



**2011 Special Retirement Incentive Program
Limited Duration
Health Reimbursement Arrangement (HRA) Plan
Plan Document and Summary Plan Description**

Wayne State University
Health Reimbursement Arrangement (HRA) Plan
and Summary Plan Description

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Wayne State University Health Reimbursement Arrangement (HRA) Plan

As Adopted Effective June 1, 2011

ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

Wayne State University (the employer) hereby establishes the Wayne State University 2011 Special Retirement Incentive Program Limited Duration Health Reimbursement Arrangement (HRA) Plan (the "Plan") effective June 1, 2011 (the "Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is intended to permit an Eligible Retiree to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the HRA Account.

1.2 Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code § 105 and 106 and regulations issued there under, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b).

ARTICLE II. DEFINITIONS

2.1 Definitions

"Administrator" means Wayne State University. The contact person is the Director Total Compensation & Wellness, who has the full authority to act on behalf of the Administrator, as described in Section 8.1.

"Benefits" means the reimbursement benefits for Medical Care Expenses described under Article VI.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Covered Individual" means, for purposes of Article VII, a Participant, Spouse or Dependent.

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code § 105(b), with the following exception: any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc. where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Claims Processing Administrator" ("CPA") means Connect Your Care, LLC.

"Effective Date" of this Plan has the meaning described in Section 1.1.

"Electronic Protected Health Information" has the meaning described in 45 CFR §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"Eligible Retiree" means a Retiree eligible to participate in this Plan, as provided in Section 3.1.

“**Retiree**” means any former eligible employee for the limited purpose of allowing continued eligibility for benefits in accordance with Section 3.2.

“**Employer**” means Wayne State University.

“**Health FSA**” means a health Flexible Spending Account as defined in Prop. Treasury Reg. §1.125-2, Q/A-7(a).

“**Health Insurance Plan**” means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance arrangement(s).

“**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“**HRA**” means a health reimbursement arrangement as defined in IRS Notice 2002-45.

“**HRA Account**” means the HRA Account described in Section 6.4.

“**Medical Care Expenses**” has the meaning defined in Section 6.2.

“**Participant**” means a person who is an Eligible Retiree and who is participating in this Plan in accordance with the provisions of Article III. In the event of the retiree’s death, the surviving spouse and dependents will be considered a participant.

“**Period of Coverage**” means the Plan Year.

“**Plan**” means the Wayne State University 2011 Special Retirement Incentive Program Limited Duration HRA Plan as set forth herein.

“**Plan Year**” means the 12-month period commencing June 1 and ending on May 31.

“**Privacy Official**” shall have the meaning described in 45 C.F.F. § 164.530(a).

“**Protected Health Information**” shall have the meaning described in 45 C.F.R. § 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

“**QMCSO**” means a qualified medical child support order, as defined in ERISA § 609(a).

“**Spouse**” means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

“**SPD**” means the summary plan description describing the terms of this Plan.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if by May 31, 2011 the individual satisfies the definition of a retiree who has elected the Wayne State University Special Retirement Incentive Program special one-time limited duration retirement program. Once the Employer has determined that a former Employee has met the Plan’s eligibility requirements, the participant’s coverage will commence on their date of retirement. In the event of the participant’s death, the surviving spouse and/or dependents will be considered participants and remain eligible for benefits in accordance with the provisions of Article VI.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the termination of this Plan; or
- the date of December 31, 2021; or
- the Retiree’s death except that the surviving spouse and dependents remain eligible for benefits; or
- the date on which the Retiree’s HRA Account balance becomes zero as a result of claim payment.

Reimbursements from the Plan after termination of participation will be made pursuant to Section 6.7 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA).

ARTICLE IV. METHOD AND TIMING OF ENROLLMENT

4.1 Effective date of Participation

A Retiree who first becomes eligible to participate in this Plan will commence participation on the later of the effective date of the plan or retirement date. Once enrolled, the Retiree's participation will continue year-to-year until the Retiree's participation ceases pursuant to Section 3.2.

ARTICLE V. BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

When an Eligible Retiree becomes a Participant in accordance with Articles III and IV, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in Article VI. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

5.2 Employer and Participant Contributions

- (a) *Employer Contributions.* The Employer funds the full amount of the HRA Accounts.
- (b) *Participant Contributions.* There are no Participant contributions for Benefits under the Plan.
- (c) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded under a cafeteria plan.

5.3 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

ARTICLE VI. HEALTH REIMBURSEMENT BENEFITS

6.1 Benefits

The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's HRA Account, as set forth and adjusted under Section 6.3.

6.2 Eligible Medical Care Expenses

Under the Plan, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage.

- (a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible.

- (b) *Medical Care Expenses Generally.* “Medical Care Expenses” means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs) and health insurance premiums for long term care insurance, individual health and dental insurance policies, Medicare Part B and TEFRA, but shall not include expenses that are described in subsection (c). Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant’s Spouse or Dependents shall be charged against the Participant’s HRA Account.
- (c) *Medical Care Expenses Exclusions.* “Medical Care Expenses” shall not include the expenses listed as exclusions under the Appendix to this Plan.
- (d) *Cannot Be Reimbursed or Reimbursable from Another Source.* Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance, or any other accident or health plan (see Section 6.9 if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), the Plan can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VI.

6.3 Maximum Benefits

- (a) *Maximum Benefits.* The maximum dollar amount that may be credited to an HRA Account for an Eligible Retiree who participates shall be 100% of the incentive payment at time of retirement. Unused amounts may be carried over to the next Period of Coverage, as provided in Section 6.5.

6.4 Establishment of Account

The Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts. The account does not bear interest or accrue earnings of any kind.

- (a) *Crediting of Accounts.* At the inception of the plan the participant will receive a one-time contribution, as provided in Section 6.3.
- (b) *Debiting of Accounts.* A Participant’s HRA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.
- (c) *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant’s HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

6.5 Carryover of Accounts

If any balance remains in the Participant’s HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Period of Coverage. The Participant’s coverage will terminate upon loss of eligibility and all expenses incurred up until such time shall be eligible for reimbursement under the terms of this document.

6.6 Reimbursement Procedure

- (a) *Timing.* Within 30 days after receipt by the Claims Processing Administrator (CPA) of a reimbursement claim from a Participant, the CPA will reimburse the Participant for the Participant's eligible Medical Care Expenses or the CPA will notify the Participant that the claim has been denied (see Section 8.1 regarding procedures for claim denials and appeals procedures). This time period may be extended for an additional 15 days for matters beyond the control of the CPA, including in cases where a reimbursement claim is incomplete. The CPA will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.
- (b) *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the CPA in such form as the CPA may prescribe, by no later than 90 days following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:
- the person or persons on whose behalf Medical Care Expenses have been incurred;
 - the nature and date of the Expenses so incurred;
 - the amount of the requested reimbursement; and
 - a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Expenses has been exhausted.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that CPA may request.

- (c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article VIII.

6.7 Reimbursements After Termination

When a Participant ceases to be a Participant under Section 3.2, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim within 90 days following the close of the Plan Year in which the Medical Care Expense was incurred. In the event the Plan terminates on or before December 31, 2021, the Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim within 90 days following the date the Plan terminates. Thereafter, if any balance remains in the account, such balances shall be managed pursuant to section 6.5.

6.8 Named Fiduciary; Compliance With HIPAA, etc.

- (a) *Named Fiduciary* Wayne State University is the named fiduciary for the Plan.
- (b) *Laws Applicable to Group Health Plans.* Benefits shall be provided in compliance with HIPAA and other group health plan laws to the extent required by such laws.

6.9 Coordination of Benefits; Health FSA to Reimburse First

Benefits under this Plan are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's

Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

ARTICLE VII. HIPAA PRIVACY AND SECURITY

7.1 Employer's Certification of Compliance

The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 CFR § 164.504(f)(2)(ii), and that Employer agrees to conditions of disclosure set forth in this Article VII.

7.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Employer or the Administrator information on whether the individual is participating in the Plan.

7.3 Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the Employer or the Administrator, provided that the Employer or the Administrator requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

7.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article VII (including, but not limited to the restrictions on Employer's use and disclosure described in 7.5) and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64.

7.5 Restrictions on Employer's Use and Disclosure of Protected Health Information

- (a) Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.
- (b) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to Protected Health Information.

- (c) Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.
- (d) Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.
- (e) Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 C.F.R. § 164.524.
- (f) Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 C.F.R. § 164.526.
- (g) Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.
- (h) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 C.F.R. Part 164, Subpart E.
- (i) Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.
- (j) Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

7.6 Adequate Separation Between Employer and the Plan

- (a) Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Covered Individual's Protected Health Information received from the Plan or a business associate servicing the Plan:
 - Privacy Official;
 - Employees in the Employer's Human Resources and Total Compensation and Wellness Departments;
 - Employees in the Employer's Office of General Counsel; and
 - Any other class of employees designated in writing by the Privacy Official.
- (b) The employees, classes of employees or other workforce members identified in Section 7.4(a), above, will have access to a Covered Individual's Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 7.2(a), above.
- (c) The employees, classes of employees or other workforce members identified in Section 7.4(a), above, will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure

of a Covered Individual's Protected Health Information in breach or violation of or noncompliance with the provisions of this Article VII.

ARTICLE VIII. APPEALS PROCEDURE

8.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the SPD. The Administrator is responsible for appeals.

ARTICLE IV. RECORDKEEPING AND ADMINISTRATION

9.1 Administrator

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

9.2 Powers of the Administrator

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 9.2, the Administrator shall exercise such exclusive power with respect to an appeal of a claim under Section 8.1);
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;
- (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;
- (f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;
- (g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- (h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

- (j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

9.3 Reliance on Participant, Tables, etc.

The Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

9.4 Provision for Third-Party Plan Service Providers

The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

9.5 Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

9.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

9.7 Inability to Locate Payee

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

9.8 Effect of Mistake

In the event of a mistake as to the eligibility or participation of a Retiree, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the Plan or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE X. GENERAL PROVISIONS

10.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

10.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

10.3 Amendment and Termination

This Plan has been established with the intent of being maintained for a stated definite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of Wayne State University or by any person or persons authorized by Wayne State University to take such action.

10.4 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of Michigan to the extent not superseded by the Code or any other federal law.

10.5 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.6 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

10.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.9 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

10.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

10.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Wayne State University 2011 Special Retirement Incentive Program Limited Duration HRA Plan, Wayne State University has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 2011.

WAYNE STATE UNIVERSITY

By: _____

Its: Associate Vice President, Human Resources

Wayne State University

Health Reimbursement Arrangement (HRA) Plan

Summary Plan Description

Introduction

Wayne State University is pleased to provide the 2011 Special Retirement Incentive Program Limited Duration Health Reimbursement Arrangement (HRA) Plan (the Plan) for eligible retirees. Under federal tax law, the HRA Plan is known as a “Health Reimbursement Arrangement” or “HRA” Plan.

This Summary Plan Description describes the basic features of the HRA Plan, how it operates, and how you can get the maximum advantage from it. This is only a summary of the key parts of the HRA Plan. If there is a conflict between the official, complete HRA Plan document and this summary, the official Plan Document will control. Definitions of terms used in this summary are contained in Article II of the HRA Plan Document.

PART I. General Information About the Plan

I-1. What is the purpose of the HRA Plan?

The purpose of the HRA Plan is to reimburse eligible retirees, up to certain limits, for their own and their covered spouses’ and dependents’ medical care expenses. Reimbursements for medical care expenses paid by the HRA Plan generally are excludable from taxable income.

I-2. When did the HRA Plan take effect?

The HRA Plan became effective June 1, 2011.

I-3. Who can participate in the HRA Plan?

You are eligible to participate in this Plan if, as of June 1, 2011, you are an employee who meets the following criteria:

- Age 50 or older,
- Have a total of 75 points (combined age and completed years of service), and
- A subsidized benefits eligible active employee, and
- For non-tenured employees, at least half of your salary is paid through the general fund or one of the University auxiliary/independent operations. Non-tenured employees whose salaries are paid primarily (50% or more) by grants, gifts, or contracts are not eligible. Tenured employees whose salaries are paid primarily (50% or more) by grants, gifts, or contracts are eligible subject to meeting all other eligibility criteria.

and have elected the Wayne State University special one-time limited duration Special Retirement Incentive Program.

I-4. What Benefits are offered through the HRA Plan?

Once you become a participant, the HRA Plan will maintain an “HRA Account” in your name to keep a record of the amounts available to you for the reimbursement of eligible medical care expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of Wayne State University), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from any health insurance plan before any benefits are payable from this Plan.

At the inception of the plan, a one-time contribution in the elected amount of will be made to your HRA Account. Your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible medical care expenses. At the end of the Plan Year, the unused amount (if any) will remain available in the next Plan Year.

I-5. How will the HRA Plan Work?

The HRA Plan will reimburse you for eligible medical care expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- You must submit a claim to the Administrator and provide any additional information requested by the Administrator.
- A request for payment must relate to medical care expenses incurred by you, your spouse, or your dependent during the time you were a participant under this Plan; and
- A request for payment must be submitted within 90 days following the close of the Plan Year in which the medical expense was incurred or within 90 days following the termination of the Plan.

Claims must be submitted in writing. The Administrator may require that participants submit claims on a form provided by the Administrator. The claim must set forth:

- The individual(s) on whose behalf the medical care expenses were incurred;
- The nature and date of the medical care expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such medical care expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g. a hospital, physician, or pharmacy) showing that the medical care expenses have been incurred and showing the amounts of such medical care expenses, along with any additional documentation that the Administrator may request.

I-6. Are there any limitations on benefits available from the HRA Plan?

Only medical care expenses are covered by the HRA Plan. A medical care expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible medical care expenses are (a) prescription drugs and over-the-counter medicines that are prescribed by your physician; (b) dental expenses; (c) dermatology; (d) physical therapy; and (e) contact lenses or glasses used to correct vision impairment. Your employer or Administrator can provide you with more information about which expenses are eligible for reimbursement. Please refer to the Appendix for examples of expenses that are not medical care expenses and are not eligible for reimbursement.

I-7. How long will the HRA Plan remain in effect?

The plan will remain in effect from June 1, 2011 through December 31, 2021. You will forfeit all unused funds in your HRA Account as of December 31, 2021. Forfeitures will be determined after the run-out period, which is 90 days after the termination of the plan.

I-8. Are my benefits taxable?

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA Plan are generally not taxable to you. However, the employer cannot guarantee the tax treatment to any given participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

I-9. What happens if my claim for benefits is denied?

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the HRA Plan are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days of the extension if necessary due to conditions beyond the control of the Administrator. The Administrator will notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Administrator will make the decision based on the information that is has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- The specific reason for the denial;
- A reference to the specific HRA Plan provision(s) on which the denial is based; and
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to appeal the Administrator's denial of your claim.

D. What are the requirements of my appeal?

Your appeal must be in writing, must be provided to the Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Administrator informed you of the denied claim; and

- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator’s act or omission.
- You should also include any documentation that you have not already provided to the Administrator.

E. Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator’s act or omission. If you do not file your appeal within this 180-day period, you lose your right to appeal. Your appeal will be heard and decided by the committee.

F. How will my appeal be reviewed?

Any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the committee. The HRA Plan will provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the HRA Plan who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination.

G. When will I be notified of the decision on my appeal?

The committee will notify you of the decision on your appeal within 60 days after receipt of your request for review.

No action may be brought against the Plan, the employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination from the Administrator.

PART II. Administrative Information

Plan Administrator’s Contact: Department of Total Compensation and Wellness

Plan Administrator’s Phone Number: 313-577-3717

Plan Administrator’s Tax ID Number: 38-6028429

Plan Year: June 1 through May 31

Agent for Service of Process: Service may be made on the Administrator at the address listed above.

The financial records of the HRA Plan are kept on a Plan Year basis. The Plan Year ends on each May 31.

Type of Plan: The HRA Plan is intended to qualify as an employer-provided medical reimbursement plan under Code sections 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.

Type of Administration: The Administrator pays applicable benefits from the general assets of the employer.

Funding: The HRA Plan is paid for by the employer out of the employer's general assets. There is no trust or other fund from which the benefits are paid.

PART III. Miscellaneous

III -1. Prohibition against assignment of benefits

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

III-2. Overpayments or errors

If it is later determined that you and/or your spouse or dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan.

If you do not refund the overpayment or erroneous payment, the HRA Plan and the employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

APPENDIX

Exclusions — Medical Expenses That Are Not Reimbursable

The Wayne State University HRA Plan document contains the general rules governing what expenses are reimbursable. This Appendix, as referenced in the Plan document, specifies certain expenses that *are not reimbursable*, even if they meet the definition of “medical care” under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

Exclusions:

The following expenses are not reimbursable, even if they meet the definition of “medical care” under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

- Premiums that a participant pays on a pre-tax basis under any employer sponsored group plan.
- COBRA or benefit continuation premiums that a Participant pays on a pre-tax basis under any employee group plan that is sponsored by the Wayne State University.
- Premiums that a participant pays for disability insurance.
- Pregnancy testing kits.
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee’s or Dependent’s inability to perform physical housework).
- Massage therapy (unless prescribed by a doctor to treat a medical condition).
- Home or automobile improvements.
- Custodial care.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, unless prescribed by a physician for a specific medical condition.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code § 213.