependent Care Account. If the balance 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. You can carry over unpaid amounts to a subsequent Plan Year, but only through to the end of the Grace Period. Eligible Dependent Care expenses incurred after the Grace Period cannot be paid from amounts in your Dependent Care Account from the prior 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 mentally or physically disabled spouse or tax dependent (regardless of age) who is physically or mentally incapable to care for himself or herself and resides with you for at least one-half of your tax 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 Incurred for household services or care of a Qualifying Individual necessary to enable you to be gainfully employed. Eligible Dependent Care Expenses also include Social Security and unemployment taxes paid by you on behalf of the person who cares for your Qualifying Individual.

Expenses for care at a dependent care center may be claimed only if the center: provides care for more than six individuals, other than those who reside at the facility; receives a fee, payment, or grant for providing the services, regardless of whether the center is operated for profit; and complies with all applicable state and local laws and regulations.

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

Ineligible Dependent Care Expenses

There are certain kinds of dependent care expenses that do not qualify for dependent care reimbursement. These "**Ineligible Dependent Care Expenses**" include:

- expenses paid on behalf of an individual who is not a Qualifying Individual;
- expenses paid to your spouse, a parent of a Qualifying Individual child, your or your spouse's tax dependent, or your Child under age 19, to care for a Qualifying Individual;
- expenses for which you have received or will receive federal dependent care tax credits;

- expenses in excess of your annual elected amount or the maximum amount under the Dependent Care FSA Program;
- expenses paid to an ineligible provider (for example, 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, unless they were Incurred during the 75-day period following the close of a Plan Year (*i.e.*, between November 1 and January 14), if you were covered on the last day of that Plan Year (*i.e.*, October 31) (the “**Grace Period**”);
- expenses Incurred for food, clothing, or education, unless incidental to and inseparable from the care provided (for example, nursery school expenses are considered Eligible Dependent Care 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 furnished by a dependent care provider may be reimbursable if the expenses are otherwise Eligible Dependent Care Expenses;
- expenses for which there is no satisfactory proof of payment;
- expenses for which the name, address and Social Security number of the dependent care provider has not been reported to the Claims Administrator; and
- expenses Incurred on or before January 14, but claimed later than the March 30 following the end of the Plan Year.

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	<u>3,000</u>	<u>N/A</u>
Your Taxable Income	57,000	60,000
Your Income Taxes (25%)	14,250	15,000
Your Post Tax Dependent Care Expenses	<u>0</u>	<u>3,000</u>
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 determine that reimbursement under the Dependent Care FSA Program is more advantageous to you than the \$6,000 maximum federal dependent care tax credit.

The federal dependent care tax credit is reduced by the amount that the Dependent Care FSA Program reimburses you for child care expenses. For example, if you have two Qualifying Individuals for whose care you incur \$7,000 in dependent care expenses, and you pay \$5,000 on a tax-free basis through the Program, you cannot take a tax credit with respect to the entire remaining \$2,000; you can only take a tax credit of \$1,000. If you paid only \$4,000 on a tax-free basis through the Dependent Care FSA Program, you could take the tax credit with respect to \$2,000.

Provider Information

When you submit your first Claim of each year, you must provide the Claims Administrator with information about the dependent care provider including the provider's name, address and Social Security number or employer identification number. 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."

Expenses Eligible Under More Than One Dependent Care Spending Account Program

If a dependent care benefit is payable under two or more dependent care spending account programs, you may submit a Claim for the expense to either program, but this Dependent 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

Because of 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 or its Grace Period, the amount remaining will be forfeited on the March 30 following the end of the Plan Year, and will not be returned to you. An expense is "**Incurred**" on the date the service that gives rise to the expense takes place. This definition applies not only to expenses under the Dependent Care FSA Program, but to expenses under all Benefit Programs of the Plan. Forfeited amounts will be used to pay the administration expenses of the Dependent Care FSA Program.

Termination Of The Dependent Care FSA Program

In the event the Dependent Care FSA Program is terminated, any amounts in your Dependent Care Account will remain available for reimbursement of expenses Incurred during the Plan Year while the Program was in effect until 90 calendar days after the date of termination of the Program.

Participation During An Unpaid Leave Of Absence

If you take an unpaid leave of absence that is not short-term or temporary, based on the particular facts and circumstances of your leave, whether or not FMLA-qualified, you may not be able to participate in the Dependent Care FSA Program during the period of 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 Benefit Contribution election.

You should contact the Human Resources Department 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. This lowers your income that is subject to federal, state, most municipal, and Social Security taxes.

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**") for you for that Plan Year. Your Health Care Account will be credited each pay period with the Benefit Contribution amount

you authorized. Your Health Care Account is for bookkeeping purposes only. The amounts credited to your Health Care Account are not assets that belong to you.

Annual Contribution Amount

You may contribute up to \$3,000 each Plan Year to your Health Care Account. 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 annualized value of the 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 the annual maximum of \$3,000 under the Health Care FSA Program, you may be reimbursed in full for a \$3,000 Claim Incurred on your first day of participation in the Health Care FSA Program.

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, or during the Grace Period.

A "**Qualified Dependent**" is:

- your spouse, or
- any individual that you can claim as a dependent on your federal income tax return under Code Section 152.

"**Eligible Health Care Expenses**" are expenses that qualify as medical care under Sections 213(d)(1)(A) and (B) of the Code and are for the benefit of 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 related services. Eligible Health Care Expenses do not include payment for long-term care services or insurance premiums other than COBRA premiums.

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

- hospital expenses;
- medical, dental, or vision expenses;
- over-the-counter medications or drugs purchased for medical care;
- prescription drugs; and
- insurance deductibles and copayments that are not reimbursed by another insurance plan or reimbursement account.

Ineligible Health Care Expenses

There are certain kinds of “**Ineligible Health Care Expenses**” that do *not* qualify for reimbursement. These include:

- expenses paid on behalf of an individual who is not a Qualified Dependent;
- expenses that are payable under any other insurance plan or group health plan (including one sponsored by the College) or that were paid under another employer’s health care spending account 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);
- expenses for which you have received, or will receive, an itemized deduction on your federal tax return;
- expenses for premiums for insurance not provided by your employer (for example, premiums paid for your spouse’s insurance);
- expenses in excess of the annualized elected amount;
- expenses Incurred during a time you were not covered by the Health Care FSA Program, unless they were Incurred during the Plan Year (*i.e.*, on or before October 31) or the immediately following Grace Period (*i.e.*, from November 1 through January 14);
- expenses for which you have not provided satisfactory proof of payment; and
- expenses Incurred on or before January 14, but claimed later than the March 30 following the end of a Plan Year.

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	<u>1,500</u>	<u>N/A</u>
Your Taxable Income	28,500	30,000
Your Income Taxes (25%)	7,125	7,500
Your Post-tax Health Care Expenses	<u>0</u>	<u>1,500</u>
Your Net Take Home Pay	\$21,375	\$21,000
Your Tax Savings	\$375	N/A

Federal Itemized Deduction

You are not entitled to receive both a federal itemized deduction for medical expenses and a 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 their 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

Because of Code requirements, 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 or its Grace Period, the amount remaining will be forfeited on the March 30 following the end of the Plan Year, and will not be returned to you. Forfeited amounts will be used to pay the administration expenses of the Health Care FSA Program.

Termination Of The Health Care FSA Program

In the event the Health Care FSA Program is terminated, any amounts in your Health Care Account will remain available for reimbursement of expenses Incurred during the Plan Year while the Health Care FSA Program was in effect until 75 calendar days after the date of termination of the Health Care FSA Program.

Participation During An Unpaid Leave Of Absence

If you take an unpaid leave of absence that qualifies under the FMLA, you have the following options under the Health Care FSA Program:

- Revoke your coverage under the Health Care FSA Program and discontinue making contributions to your Health Care Account. You are not entitled to receive reimbursements for Claims Incurred during the period your Health Care FSA Program coverage is terminated. Upon your return from your leave during the same Plan Year, you resume participation in the Health Care FSA Program and your Health Care Account is reinstated. When you begin again to participate in the Health Care FSA Program, you may either:
 - resume coverage at the level in effect before your leave started and increase your before-tax salary reductions for the remaining portion of the Plan Year to make up the unpaid before-tax contributions; or

- resume coverage under the Health Care FSA Program at a reduced level (the level of coverage is pro-rated for the period during which no contributions were made) and keep your Benefit Contributions 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, but discontinue contributions. The full annualized value of the 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 Benefit Contributions automatically will resume and be increased for the remaining portion of the Plan Year to catch-up on the contributions missed during your leave.
- Continue your coverage under the Health Care FSA Program during your leave and make contributions on an after-tax basis. The full annualized value of the 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 your leave, your pre-tax Benefit Contributions will resume at the same level as was in effect before your leave started.

If you take an unpaid leave of absence that does not qualify under the FMLA, coverage under the Health Care FSA Program will end as of the last day of the calendar month during which your leave began. You are not entitled to receive reimbursement for Claims Incurred during your leave. Upon your return to work, you may resume your participation in the Health Care FSA Program and make a new Benefit Contribution election in accordance with the Plan enrollment and Change Event rules.

You should contact the Human Resources Department before taking a leave of absence.

IMPORTANT INFORMATION ABOUT THE PLAN

The claims filing and review procedures described below will apply to the EAP, the Pre-Tax Payment, Opt-Out and Health Care and Dependent Care FSA Benefit Programs. For the insured Benefit Programs and the self-funded Dental and Vision Benefit Programs, the Booklets distributed by the insurer or the Claims Administrator listed in the Benefit Program Information Chart will describe the claims filing and review procedures for those Benefit Programs. Always check the appropriate insurance or benefit Booklet when filing a Claim or seeking review of a denied Claim for an insured benefit.

CLAIM FILING AND REVIEW PROCEDURES

Whenever you wish to receive benefits under the Plan, you must file a Claim for benefits with the Plan. Only those Claims that are for covered benefits under the Plan will be paid. A **"Claim"** is any request for a Plan benefit made by a claimant in accordance with the Plan's reasonable procedures for filing benefit Claims. If your Claim is denied, you have a right to an appeal of that denial by the Claims Administrator. The Plan's procedures for filing a Claim and

for requesting an appeal of a denied Claim are explained below and differ depending on the kind of Claim that is filed.

Time limits apply to you for filing a Claim, providing more information to complete a Claim, and appealing a denied Claim. The Claims Administrator also must comply with time limits for notifying you of an improper or incomplete Claim, deciding your initial Claim, and reviewing your appeal of denied Claim. At the end of this section, a Claim Procedures Time Limits Chart lists all these time limits.

For purposes of these Claim filing and appeal procedures, the entity or individual that is responsible for determining your Claim under a particular Benefit Program is always referred to as the "**Claims Administrator.**" This reference applies to the Plan Administrator or a third party hired by the Plan Administrator for the Self-funded Benefit Programs and it applies to an insurance company or a Claims Administrator designated by the insurance company for the insured Benefit Programs. Refer to the Benefit Program Information Chart for the Claims Administrator for each Benefit Program. The Claims Administrator who reviews a denied Claim may be different than the Claims Administrator who reviews the initial Claim.

General Procedures For All Benefit Programs

Authorized Representatives

You may appoint an authorized representative to deal with the Plan on your behalf with respect to any benefit Claim that you file or any appeal of a denied Claim that you choose to pursue. The Human Resources Department has forms that you may fill out at any time, identifying for the Plan the person you wish to appoint as your authorized representative. The Plan will only recognize the person you have authorized on the last dated form you filed with the Plan. For the Medical, Dental, Vision, EAP, and Health Care FSA Programs, your health care provider with knowledge of your condition will also be treated as your authorized representative. Once you have appointed an authorized representative, the Claims Administrator will communicate directly with your representative, and will not also inform you of the status or outcome of your Claim; you will have to seek that information from your representative. If you have not appointed a representative, the Claims Administrator will communicate with you directly. Claims may be filed and an appeal of any denied Claim may be sought by any employee participating in the Plan, any Covered Dependent, or any properly authorized representative.

Notice Of Initial Claim Denial

If your initial Claim under any Benefit Program is denied in whole or in part, the Claims Administrator will provide to you in writing or electronically (for example, by e-mail) an explanatory notice ("**Notice of Initial Claim Denial**"). Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, is a Claim denial. This includes any determination based on the eligibility of the person on whose behalf the expense was Incurred or whether the expense itself is eligible for reimbursement.

Notice Of Denial On Appeal

If you appeal the initial denial of your Claim, and your Claim is denied in whole or in part on appeal, the Claims Administrator will provide to you in writing or electronically (for example, by e-mail) an explanatory notice ("**Notice of Denial on Appeal**").

The decision of the Claims Administrator following the decision on appeal is final, unless you elect to proceed to an additional voluntary level of appeal offered by the Plan, if any.

Claim Review Procedures

In all cases where your Claim has been denied, in whole or in part, you will receive a written Notice of Initial Claim Denial. If you receive a Notice of Initial Claim Denial and you disagree with that decision, you must file an appeal of that decision by submitting your appeal to the Claims Administrator listed in the Benefit Program Information Chart. Your appeal must be in writing, and transmitted either by mail or any reasonably available electronic media. Your appeal must include an explanation of why you think your Claim should not have been denied and any additional information, materials, or documentation supporting your Claim.

Depending on the Claims Administrator for these Benefit Programs, you may have one or two required levels of appeal and voluntary levels of appeal. Refer to each Benefit Program's Booklet to find out whether the Claims Administrator has one or two required levels of appeal or any voluntary levels of appeal.

You will be notified in writing of each decision on appeal, whether favorable or adverse, within the time frames listed in the Claims Procedures Time Limits Chart or the Booklets of the Claims Administrators listed on the Benefit Program Information Chart.

If the Benefit Program option has two required levels of appeal and you disagree with the first-level appeal decision, you must complete a second level of appeal on your Claim. You must submit your request for second-level appeal to the Claims Administrators listed in the Benefit Program Information Chart.

State-Sponsored External Claim Review Procedures For Insured Health Care Benefits

With respect to any health care benefits insured by a company subject to the insurance laws and regulations of the State of Michigan, if you disagree with the Claims Administrator's final decision following whatever required or voluntary levels of appeal are available, you may request an external review from the Michigan Office of Financial and Insurance Regulation ("**OFIR**"). Once you have exhausted the internal appeal procedures described above, you or your authorized representative has the right to request an external review from OFIR. This external review procedure is voluntary and you are not required to seek to have your Claim reviewed under this procedure in order to have your Claim determined by a court.

For expenses insured by companies subject to the insurance laws of other states, there may be a comparable procedure available. Please look in the applicable benefits Booklet or certificate to find out if such a program is available.

Within 60 days of the date you either received a final determination on appeal, or should have received it, you may send a written request for an external review to OFIR. Mail your request, including the required forms that may be obtained from the Claims Administrator, to:

Office of Financial and Insurance Regulation
Office of Policy, Conduct and Consumer Assistance, Health Plans Division
Benefit Inquiry Section
P.O. Box 30220
Lansing, MI 48909-7720
(877) 999-6442

If your request for external review involves an issue of medical judgment, and is otherwise found to be appropriate for external review (a decision to be made by OFIR), OFIR will send your Claim to an Independent Review Organization ("**IRO**"), consisting of independent clinical peer reviewers. You will have an opportunity to provide additional material to OFIR within seven days after you submit your request for an external review. The insurance carrier must give documents and information which it considered in making its final determination to the IRO within seven business days after it receives notice of your request to the Commissioner. The IRO will recommend, within 14 days, whether OFIR should uphold or reverse the insurance carrier's determination of your Claim. OFIR must then decide within seven business days whether or not to accept the IRO's recommendation and will notify you of its decision. OFIR's decision is the final administrative remedy under Michigan's Patient's Right to Independent Review Act.

If your request for external review is related to a non-medical issue, and is otherwise found to be appropriate for review, OFIR's staff will conduct the external review. OFIR's staff will then recommend whether OFIR should uphold or reverse the insurance carrier's determination. OFIR will notify you of the decision, and that decision is your final administrative remedy.

If your request for an external review involves an Urgent Care Claim, and if you have filed a request for an expedited internal appeal, you may request an expedited external review procedure from OFIR. To request the expedited procedure, you or your authorized representative must send your request, in writing, and within 10 days of your receipt of the insurance carrier's denial, termination or reduction of the benefit to which you believed you are entitled, including the required forms which can be obtained from the insurer, to:

Office of Financial and Insurance Regulation
Office of Policy, Conduct and Consumer Assistance, Health Plans Division
Benefit Inquiry Section
P.O. Box 30220
Lansing, MI 48909-7720
(877) 999-6442

Immediately after receiving your request for an expedited review, the OFIR will decide if your Claim is appropriate for external review and assign it to an IRO. If the IRO decides that you do not have to first complete the expedited internal review procedure, it will review your request and make its recommendation to the OFIR within 36 hours. The OFIR must then decide within 24 hours whether or not to accept the recommendation of the IRO. The OFIR's decision is the final administrative remedy under Michigan's Patient's Right to an Independent Review Act.

Claims For Pre-Tax Payment, Opt-Out, EAP, And Dependent Care FSA Programs

Filing A Claim

Pre-Tax Payment And Opt-Out Programs

For the Pre-Tax Payment and Opt-Out Programs, you do not need to file a specific Claim for benefits. Once you enroll in the programs, the benefits automatically follow. If for any reason, however, you believe you have been improperly excluded from participation in the Pre-Tax Payment and Opt-Out Programs, you may file a formal Claim in writing to the Claims Administrator. Be sure to state:

- why you think you should receive the benefits available under the Pre-Tax Payment and Opt-Out Programs,
- why you think you have not been getting the benefits and
- your name and Social Security number.

Notice of the decision on your Claim under the Pre-Tax Payment and Opt-Out Programs will be issued within a reasonable time period, but no later than the time periods specified in the Claims Procedures Time Limits Chart.

EAP Program

For the EAP Program, it should not be necessary to file a Claim since the consultation regarding the problem you called about will take place directly over the phone. If, however, you have a problem with getting your call answered or your problem addressed in a satisfactory manner, you should file a claim with the Claims Administrator listed in the Benefit Program Information Chart. You should include information sufficient to identify yourself, the person at the EAP Program with whom you interacted and a complete description of the problem you encountered. If you were advised and scheduled to receive treatment for your problem from a health care provider, and your claim is about that part of your treatment, you should file a claim under the Medical Program procedures.

Dependent Care FSA Program

You must file a proper Claim to receive reimbursement of Eligible Dependent Care Expenses under the Dependent Care FSA Program. Claims for reimbursement must be submitted on Claim forms available from the Human Resources Department. You can file a Claim at any time during the Plan Year, or up to the March 30 following the end of the Plan Year as explained below.

If you submit a proper Claim, the Claims Administrator will reimburse you out of your Dependent Care Account for Eligible Dependent Care Expenses. All Claims must meet each of the requirements described in the Dependent Care FSA Program section of this Plan and each of the following additional important requirements.

- The Claim must be for a paid expense that was Incurred during the Plan Year, or during the Grace Period.

- The Claim must be made on a form available from the Human Resources Department, and must include:
 - the amount, date, and nature of the expense;
 - the name, address, and the federal taxpayer identification number or employer identification number of the person, organization, or entity to which the expense was or is to be paid;
 - the name of the person for whom the expense was Incurred, and the relationship of that person to you;
 - the amount recovered or recoverable from any other source with respect to the expense; and
 - written evidence from an independent third party stating that the expense has been Incurred, the amount of the expense (for example, bills, invoices, receipts, or other writings showing the amount of the expense).

If you discontinue participation in the Dependent Care FSA Program during the Plan Year, dependent care expenses Incurred after discontinuation in the Program will **not** be eligible for reimbursement, regardless of whether funds remain in your Dependent Care Account. If you terminate your employment with the College before the end of the Plan Year for which you have established a Dependent Care Account, any amounts remaining in your Account will remain available for reimbursement of Eligible Dependent Care Expenses Incurred while you were a Participant in the Dependent Care FSA Program for 75 days following your date of termination.

The Claims Administrator will review all Dependent Care FSA Program Claims that are submitted and reserves the right to deny ineligible or improperly documented expenses and require additional verification of expenses. Deliberate submission of Ineligible Dependent Care Expenses may result in your removal from the Dependent Care FSA Program.

Decision On Your Initial Claim

Notice of the decision on your Claim will be issued within a reasonable time period, but no later than the time periods specified in the Claims Procedures Time Limits Chart.

Claim Review Procedures

If your Claim for benefits under the EAP, the Pre-Tax Payment, Opt-Out, and Dependent Care FSA Programs is denied, in whole or in part, and you disagree with this decision, you must make a written appeal to the Benefit Program's Claims Administrator for a review of the denial of your Claim. Your appeal must be submitted to the Claims Administrator at the address listed in the Benefit Program Information Chart.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your appeal to the Claims Administrator.

The review on your appeal will take into account all comments, documents, records, and other information submitted by you relating to your appeal, even if that information was not submitted or considered in the initial decision of your Claim. The Claims Administrator will make its decision on your appeal within a reasonable time, but no later than the time periods indicated in the Claims Procedures Time Limits Chart.

Claims For The Health Care FSA Program

Filing A Claim

You must file a proper Claim to receive reimbursement of Eligible Health Care Expenses under the Health Care FSA Program. Claims must be submitted on the Claim forms available from the Human Resources Department. You can file a Claim at any time during the Plan Year, or up to the March 30 following the end of the Plan Year.

If you submit a proper Claim, the Claims Administrator will reimburse you out of your Health Care Account for Eligible Health Care Expenses. All Claims must meet each of the requirements described in the Health Care FSA Program section of this Plan and must be for an expense that was Incurred during the Plan Year, or during the Grace Period.

If you discontinue participation in the Health Care FSA Program during the Plan Year, and you subsequently incur additional expenses, then these new Claims will **not** be eligible for reimbursement, regardless of whether or not funds remain in your Health Care Account. If you terminate your employment with the College before the end of the Plan Year for which you have established a Health Care Account, any amounts remaining in your Health Care Account will remain available for reimbursement of Claims Incurred while you were a Participant until 75 days following your termination date.

The Claims Administrator will review all Claims submitted and reserves the right to deny ineligible or improperly documented expenses and require additional verification of expenses. Deliberate submission of ineligible Claims may result in your removal from the Health Care FSA Program.

Filing Debit Card Claims

Upon enrollment in the Health Care FSA Program, the College will issue you a debit card to pay for Eligible Health Care Expenses. The card can be used wherever MasterCard is accepted. You may use this card to pay for Eligible Health Care Expenses or you may pay using cash or a check and seek reimbursement by filing a paper Claim.

At the time of enrollment, and each Plan Year thereafter, you will be required to sign a form certifying that you will only use the debit card for Eligible Health Care Expenses for yourself and your Eligible Dependents. This certification will also be printed on the back of the card. Each time you pay for an Eligible Health Care Expense by using the card, you reaffirm the certification. Your card will be cancelled if you fail to sign the certification form for any Plan Year.

The debit card will only be effective at merchants or providers with merchant codes (which are verified at the time of use) that relate to health care, and is only valid up to the value of your Health Care Account. Each time you use the card, your Health Care Account balance, as applicable, will be reduced by the amount of the transaction.

You must obtain a **“Third Party Statement”** from the merchant or provider (for example, a receipt, invoice, *etc.*) each time you use the card that includes the following information:

- The nature of the expense (for example, what type of service or treatment was provided). If the expense is for an over-the-counter drug or medication, the written statement must indicate the name of the drug.
- The date the expense was Incurred.
- The amount of the expense.

You must retain this receipt for one year following the close of the Plan Year in which the expense is Incurred to prove that you used the debit card for an Eligible Health Care Expense. Under certain circumstances, the Claims Administrator must substantiate debit card transactions and will request that you submit a Third Party Statement, along with the following information:

- the name and address of the person, organization or entity to which the expense was paid;
- the name of the person for whom the expense was Incurred, and the person’s relationship to you; and
- the amount recovered or recoverable from any other source with respect to the expense.

You must provide the Third Party Statement, along with the other above information, to the Claims Administrator on or before the date that is 45 days (or such longer period provided in the letter from the Claims Administrator) after the date of the request. If you fail to provide a Third Party Statement or other proof that your Claim is for an Eligible Health Care Expenses within this time period, or it is determined that you have used the card for an Ineligible Health Care Expense, your use of the card will be suspended until such a statement or other proof is provided, or the Plan is reimbursed by you for the Ineligible Health Care Expense. You should always obtain and keep a sufficient receipt or invoice from the merchant or provider so that you can provide it to the Claims Administrator upon request.

If one of the following exceptions applies, the Claims Administrator will not require you to provide a written Third Party Statement:

- The dollar amount of the transaction equals the dollar amount of the Copayment, if any, for that Eligible Health Care Expenses;
- The transaction is a recurrence of a previously approved Eligible Health Care Expenses as to amount, provider, and time period; or
- The merchant or provider, at the time of the transaction, provides information to verify that the charge is for an Eligible Health Care Expenses. This information may be provided by telephone, mail, e-mail, the internet, or any other method acceptable to the Claims Administrator.

If you did not pay for an Eligible Health Care Expenses with your debit card, you must file a paper Claim in order to receive reimbursement.

Filing Paper Claims

To file Paper Claims, you need to submit the Claim on the Claim forms available from the Human Resources Department or from the Claims Administrator listed in the Benefit Program Information Chart. Although you may submit more than one Claim each payroll period, Claims may be accumulated whenever possible and paid together bi-weekly or at other reasonable intervals. Your Claim must include the following:

- the amount, date and nature of the expense;
- the name and address of the person, organization or entity to which the expense was paid;
- the name of the person for whom the expense was Incurred, and the relationship of that person to you;
- the amount recovered or recoverable from any other source with respect to the expense; and
- written evidence from an independent third party stating that the expense has been Incurred, the amount of the expense (for example, bills, invoices, receipts, or other writings showing the amount of the expense).

If you terminate your employment with the College before the end of the Plan Year for which you have established a Health Care Account, any amounts remaining in your Health Care Account will remain available for reimbursement for Eligible Health Care Expenses Incurred while you were a participant in the Health Care FSA Program for 75 days following your date of termination.

Decision On Your Initial Claim

Notice of the decision on your Claim will be issued within a reasonable time period, but no later than the time period specified in the Claims Procedures Time Limits Chart.

Claim Review Procedures

If your initial Claim for benefits is denied and you disagree with this decision, you must make an appeal to the Claims Administrator for a review of that decision.

Your appeal must be in writing, and transmitted either by mail or any reasonably available electronic media to the Claims Administrator listed in the Benefit Program Information Chart. Your appeal must include an explanation of why you think your Claim should not have been denied. You must include any additional information, materials or documentation that you believe supports your Claim.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your appeal to the Claims Administrator.

The person(s) reviewing your appeal will grant no deference to the original Claim denial, and will assess the information you provide as if they were looking at your Claim for the first time. Also, the person(s) reviewing your appeal will not be the same person(s) who made the determination on your initial Claim, nor will they be subordinates to those individuals.

If the initial Claim denial was based on a medical judgment, the Claims Administrator will consult with an expert in the appropriate field when reviewing the appeal. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your appeal, will be retained as information relevant to your Claim.

The Health Care FSA Program has only one level of appeal. The Claims Administrator will make its decision on your appeal within a reasonable time, but no later than the time periods indicated in the Claims Procedures Time Limits Chart. There are no time extensions permitted for making appeal decisions.

Claims Procedures Time Limits

Time Limits For The EAP, Pre-Tax Payment, Opt-Out, Health Care and Dependent Care FSA Benefit Programs

Claims Administrator's Notice of Initial Claim Denial	90 days after receiving the initial Claim. 180 days after receiving the Claim if the Claims Administrator needs extension for special circumstances and if Claims Administrator provides an extension notice during initial 90-day period.
Participant Deadline to Appeal Decision	60 days after receiving the Claim denial.
Claims Administrator's Notice of Appeal Decision	60 days after receiving the request for appeal. 120 days after receiving the request for appeal if Claims Administrator needs an extension.

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 the Claims Administrator of the insured Benefit Programs identified in the Benefit Program Information Chart.

With respect to the Self-funded benefits, the Plan will coordinate with:

- another "**Group Health Plan**" (including any employer-sponsored welfare benefit plan, whether or not insured, that provides medical or dental coverage, including prescription drugs), such as insurance provided by a spouse's employer;
- automobile accident insurance; and
- money you or your Covered Dependent could receive from another person or entity who caused the injuries on account of which a Claim was made.

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 the 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 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 patient as an employee, rather than as a dependent, will pay.
- Third: Then in the case of a Group Health Plan covering a patient who is a dependent and a 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 Group Health Plan (that also covers the Child) will pay;
 - then a Group Health Plan that covers the Child as a dependent of a custodial parent will pay;
 - then a Group Health Plan that covers the Child as a dependent of the spouse of the custodial parent will pay;
 - then a Group Health 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 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 later in the year will pay.
- Sixth: Then the Group Health Plan that has covered the patient for the longer period of time will pay.
- Seventh: 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 Automobile Accident Insurance

The Plan coordinates payment of its health care benefits in accordance with the coordination of benefit provisions of Michigan's No-Fault Automobile Insurance Act, MCL § 3109a.

You are considered covered under an automobile insurance policy if you are:

- an owner or principal named insured under the policy;
- a family member of a person insured under the policy; or

- a person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

If you do not have automobile insurance coverage even though you are legally required to do so, the Plan will not pay more benefits than it would have paid if you had purchased standard automobile insurance coverage.

Coordination With Medicare

The general rule is that the Plan will be Secondary to Medicare in all circumstances where federal law does not require the Plan to be Primary. If you are covered under the Medical Benefit Program and you or your spouse are over 65 years old and eligible for Medicare, you may reject coverage in this Plan and rely on Medicare as your sole source of coverage. If you do not reject coverage under this Plan, you will have coverage under both this Plan and Medicare, and Medicare will be Secondary.

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.

It is your responsibility to apply for Medicare benefits that are available. If Medicare is Primary under these rules, the Plan will calculate the benefits it provides as if you were enrolled in Medicare, regardless of whether you have applied.

Coordination With Third Parties

If a third party negligently or tortiously causes a health problem on account of which you have Incurred medical expenses, the Plan is Secondary to the third party's liability to you. If benefits are available under any insurance policy as a result of this negligent or tortious conduct, the Plan is Secondary to those benefits.

Facility Of Payment

If an expense or benefit that should have been paid by the Plan is paid by another person or entity, the Plan may pay to that person or entity any amount that it considers necessary to satisfy the intent of the Plan's coordination provisions. The Plan will then have no further liability for those expenses or benefits.

Subrogation/Right Of Recovery

The subrogation rights and rights of recovery with respect to the insured Benefit Programs are explained in the applicable provision of the various insurance policies and Booklets provided by the insurance companies and their designated Claims Administrators. The subrogation and rights of recovery for the Dental and Vision Programs are set forth in the Booklet provided by the Claims Administrator for those Benefit Programs.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("**COBRA**") gives you and your Covered Dependents the right to continue coverage under the Medical, Dental, Vision, EAP, and Health Care FSA Programs beyond the time the coverage would normally end ("**Continuation Coverage**"), under certain circumstances. COBRA Continuation Coverage can become available to you and your Covered Dependents when you or they would otherwise lose group health 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.

The American Recovery and Reinvestment Act of 2009 ("**ARRA**"), signed into law on February 17, 2009, changes some of the rules about how COBRA benefits are to be provided and administered. To find out about the new rules, read the sub-section entitled "COBRA Under the ARRA." Note, however, that the new rules under the ARRA will not apply to any individual who first becomes COBRA-eligible on or after January 1, 2010.

Continuation Coverage is the same coverage that you and your dependents were entitled to under the Plan, and should you elect Continuation Coverage, will be the same coverage available to other participants or beneficiaries who are not receiving Continuation Coverage. **[INSERT THE FOLLOWING SENTENCES IF YOU, THE EMPLOYER, CHOOSE TO PROVIDE THE ELECTION OF A LESS COSTLY BENEFIT OPTION: If you are an "Assistance Eligible Individual," you have the opportunity to elect less costly coverage options available under the Plan. See "COBRA Under the ARRA" below.]** Upon the occurrence of one of the Qualifying events listed below, you will have the opportunity to continue the coverage you had under the Plan(s) immediately prior to the occurrence of the event. Each person who is qualified and who elects Continuation Coverage will have the same rights under the Plan as other participants and beneficiaries, with respect to whom none of these events occurred, including open and special enrollment rights.

COBRA Continuation Coverage for the Plan is administered by the "**COBRA Administrator**," whose name, address, and phone number can be found in the Benefit Program Information Chart.

Qualifying Events

COBRA Continuation Coverage is a continuation of coverage under the Medical, Prescription Drug, Dental, Vision, EAP, or Health Care FSA Programs when coverage would otherwise end on account of a life event known as a "**Qualifying Event**." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone who will lose coverage under the Plan because of a 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 College where you are not eligible to participate in the Plan.
- Your employment ends for any reason other than your gross misconduct.

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 are divorced or legally separated from your spouse.
- Your hours of work are reduced or you move to a position with the College 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 (under Part A, Part B, or both).

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 College 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 (under Part A, Part B, or both).
- Your Child stops being eligible for coverage under the Plan as a dependent Child.

Sometimes, a bankruptcy filing with respect to the Company 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

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the COBRA Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the reduction of your hours or end of your employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the College must notify the COBRA 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 COBRA Administrator within 60 days after the Qualifying Event occurs. You must provide written notice of the Qualifying Event to the COBRA 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 COBRA 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 COBRA Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. To elect Continuation Coverage, you must complete the election form and send it in according to the directions 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 for 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 Continuation Coverage, you will be provided with a written explanation of why the election of Continuation Coverage could not be honored.

If you are an assistance eligible individual who was involuntarily terminated after September 1, 2008, and previously had not elected COBRA Continuation Coverage, you will be notified of your second chance to elect COBRA. See "COBRA Under the ARRA" below.

In considering whether to elect COBRA Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, other Group Health Plans can apply pre-existing conditions exclusions to you if you have more than a 63-day gap in health coverage; election of COBRA Continuation Coverage may help you avoid a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies without pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. 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 days after your Group Health Plan 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.

If you do not choose Continuation Coverage, or if it is determined that you are not eligible for Continuation Coverage, your group health coverage will end.

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.

If you are an Assistance Eligible Individual, you may qualify for the COBRA subsidy, allowing you to pay only 35% of the premium. See "COBRA Under the ARRA" below.

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 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) 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 COBRA Administrator 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 dates 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 days after the first day of each coverage period to make each periodic 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 either the amount paid will be deemed payment in full for that period or you will be asked to pay the shortfall. If the notice says the shortfall must be paid and you do not pay within 30 days after the date the notice is received, COBRA Continuation Coverage will end retroactive to the date the shortfall payment was due.

Duration Of 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;

- for your Covered Dependents for 36 months 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, when the Qualifying Event is your end of employment or reduction in your work hours, and you enrolled in Medicare fewer than 18 months before the Qualifying Event, for 36 months after the date you enrolled in Medicare. For example, if you enrolled in Medicare eight 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.

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

- any required premium payment was due but not timely paid;
- after electing COBRA Continuation Coverage, a Qualified Beneficiary:
 - becomes covered under another employer's Group Health Plan that does not impose any pre-existing condition exclusion for a Qualified Beneficiary's pre-existing condition; or
 - becomes enrolled in Medicare benefits, under Part A or Part B, or both; or
- the College 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. 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 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.

Newborns and Adopted Children

If you or your spouse elect Continuation Coverage, any child born to, or adopted by, you and your spouse during the period of Continuation Coverage will also be entitled to Continuation Coverage for the maximum period of coverage available to any family member.

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: if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Plan or COBRA 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 or COBRA 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 and must last at least until the end of the 18-month period of COBRA Continuation Coverage.

You or a Covered Dependent must notify the Plan or COBRA 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. This disability notice must include the name of the disabled person, the effective date of the Social Security Administration's disability determination, and any accompanying documentation.

Each Qualified Beneficiary who has elected COBRA Continuation Coverage on account of your employment-related Qualifying Event 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 or COBRA 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 another 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), or get 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 or COBRA Administrator within 60 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.*

Bankruptcy

If you have Plan coverage as a retiree from the College and if the College substantially eliminated the coverage you or your covered dependents would otherwise have within one year before or after the date the College begins a bankruptcy proceeding, you and/or your Covered Dependents also have the right to continue coverage under the Plan, at your/their expense.

The procedure for continuing coverage and your cost is the same as stated above. Coverage will continue until the earliest of the following:

- the last day of the period for which a premium payment has been paid;
- the date, after the date of election of Continuation Coverage, the person continuing coverage first becomes covered under another employer's group health plan that does not contain any exclusion or limitation that affects coverage of a covered individual's pre-existing condition;
- the date the College terminates all of its group health plans;
- the date the person continuing coverage dies;
- 36 months from the date the covered retiree dies; or
- the date coverage ends under ERISA or the Code.

COBRA Under the ARRA

Assistance Eligible Individuals

- The ARRA provides a 65% government subsidy, allowing Assistance Eligible Individuals to pay only 35% of the COBRA premium. "**Assistance Eligible Individuals**" are COBRA-eligible employees who are involuntarily terminated from employment (for reasons other than gross misconduct) between September 1, 2008, and December 31, 2009, and their covered Dependents. Assistance Eligible Individuals include those who: (i) had elected COBRA and were covered under the Plan as Qualified Beneficiaries as of February 17, 2009, (ii) had elected COBRA, but were no longer covered as of February 17, 2009 because of a failure to timely pay the premium, (iii) did not elect COBRA at the time it was initially offered, or (iv) become eligible for COBRA as a result of an involuntary loss of employment after February 17, 2009, but on or before December 31, 2009.

Assistance Eligible Individuals are required to pay only 35% of the COBRA premium that they would have had to pay, and the employer will be entitled to a government subsidy for paying the remaining 65% of that COBRA premium. The subsidy applies to any family members of the Assistance Eligible Individual. The subsidy is available only for a maximum of nine months. The subsidy is not taxable income to the Assistance Eligible Individual and it will not be treated as eligible income for any public assistance or benefit program.

Second Chance to Elect

Assistance Eligible Individuals who do not have COBRA coverage on the Effective Date will have a second chance to elect COBRA. The period of coverage will be deemed to have begun on the date coverage was originally lost due to the involuntary termination of employment and will not apply retroactively. The period of subsidized COBRA coverage will begin as of the first month the employee elects coverage after February 17, 2009, and end as explained in the "Scope of the Subsidy" provisions, below.

Special Appeals Procedures

If you are claiming treatment as an Assistance Eligible Individual and are denied such treatment, you have the right to an expedited appeal to the Secretaries of either Labor or DHHS (in consultation with the Secretary of the Treasury) with a determination to be made within 15 days. Such review will be de novo and will be final.

Scope of the Subsidy

- The subsidy is available only for periods of COBRA coverage that begin on or after February 17, 2009. Where the COBRA period begins on the first of the month, this will be March 1, 2009. The COBRA subsidy will terminate on the earlier of the date that is:
 - nine months from the first day of COBRA coverage beginning after February 17, 2009;
 - the end of the COBRA coverage period to which the Assistance Eligible Individual would be entitled;
 - the date the Assistance Eligible Individual loses coverage due to failure to pay the 35% of the premium he or she is responsible for; or
 - the date the Assistance Eligible Individual becomes eligible for coverage (though they need not, in fact, be covered) under the group health plan of a new employer, the group health plan of a spouse's employer, or Medicare. Note that under the traditional COBRA rules, Continuation Coverage is lost only when you become covered under a Group Health Plan or Medicare. Here the coverage is lost when you become entitled to that coverage, even if you do not become covered.
 - The COBRA subsidy is available regardless of your income level. If, however, while you are on COBRA you have taxable income of \$125,000 (\$25,000 if you file a joint return), you will have to repay some of the subsidy amount when you file your tax return. If you have taxable income of \$145,000 or more (\$290,000 if filing jointly), you will have to repay the entire subsidy amounts. You may avoid this, however, by choosing to irrevocably waive your right to the subsidy from the outset.
 - The subsidy does not apply to COBRA for Health Care FSAs.
 - The Assistance Eligible Individual is obligated to report eligibility for new coverage, whether under another group health plan or Medicare, and there are tax penalties for failing to do so. These penalties will be enforced at the time you file your individual income tax return.

Transition Period

- Because there is little time to implement these new rules, the ARRA creates a two-month transition period for employers or COBRA Administrators who cannot modify the COBRA billing arrangements for Assistance Eligible Individuals in March or April. You may be charged the full COBRA premium for these two months, and the 65% subsidy will then be credited against future premium payments. If this crediting method will not bring you to the break-even point within 180 days, the excess amount will be paid directly to you.

- **IMPORTANT NOTE:** The COBRA rules under the ARRA do not apply to any individuals who first become COBRA-eligible on or after January 1, 2010.

Special Rule For Health Care FSA Program

The COBRA Continuation Coverage you may elect with respect to the Health Care FSA Program is different from the COBRA Continuation Coverage you may elect with respect to other COBRA-eligible Benefit Programs offered by the College.

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 premium, and the College is entitled to add 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 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 ($\$1,800 \times 102\% = \$1,836/12 = \$153/\text{month} \times \text{the 9 months remaining in Plan Year}$). In this case, you would **not** be entitled to COBRA Continuation Coverage under the Health Care FSA Program.

Trade Act Tax Credit And Extended Election Period

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation. Eligible individuals can either take a tax credit or get advance payment of up to 65% of their premiums for qualified health insurance, including COBRA Continuation Coverage. If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282 (TTD/TTY). More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Questions About COBRA Continuation Coverage

If you have questions concerning the Plan or your COBRA Continuation Coverage rights, you should contact the Plan or COBRA Administrator. For more information about your rights under COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA Website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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 or COBRA Administrator informed of any changes in the addresses of family members.

Notice Procedures

In all instances where you, a Covered Dependent or another person is required to notify the College or the COBRA Administrator of the occurrence of an initial Qualifying Event, a second Qualifying Event, a determination regarding disability by the Social Security Administration, or eligibility for new coverage, it must be done in writing and sent to the College or COBRA Administrator as applicable. Please include the information designated above with respect to each of these notices and any and all relevant documentation (*e.g.*, divorce papers, Social Security determination letters, *etc.*) that confirm the events you wish to communicate. You should keep a copy, for your records, of any notices or communications you send to the College or the COBRA Administrator.

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 coverage. If your leave is less than 31 days, you will have to make the same contributions towards your coverage as do active employees, but you cannot be required to contribute more than that amount. If your leave is longer than 31 days, you may be charged 102% of the cost for the coverage, including both employer and employee contributions.

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. For leaves less than 31 days, 1 day is allowed; for leaves 31-180 days, 14 days is allowed; for leaves longer than 180 days, 90 days is allowed. The continuation coverage mandated under USERRA is alternate coverage to that provided under COBRA, so the two coverage periods run concurrently, not consecutively. Eligibility for TRICARE (formerly CHAMPUS) or active duty military coverage will not terminate coverage under this continuation coverage.

HIPAA Privacy Rule

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and the Standards for Privacy of Individually Identifiable Health Information (the "**Privacy Rule**") (available at www.hhs.gov/ocr/hipaa/finalreg.html) require health plans to protect the confidentiality of your Protected Health Information. The Privacy Rule applies to the Medical, Dental, Vision, EAP, and Health Care FSA Programs under the Plan. The Plan has also required its service providers that create, receive or maintain your Protected Health Information ("**Business Associates**") to agree to protect your Protected Health Information. The Plan may use and disclose your Protected Health Information as permitted or required by the Privacy Rule or when you authorize the use or disclosure. The Privacy Rule is summarized here and is more fully described in the Plan's Notice of Privacy Practices that was provided to you. Please contact the Plan Administrator or the Plan's Privacy Officer if you would like another copy.

"**Protected Health Information**" ("**PHI**") includes any information, whether oral or recorded, in any form or medium, that is created or received by the Plan that relates to your past,

present, or future physical or mental health, including the provision of and payment for care, that identifies you or provides a reasonable basis for your identification. PHI does not include de-identified health information or health information that the College is entitled to under applicable law (for example, the FMLA, Occupational Safety Health Act, the Americans with Disabilities Act, workers' compensation, and other state and federal laws), or health information that the College obtains through sources other than the Plan and retains as part of your employment records (for example, drug screening tests, fitness for duty examination results, or other similar information). This type of information is not subject to the Privacy Rule.

As part of its efforts to comply with the HIPAA Privacy Rule, the Plan has appointed a "**Privacy Officer.**" The Privacy Officer is the person with whom you should lodge any complaints if you believe that the confidentiality of your PHI has been compromised in the course of administering your benefit Claims. The HIPAA Privacy Officer for the Plan is:

HR Consulting Director (Compensation & Benefits)
Lansing Community College
8041 - Human Resources Department
P.O. Box 40010
Lansing, MI 48901
(517) 483-1875

Required Disclosures Of PHI By The Plan

The Plan must disclose your PHI under the following three conditions:

- to you, with respect to your own PHI;
- to the Secretary of the Department of Health and Human Services to determine whether the Plan is in compliance with the Privacy Rule; and
- where required by law. This means that the Plan will make the disclosure only when the law requires it do so, but not if the law would just allow it to do so.

Permitted Uses And Disclosures Of PHI By The Plan

The Plan may use or disclose your PHI as necessary for the operation of the Plan as described in this document and under the following conditions:

- for treatment purposes, when necessary;
- for payment and healthcare operations, as defined in the Privacy Rule;
- to Business Associates that enter into Business Associate agreements with the College;
- under certain circumstances expressly permitted by the Privacy Rule (see the Plan's Notice of Privacy Practices);
- to you about treatment alternatives or other health-related benefits or services that may be of interest to you; or
- with a proper authorization from you.

Even if a use or disclosure of PHI is permitted above, the Plan will comply with any special protections under state or federal law that are more protective of your privacy.

Disclosure Of PHI By The Plan To The College

The Plan may disclose your PHI to the College to carry out Plan administrative functions because the College agrees to:

- make these disclosures only to the Plan's Workforce;
- not use or further disclose the information other than as permitted or required by this Plan as explained in this document or the Notice of Privacy Practices or as required by law;
- ensure that any agents, including a subcontractor to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the College with respect to that information;
- not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the College, except the College may make disclosures with respect to workers' compensation;
- report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures permitted under the Plan;
- make available to you your PHI that is maintained by the Plan and provide you with the right to obtain a copy of your PHI disclosed to and retained by the College;
- permit you to amend your PHI maintained by the Plan and incorporate these amendments as required by the Privacy Rule, as described in the following section titled "Your Rights Under HIPAA And The Privacy Rule";
- permit you to have an accounting of the disclosures of your PHI made by the Plan as described in the following section titled "Your Rights Under HIPAA And The Privacy Rule";
- 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 for purposes of determining compliance with the Privacy Rule;
- if feasible, return or destroy all PHI received from the Plan that the College still maintains in any form and retain no copies of that information when no longer needed for the purpose for which disclosure was made, except that if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that adequate separation between the Plan and the College is established as described below.

The Plan and the College will take steps to provide for the adequate separation between the Plan and the College. Only the following employees of the College, identified as the "**Plan's Workforce**," will have access to your PHI:

- HR Consulting Manager (Compensation & Benefits)
- HR Consulting Manager (Compensation & Benefits)
- Benefits Assistant(s)
- Privacy Officer

The Plan's Workforce will receive PHI as needed, in the ordinary course of business, to carry out the payment, health care operation, or other functions necessary for the proper operation of the Plan. The Plan will restrict the access to, and use and disclosure of, your PHI by these employees to those administrative functions that the College performs for the Plan. The Plan may also disclose limited health information to the Plan's Workforce in connection with enrollment or disenrollment of individuals into or out of the Plan. The College will handle any complaint relating to non-compliance by addressing that issue with the employee. The College will also provide a mechanism for resolving issues of noncompliance, including disciplinary action up to and including discharge.

To maintain the confidentiality of your PHI, you should only communicate with one of these individuals to inquire about any aspect of the Plan, a benefit Claim, your entitlement to coverage or any other matter regarding your health care benefits under the Plan, and the matter you wish to discuss requires that you share or communicate medical information about yourself.

Your Rights Under HIPAA And The Privacy Rule

You have certain rights, under HIPAA and the Privacy Rule, relating to your PHI maintained by the Plan. All requests to exercise your individual rights must be made in writing to the Privacy Officer. The Plan's insurers or HMO's keep their own records and you must make any requests relating to your PHI in those records directly to the insurer or HMO.

Your rights include:

- ***Right to Notice.*** You have the right to receive a copy of the Plan's Notice of Privacy Practices. Contact the Human Resources Department for a copy of the Notice.
- ***Right to Access.*** You have the right to access your PHI, so long as the information is retained in the Plan's medical, billing, and Claim adjudication (the "**Designated Record Set**"). The Plan may charge a reasonable fee for copying the information you request, and the cost of any mailing. The Plan may deny your request for access, and, in certain circumstances, that decision will not be subject to appeal; while, in other circumstances, you may seek an appeal of the Plan's denial. In either case, if your request is denied, the Plan will respond in writing, explaining its reasons for the denial, whether the reason is appealable, and the procedures for seeking appeal, if applicable. Any review will be conducted by someone designated by the Plan who was not involved in the original decision.
- ***Right to an Accounting.*** Within a single 12-month period, you may request one accounting of disclosures of your PHI made by the Plan at no charge. If you request more than one accounting within the same 12-month period, the Plan may charge you a reasonable fee. You will be informed in advance of the proposed fee and will have an opportunity to revise or

withdraw your request in order to avoid or reduce the fee. The Plan is obligated to provide you with an accounting of any disclosures of your PHI made within the 6-year period immediately prior to the date of your request, except disclosures made:

- for purposes of treatment, payment, or healthcare operations;
 - directly to you or close family members involved in your care;
 - for purposes of national security;
 - incidentally (as defined in the Privacy Rule);
 - as part of a limited data set (as defined in the Privacy Rule);
 - to correctional institutions or law enforcement officials; and
 - pursuant to your express authorization.
- **Right to Amend.** You may request that your PHI maintained in the Designated Record Set of the Plan be amended. When requesting an amendment, you are also required to state the reason why you believe that the existing information is in error and needs to be revised. The Plan need not agree to your request. If your request is granted, the Plan will inform you of what changes or corrections it is making and how that will be done. If your request is denied, the Plan will provide you with: (a) the reasons for the denial; (b) an explanation of your right to submit a statement of disagreement and directions about how to do that; (c) a statement that even if you do not choose to submit a statement of disagreement, you may ask that your request for an amendment and the Plan's denial be provided with any future disclosures of the PHI that was the subject of your request; and (d) a description of the Plan's complaint procedures, including the name, address, and phone number of the person with whom any complaint should be lodged. If you elect to submit a statement of disagreement, the Plan may submit a rebuttal statement in response. If the Plan chooses to submit a rebuttal statement, it will provide you with a copy.
 - **Right to Request Restrictions.** You may also request that the Plan restrict its uses and disclosures of your PHI for purposes that would otherwise be permissible under HIPAA and the Privacy Rule. The Plan Administrator, or the appropriate Claims Administrator, need not agree to any restriction that you may request, but if it does agree to your request, the Plan will be bound to honor the restriction, until you indicate in writing that you are withdrawing the restriction, or the Plan or Claims Administrator informs you that it is withdrawing its consent to the restriction. The Plan's withdrawal of consent, however, will only apply to PHI created or received after you have been notified of the termination.
 - **Right to Request Confidential Communications.** You may also request that the Plan communicate with you in a confidential manner, for example, by sending information to an alternate address. The Plan will accommodate any reasonable request, though it will require that any alternative used still allow for payment information to be effectively communicated and for payments to be made.

- **Right to File a Complaint.** If you believe your rights have been violated, you have a right to file a complaint with the Plan's Privacy Officer or with the Secretary of the United States' Department of Health and Human Services. If you have questions about the status of your PHI or what is being done to protect its confidentiality, or if you wish to file a complaint, contact the Privacy Officer.

HIPAA Security Rule

HIPAA and the Standards for Security of Electronic Protected Health Information (the "**Security Rule**") require health plans to protect the confidentiality, integrity, and availability of your Electronic PHI ("**EPHI**") that they create, receive, transmit, or maintain about you in the course of providing health care benefits. To ensure the security of your EPHI, the College will comply with the Security Rule as set out below. The Plan has also required its Business Associates to agree to protect your EPHI.

EPHI includes any PHI that is transmitted or maintained in an electronic media. "**Electronic Media**" includes media used to store EPHI such as a hard drive in a computer, as well as media used to transmit your EPHI; for example, the Internet. The Security Rule does not cover EPHI that did not exist in electronic form before being electronically transmitted. For example, EPHI transmitted paper-to-paper, by fax, telephone, video conferencing, or through messages left on voice-mail, are not covered by the Security Rule. However, telephone voice response and fax-back systems are considered EPHI (and these are covered by the Security Rule) because they are used as input and output devices for computers.

Disclosures Of EPHI Expressly Permitted By The Security Rule

The Security Rule permits the Plan to disclose your EPHI to the College as follows:

- de-identified health information to the College, if the College requests the information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan;
- de-identified health information to the College, if the College requests the information for the purpose of modifying, amending, or terminating the Plan;
- to the College when you authorize the disclosure; and
- to the College to determine your enrollment or eligibility status in the Plan.

Disclosures Of EPHI By The Plan To The College

The Plan may disclose your EPHI to the College to carry out Plan administrative functions because the College agrees to:

- make these disclosures only to the Plan's Workforce;
- implement "**Policies and Procedures**" that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- make any documentation related to the Policies and Procedures available to the Secretary of the United States Department of Health and Human Services for the purpose of determining the Plan's compliance with the Security Rule;
- ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect the EPHI;
- report to the Plan any "**Security Incident**" of which it becomes aware, including an attempted or successful unauthorized access, use, disclosure, modification, or destruction of EPHI; and
- ensure that adequate separation between the Plan and the College is established and described below.

The Plan and the College will take steps to provide for the adequate separation between the Plan and the College for purposes of exposure to EPHI. Only members of the Plan's Workforce will have access to your EPHI.

Qualified Medical Child Support Orders

The Plan Administrator will honor 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 within the meaning of the U.S. Supreme Court's decision in Firestone Tire & Rubber v. Bruch (1989) to determine whether a medical child support order is "qualified" within the meaning of ERISA Section 609(a)(2)(A), 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, within 20 business days:

- 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 dependent coverage is not provided.
- Determine if the Order or Notice conforms to the requirements of a QMCSO.
- Notify the issuing court or agency, the Participant, and the affected child(ren) if the Order or Notice is determined not to meet the requirements of a QMCSO.
- 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). The Plan Administrator must provide sufficient information for the Participant and/or affected child(ren) to understand available options and to assist in appropriately completing the Order or Notice.

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.

Certificates Of Creditable Coverage

A certificate of Creditable Coverage documenting the nature and duration of Plan coverage will be sent by first class mail to the last known address of any Participant and spouse (and Covered Dependent if living separately):

- when the individual ceases to be covered under the Medical Program, and
- if the individual elects COBRA Continuation Coverage, then again when COBRA Continuation Coverage ceases.

In addition, an individual may request a certificate of Creditable Coverage from the Plan Administrator anytime within a period of 24 months after the end of coverage (including COBRA Continuation Coverage).

"**Creditable Coverage**" is coverage under any of the following medical programs: this Plan; another Group Health Plan; group or individual health insurance coverage issued by a state regulated insurer (including Blue Cross Blue Shield or an HMO); Medicare Part A or Part B; Medicaid; the United States uniformed services medical and dental program (known as "**TRICARE**"); an American Indian health care program; a state health benefits risk pool; a public health plan; (for example, the Federal Employees Health Benefit Program ("**FEHBP**"), but also, including a plan established or maintained by a foreign country or political subdivision); health benefits under the Peace Corp Act; or a state Children's Health Insurance Program ("**CHIP**").

Maternity 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.

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 a 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 College 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 (including the Enrollment Form); to exercise all of the power and authority contemplated by the Internal Revenue Code of 1986, as amended ("**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 Plan has other advisors, and service providers. The Plan Administrator may delegate responsibilities to others. 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 Plan Administrator retains all discretionary authority with respect to the EAP, Pre-Tax Payment, Dependent Care FSA, and Health Care FSA Programs, except to the extent expressly delegated to others.

Indemnification

The College 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 College 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.

Discretion

Wherever it is provided in the Plan that the College or Plan Administrator may perform or not perform any act, or permit or consent to any action, non-action, or procedure, or wherever they are given discretionary power or authority, they have exclusive discretion; provided, however, that they may not exercise their discretion so as to violate the Code or knowingly to discriminate either for or against any employee, Participant, or covered individual or any group of these persons.

OTHER IMPORTANT PROVISIONS

Plan Name

Lansing Community College Benefit and Welfare Plan

Employer Identification Number

38-1787641

Plan Year

Twelve month period ending October 31

Plan Sponsor And Agent For Service Of Legal Process

Lansing Community College
8041 - Human Resources
P.O. Box 40010
Lansing, Michigan 48901
(517) 483-1875

Plan Administrator

Lansing Community College
8041 - Human Resources
P.O. Box 40010
Lansing, Michigan 48901
(517) 483-1875

Type Of Plan

The Plan is a cafeteria plan intended to satisfy the requirements of Section 125 of the Code. The Plan also provides various welfare benefits.

Funding

The College pays the cost of the Benefit Programs, other than any amounts you are required to pay to participate in each Benefit Program ("**Benefit Contributions**") and any copayments and deductibles that may be required under the terms of the Benefit Programs. You will be informed of the amount of any Benefit Contributions at your Initial Enrollment Period and each Open Enrollment Period.

The benefits provided under the Plan will be paid, to the extent permitted by the Code, from the general assets of the College and through insurance. Nothing in this Plan will be construed

to require the College 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 College from which any payment under the Plan may be made.

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 College 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 liable 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 College, acting through its Board of Trustees or its delegate, 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 the Code or other 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.

Nondiscrimination Rules

For each calendar year, the nontaxable benefits under the Plan provided to key employees, as defined in Code Section 416(i), cannot exceed 25% of the aggregate nontaxable benefits provided to all Participants under the Plan. In addition, the Plan cannot discriminate in favor of "highly compensated individuals," as defined in Code Section 105(h)(5), as to eligibility to participate or as to contributions or benefits, or as defined in Code Section 125(e)(2), as to eligibility to participate, or in favor of "highly compensated participants," as defined in Code Section 125(e)(1), as to contributions or benefits.

If the College determines at any time that the Plan may not satisfy any nondiscrimination rule in the Code, the College 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 your Enrollment Forms, with or without your 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 law, including Section 125 of the Code. It will be considered amended to the extent necessary to comply with Section 125. 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 between you and the College. Nothing contained in the Plan gives you the right to be retained in the service of the College or to interfere with the right of the College to discharge you at any time, with or without cause, regardless of the effect that the discharge will have upon you as a Participant in the Plan (subject only to the provisions of any relevant collective bargaining agreement).

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 Benefit Contributions you paid for coverage for the person while ineligible.

Entire Representation

This document, along with any summary, schedule of benefits, separate insurance contract or certificate, or Booklet describing any Benefit Program, together 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; 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.

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EXECUTION

IN WITNESS WHEREOF, Lansing Community College has caused this amendment and restatement of the Plan, captioned "Lansing Community College Benefit and Welfare Plan," to be executed by its duly authorized officer this _____ day of _____, _____, to be effective November 1, 2008.

LANSING COMMUNITY COLLEGE

By: _____

Its: _____

BENEFIT PROGRAM INFORMATION CHART

Benefit Program	Claims Filing and Review Procedures	Insurance Company or Claims Administrator Contact Information
<p>Medical Program Insured</p> <p>There are three Program Options under the Medical Program:</p> <p>(i) Tri-Med – providing point of service insurance coverage to end Dec 31, 2009. To be replaced by Choices II PPO</p> <p>(ii) Supercare 1 – providing traditional indemnity insurance coverage</p> <p>(iii) Limited – providing catastrophic insurance coverage that is offered only to Part-time non-probationary employees.</p>	<p><u>Filing a Claim</u></p>	<p>MESSA www.messa.org (800) 292-4910 (Toll free)</p> <p>MESSA 1475 Kendale Blvd. P.O. Box 2560 East Lansing, MI 48826-2560 (800) 292-4910 (Toll free)</p>

Benefit Program	Claims Filing and Review Procedures	Insurance Company or Claims Administrator Contact Information
<p>The insurance coverage for all three Program Options is provided by Blue Cross Blue Shield of Michigan</p> <p>Prescription drug coverage is provided under all three Program Options</p>	<p><u>Appeal of Denied Claim</u></p> <ul style="list-style-type: none"> ▪ First Level: 	<p>MESSA 1475 Kendale Blvd. P.O. Box 2560 East Lansing, MI 48826-2560 (800) 292-4910 (Toll free)</p>
<p>Third Party COBRA Administrator</p>		<p>Meritain Health www.meritain.com 2370 Science Parkway Okemos, MI 48864 (800) 748-0003 (Toll free) (517) 349-7010 (Telephone) (517) 349-8555 (Fax)</p>

Benefit Program	Claims Filing and Review Procedures	Insurance Company or Claims Administrator Contact Information
<p>Dental Program Self-Funded</p>	<p><u>Filing a Claim</u> (only Post-Service Claims for the Dental Program):</p> <p><u>Appeal of Denied Claim</u> (only one level of appeal):</p>	<p>AssureCare www.assurecare.com (800) 968-6616 (Toll free)</p> <p>AssureCare 4050 Hunsacker Drive, Ste. 110 East Lansing, MI 48823 (800) 968-6616 (Toll free)</p> <p>AssureCare 4050 Hunsacker Drive, Ste. 110 East Lansing, MI 48823 (800) 968-6616 (Toll free)</p>
<p>Third Party COBRA Administrator</p>		<p>Meritain Health www.meritain.com 2370 Science Parkway Okemos, MI 48864 (800) 748-0003 (Toll free) (517) 349-7010 (Telephone) (517) 349-8555 (Fax)</p>

Benefit Program	Claims Filing and Review Procedures	Insurance Company or Claims Administrator Contact Information
<p>Vision Program Self-Funded</p>	<p><u>Filing a Claim</u> (only Post-Service Claims for the Vision Program):</p> <p><u>Appeal of Denied Claims</u> (only one level of appeal):</p>	<p>Health Applications Network (HAN) No website available (800) 445-2363 (Toll free)</p> <p>Health Applications Network (HAN) P.O. Box 1570 East Lansing, MI 48826 (800) 445-2363 (Toll free)</p> <p>Health Applications Network (HAN) P.O. Box 1570 East Lansing, MI 48826 (800) 445-2363 (Toll free)</p>
<p>Third Party COBRA Administrator</p>		<p>Meritain Health www.meritain.com 2370 Science Parkway Okemos, MI 48864 (800) 748-0003 (Toll free) (517) 349-7010 (Telephone) (517) 349-8555 (Fax)</p>

Benefit Program	Claims Filing and Review Procedures	Insurance Company or Claims Administrator Contact Information
<p>LTD Program Insured</p>	<p><u>Filing a Claim:</u></p> <p>Note: <i>You must submit your completed Proof of Loss Forms within 30 days after the waiting period (90 days of disability) for the LTD Program</i></p> <p><u>Appeal of Denied Claim</u> (only one level of appeal):</p>	<p>Life Insurance Company of North America, a CIGNA Company www.cigna.com (800) 352-0611 (Toll free)</p> <p>Life Insurance Company of North America Paper Intake Team 12225 Greenville Ave., Ste. 1000 Dallas, TX 75243 (800) 352-0611 ext. 5615 (Toll free) (860) 731-3075 (Fax)</p> <p>Life Insurance Company of North America Paper Intake Team 12225 Greenville Ave., Ste. 1000 Dallas, TX 75243 (800) 352-0611 ext. 5615 (Toll free) (860) 731-3072 (Fax)</p>

Benefit Program	Claims Filing and Review Procedures	Insurance Company or Claims Administrator Contact Information
<p>Employee Assistance Program Self-Funded</p>	<p><u>Filing a Claim:</u></p> <p><u>Appeal of Denied Claim (only one level of appeal):</u></p>	<p>Sparrow CARES www.sparrow.org (800) 234-4191 (Toll free)</p> <p>Sparrow CARES Medical Arts Bldg. 1322 E. Michigan Ave., Ste. 202 P.O. Box 30480 Lansing, MI 48909-7980 (800) 234-4191 (Toll free)</p> <p>Sparrow CARES Medical Arts Bldg. 1322 E. Michigan Ave., Ste. 202 P.O. Box 30480 Lansing, MI 48909-7980 (800) 234-4191 (Toll free)</p>
<p>Third Party COBRA Administrator</p>		<p>Meritain Health www.meritain.com 2370 Science Parkway Okemos, MI 48864 (800) 748-0003 (Toll free) (517) 349-7010 (Telephone) (517) 349-8555 (Fax)</p>

