NORTHERN MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

July 1, 2020

No provisions of the Plan or this Summary Plan Description shall give any employee any rights of continued employment or shall in any way prohibit changes in or the termination of the terms of employment of any employee covered by the Plan.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

NORTHERN MICHIGAN UNIVERSITY
FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

We have amended and restated the Northern Michigan University Flexible Benefits Plan ("Plan") effective July 1, 2020, that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description ("SPD"). This SPD also describes other important information concerning the Plan, such as the requirements that you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

More specifically, the Plan is designed to permit you to pay, on a pre-tax salary redirection basis, for your contributions for benefits under the Group Medical Plan (i.e., major medical and prescription benefits offered by the Employer), Group Dental Plan (i.e., dental benefits offered by the Employer), Health Flexible Spending Account, Dependent Care Flexible Spending Account, and/or for other benefits. Some of the benefits provided on a pre-tax basis are provided under separate plans or programs (e.g., the Group Medical Plan and Group Dental Plan). This summary generally does not provide the full detail of these other benefit plans. For information on such plans, please consult the separate documents for such plans. This SPD does, however, describe the benefits available under your Employer's Dependent Care Flexible Spending Account and Health Flexible Spending Account in detail and shall constitute the summary plan description for those benefit arrangements to the extent such a summary is required by law.

Read this SPD carefully so that you understand the provisions of our Plan and the benefits you are entitled to receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document governs. Also, if there is a conflict between an insurance contract and either the Plan document or this SPD, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to certain laws, such as the Internal Revenue Code ("Code") and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service or other federal agencies. We may also amend or terminate this Plan at any time. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in Article VIII.

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan participant ("Participant"), there are certain requirements which you must satisfy.

First, you must meet the eligibility requirements and be an Employee. An "Employee" means any person that we classified as a common law employee and who is on our W-2 payroll, but does not include (a) leased employees (including individuals defined as leased employees in Code §414(n)), contract workers, independent contractors, temporary employees or seasonal employees for the period such individual is so classified by us, whether or not any such individual is on our W-2 payroll or is determined by a court, regulatory agency or others to be a common law employee of us; (b) individuals who perform services for us but are paid by a temporary or other employment or staffing agency for the period during which such individuals are paid by such agency, whether or not such individual is determined by a court, regulatory agency or others to be a common law employee of us; (c) self-employed individuals; (d) partners in a partnership; (e) non-employee directors; and (f) any more-than-2% shareholder in an S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan where allowed by this Plan.

After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 of this Article. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan if you are eligible for coverage under our Group Medical Plan.

Although your Spouse and Dependents cannot participate in the Plan, they may benefit from your participation to the extent they are eligible for the underlying benefits. The term "Spouse" means an individual who is legally married to you as determined under applicable state law and who is treated as a spouse under the Code. The term "Dependent" generally means your Spouse and any person who is your dependent within the meaning of Code §152 (however, for health benefits, a Dependent generally means any person who is a dependent as defined in Code §105(b), §106 and the regulations and other authority thereunder and who is eligible for the Group Medical Plan). Please see the underlying benefits to determine Dependent eligibility.

3. When is my entry date?

You shall become a Participant on the later of the Effective Date of this Plan or the date on which you satisfy the eligibility requirements set forth in Question 2 of this Article.

However, if you are a new Employee and became eligible under Question 2 of this Article as of your date of hire, your participation in this Plan is retroactive to your date of hire (but not prior to the Effective Date of the Plan) if you make your election within thirty (30) days after your hire date.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must, during the applicable election period, complete an application to participate in the Plan in a manner set forth by the Administrator. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected. The election shall be irrevocable until the end of the applicable Plan Year unless you are entitled to change your benefit elections pursuant to Question 5 of Article III.

5. When will my participation in the Plan terminate?

You shall no longer participate in the Plan upon the occurrence of any of the following events:

(a) *Termination of employment*. Your termination of employment, subject to the provisions of Question 5 of Article 5;

(b) *Loss of eligibility*. Your ceasing to be an eligible Employee, subject to your right to continue coverage under any insurance contract for which premiums have already been paid;

(c) *Revocation of election*. You revoke your election as permitted under the terms of the Plan;

(d) *Death*. Your death, subject to the provisions of Question 6 of Article 5; or

(e) *Termination of the plan*. The termination of the Plan, subject to the provisions of Article XI.

If you do not choose to continue participation in the Plan, termination of participation will automatically revoke your elections and benefits as of the dates specified in the insurance contracts or other benefit plans. To the extent required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X, as amended or replaced from time to time ("COBRA") or by any other state of federal law, you or your qualified beneficiaries will be permitted to continue the Group Medical Plan, Group Dental Plan, and/or Health Flexible Spending Account benefits provided under this Plan.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article VIII for the definition of "Plan Year.")

Keep in mind that participation in the Plan will reduce the amount of your taxable compensation, which could cause a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

Although you may make an election to receive benefits under this Plan, the Group Medical Plan and Group Dental Plan benefits will be provided by separate plans governed by separate plan documents.

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Based on your own situation you should decide what amount, if any, you would like to have withheld from your salary and applied on the Employer's books toward each of the optional benefits available to you. Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

In making your election, you should realize that any amounts remaining in both your Dependent Care Flexible Spending Account and your Health Flexible Spending Account after you have been reimbursed for all Employment-Related Dependent Care Expenses and Medical Expenses incurred during the Plan Year (and the applicable Grace Period with respect to the Dependent Care Flexible Spending Account) will, as required by federal law, be forfeited (except with respect to a permissible carryover for the Health Flexible Spending Account described in Question 2 of Article IV). You should also be aware that amounts designated for one type of account may not be used to make reimbursements of another type. Thus, for example, amounts you allocate to your Dependent Care Flexible Spending Account cannot be used to reimburse you for Medical Expenses.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

4. When is the election period for our Plan?

The initial election period for an individual who becomes newly eligible to participate in the Plan shall be the 30-day period immediately following his or her date of hire.

Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the annual election period. (See Article VIII for the definition of "Plan Year.")

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections, if the underlying benefit plan allows.

Change in Status

You are permitted to change elections if you have a "change in status" event, as determined by the Administrator, and you make an election change that is on account of and consistent with the event within 30 days of such event. Currently, federal law considers the following events to be a change in status if they affect eligibility for coverage:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. Generally, a change in election is not consistent with a change in status if it is your divorce, annulment or legal separation, the death of your spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage and your election is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if your spouse or dependent gains eligibility for coverage under a family member plan as a result of a change in marital status or a change in employment status, then your election to cease or decrease coverage for that individual corresponds with the change in status only if coverage for that individual becomes applicable or is increased under the family member plan. The Administrator may rely on your certification of other coverage unless there is reason to believe your certification is incorrect. Please contact the Administrator for more detailed information related to change in status events.

Special Enrollment Rights

In addition, there are laws (such as HIPAA special enrollment rights provided under Code §9801(f)) that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

Cost and Coverage Changes

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases or decreases significantly, you will be permitted to either make corresponding changes in election, including commencing participation in the Plan for a significant cost decrease. For a significant cost increase, you may revoke your election and obtain coverage under another benefit package option with similar coverage on a prospective basis, or if there is no option that provides similar coverage, to revoke your election entirely.

If the coverage under a benefit is significantly curtailed during a Plan Year, then you may revoke your election and elect to receive, on a prospective basis, coverage under another benefit plan with similar coverage. If the coverage is significantly curtailed and coverage is lost during a Plan Year, you may revoke your election, and, in lieu thereof, elect to receive, on a prospective basis, coverage under another benefit package providing similar coverage or to drop coverage if no similar coverage is offered.

In addition, if we add a new coverage option or eliminate an existing one, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan.

There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

Other

If you take leave under FMLA, you may be allowed to revoke an existing election of coverage and make a new election for the remaining period of coverage as provided under FMLA. If you revoke your election, you may also have a right to be reinstated in the same group health plan coverage upon returning from your FMLA leave.

You may prospectively revoke your election of coverage under the Employer’s Group Medical Plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under our Group Medical Plan if you are eligible to obtain coverage through the health exchanges.

A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody which requires accident or health coverage for your child allows: (1) the Plan to change an election to provide coverage for the child if the order requires coverage under your plan; or (2) you to

change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan, and such coverage is actually provided.

You may change elections to cancel your accident or health coverage or your spouse's or dependent's coverage if you or your spouse or dependent are enrolled in Employer's accident or health coverage and become entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under §1928 of the Social Security Act (the program for distribution of pediatric vaccines). If you or your spouse or dependent have been entitled to Medicaid or Medicare coverage and lose eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

The Administrator may decrease your election if you are a "highly compensated employee" as defined in the Code to prevent the Plan from becoming discriminatory.

Applicability

Importantly, any mid-year change in election events set forth in this Section do not govern the underlying insurance contracts and plan documents. While a change may be allowed under Code §125 rules and regulations, a particular plan, such as the Group Medical Plan, may not provide for such a change. The underlying plan documents control.

Temporary mid-year election rights under IRS notice 2020-29

Internal Revenue Service Notice 2020-29 grants employers the ability to provide relief for participants of Code §125 cafeteria plans. That notice is designed to provide temporary flexibility for employers and employees and assist with the national response to the 2019 novel coronavirus outbreak (COVID-19). In accordance with that notice, during the Plan Year beginning in 2020 only, a Participant may revoke an election, make a new election, or decrease or increase an existing election applicable to the Health Flexible Spending Account and/or Dependent Care Flexible Spending Account on a prospective basis, subject to the following: (1) the election shall not violate any other statute or regulation applicable to the Plan; and (2) No Participant is permitted to elect to revoke or decrease either the Health Flexible Spending Account or Dependent Care Flexible Spending Account amounts below the amount already disbursed/reimbursed from the applicable account.

6. May I make new elections in future Plan Years?

Yes, you may. During the annual election period prior to each subsequent Plan Year, you may change the elections that you previously made on an election of benefits form to be provided by the Administrator. You may also choose not to participate in the Plan for the upcoming Plan Year. Any election shall be effective for any benefit expenses incurred during the Plan Year which follows the end of the election period. With regard to subsequent annual elections, the following options shall apply:

(a) If you failed to initially elect to participate, then you may elect different or new benefits under the Plan during the election period;

(b) You may terminate your participation in the Plan by notifying the Administrator in writing during the election period that you do not want to participate in the Plan for the next Plan Year, or by not electing any benefit options (to the extent described in below);

(c) If you elect not to participate for the Plan Year following the election period, then you will have to wait until the next election period before again electing to participate in the Plan, except as provided for in Question 5 of this Article.

With regard to Health Flexible Spending Account and Dependent Care Flexible Spending Account elections, if you fail to complete a new benefit election by the end of the applicable election period, then you shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further salary redirections shall therefore be authorized or made for the subsequent Plan Year for such benefits.

With regard to Premium Conversion Plan benefits, if you fail to complete a new benefit election by the end of the applicable election period, then you shall be deemed to have made the same benefit elections as are then in effect for the current Plan Year. You shall also be deemed to have elected salary redirection in an amount necessary to purchase such benefit options.

IV
BENEFITS

1. What benefits are offered under the Plan?

Your Employer adopted this Plan to provide you with flexibility to elect among permitted taxable benefits and qualified nontaxable benefits offered through this Plan for the Plan Year. Specifically, you may elect to receive your normal compensation in cash or to reduce that compensation to receive employer-provided coverage on a pretax basis for one or more of the following optional benefits:

- Health Flexible Spending Account
- Dependent Care Flexible Spending Account
- Premium Conversion Plan
    - Group Medical Plan Benefit
    - Group Dental Plan Benefit

If you select one or more of the above benefits, you will pay all or some of the contribution as described in Article III; the Employer may contribute some or no portion of them. The applicable amounts will be described in the election materials furnished separately to you.

The coverage period for each of the above described benefits you elect is the Plan Year, with the following exceptions: (a) when you first become eligible to participate, the coverage period shall mean the portion of the Plan Year coinciding with and following the date participation commences, as described in Question 3 of Article I; and (b) if you terminate participation, the coverage period shall mean the portion of the Plan Year prior to and including the date participation terminates, as described in Question 5 of Article I. A different coverage period may be established by the Administrator and communicated to you.

2. Health Flexible Spending Account

The Plan allows you to reduce your compensation by an amount not to exceed the statutory amount under Code §125(i), as adjusted for increases in the cost of living ($2,750 for 2020) per Plan Year and have the amount of the reduction credited to a Health Flexible Spending Account for your benefit. The Health Flexible Spending Account enables you to pay for Medical Expenses (as defined below) incurred

by you or your Dependents during your period participation during the Plan Year. The amount by which you elect to have your cash compensation reduced for the entire Plan Year will be immediately credited to your account as of the first day of the Plan Year (or the beginning of your participation if you are a new Participant). Please note that, except as described in the next paragraph, any unused amounts remaining in your Health Flexible Spending Account at the end of the Plan Year must, by federal law, be forfeited. Any reimbursements you receive for Medical Expenses will be excluded from your taxable income. The amount that your compensation is reduced to purchase these benefits will not be subject to federal, state, or local income taxes or FICA taxes.

You may roll over an amount equal to up to 20 percent of the maximum salary redirection permitted under Code §125(i) for that Plan Year ("20% Maximum") of unused amounts in your Health Flexible Spending Account remaining at the end of one Plan Year to pay or reimburse you for Medical Expenses incurred in the immediately following Plan Year. Thus, for example, the maximum unused amount from a Plan Year starting in 2020 allowed to be carried over to the immediately following plan year beginning in 2021 is $550 (20 percent of $2,750, the indexed 2020 limit under §125(i)). These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of the 20% Maximum will be forfeited.

For purposes of the Health Flexible Spending Account, the definition of "Dependent" is expanded to include an adult child until the end of the calendar year in which the child turns 26 years of age. A "child" for this purpose includes your natural child, stepchild, adopted child, or a child placed with you for adoption as defined in Code §152(f)(1). The definition of "child" for this purpose shall not include a child of your child.

The phrase "placed for adoption" refers to a child whom you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The term "Medical Expenses" means expenses incurred during the Plan Year by you or your Dependents, for medical care as defined in Code §213(d) and only as allowed to be reimbursed under Code §125 and the regulations and guidance thereunder, but only to the extent that you or other persons incurring the expense are not reimbursed for the expense through insurance or otherwise. If only a portion of the Medical Expense has been reimbursed elsewhere, the Plan may reimburse the remaining portion of the expense if it otherwise meets this definition. Furthermore, you may not be reimbursed for "qualified long-term care services" as defined in Code § 7702B(c) or any premium payments for health care coverage. Medical Expenses are incurred at the time the services to which the expense relates are rendered, regardless of when you are charged for the services. Effective for expenses incurred after December 31, 2019, pursuant to §3702 of the CARES Act reimbursement of certain over-the-counter drugs and medicine are permitted without prescription and Medical Expenses shall include expenses incurred for menstrual care products (as defined in Code §223(d)(2)(D).

IRS Publication 502, Medical and Dental Expenses, located at www.irs.gov, has a checklist of medical expenses that can be deducted and those that cannot. Please use this publication with caution because it was meant to help taxpayers figure out their tax deductions and not what is reimbursable under a Health

Flexible Spending Account. Some statements in the publication are not correct for determining whether an expense is reimbursable from the Health Flexible Spending Account.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider.

The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, you shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The reimbursement form shall include any additional information deemed by the Administrator necessary to comply with the applicable substantiation requirements of the Code and Treasury regulations.

We will also provide you with a debit or credit card to use to pay for medical expenses. You shall be required to certify that such card shall only be used for Medical Expenses and that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that you will not seek reimbursement from any other plan covering health benefits. You shall also retain sufficient documentation for any expense paid with the card, including invoices and receipts, where appropriate. This certification is reaffirmed each time the card is used. The dollar amount of coverage available on the card shall be the amount you elected for the Plan Year. When you use the card, your maximum available coverage remaining is reduced by that amount. The card shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

Such purchases by the cards shall be subject to substantiation by the Administrator in accordance with all applicable requirements of the Code and Treasury regulations, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69, as applicable. All charges shall be conditional pending confirmation and substantiation. If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use legally compliant correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care. No reimbursement or payment of expenses incurred during a Plan Year shall at any time exceed the total balance of your Health Flexible Spending Account for the Plan Year. Furthermore, you shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the you and/or your Spouse or Dependents, except that if an allowable Medical Expense is payable under this Health Flexible Spending Account and under a health reimbursement arrangement sponsored by the Employer for which you participate, then the Medical Expenses shall be payable under this Health Flexible Spending Account before such Medical Expense may be payable under the health reimbursement arrangement.

Newborns' and Mothers' Health Protection Act: Group health plans and health insurance issuers generally may not, under Federal law, 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 vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related medical and surgical benefits under a group health plan and who elect breast reconstruction in connection with such mastectomy, coverage under that same group health plan will be provided in a manner determined in consultation with the attending physician and the patient, for (a) all stages of reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and treatment of physical complications of mastectomy, including lymphedemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under that group health plan. If you would like more information on WHCRA benefits, call your Administrator.

3. Dependent Care Flexible Spending Account

The Plan allows you to reduce your compensation each pay period and have the amount of the reduction credited to a Dependent Care Flexible Spending Account for your benefit. You can then draw on your account during the Plan Year for reimbursement of Employment-Related Dependent Care Expenses (as defined below), incurred by you during the Plan Year (and the following Grace Period, if applicable). Expenses are incurred when the service is provided, not when the Expense is paid. Please note that any unused amounts remaining in your Dependent Care Flexible Spending Account at the end of the Plan Year (or its Grace Period, if applicable) must, by Federal law, be forfeited.

Any reimbursements you received for Employment-Related Dependent Care Expenses will be excluded from your taxable income. The amount that your compensation is reduced to purchase these benefits will not be subject to federal, state, or local income taxes or FICA taxes.

"Employment-Related Dependent Care Expense" means expenses that are considered to be employment-related expenses under Code §21(b)(2), are incurred by you for the care of your Qualifying Dependent or for related household services, are paid or payable to a Dependent Care Service Provider, and are incurred to enable you to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to you. Employment-Related Dependent Care Expenses shall not include expenses incurred for services outside your household for the care of a Qualifying Dependent, unless the Qualifying Dependent is a Qualifying Dependent as defined in Code §152(a)(1) and is under the age of 13, or the Qualifying Dependent regularly spends at least eight hours each day in your household. Employment-Related Dependent Care Expenses do not include amounts payable to your spouse, to the parent of your Qualifying Dependent child under age 13, to an individual for whom you or your spouse may claim an exemption under Code §151(c), or to your child under the age of 19 at the end of the year in which Employment-Related Dependent Care Expenses are incurred. Employment-Related Dependent Care Expenses are incurred at the time the services to which the expense relates are rendered, regardless of when you are charged for the services.

"Qualifying Dependent" means, for purposes of the Dependent Care Flexible Spending Account, any individual who is either your dependent (who is a qualifying child within the meaning of Code §152) who is under the age of 13, or your spouse or dependent (as defined in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of such taxable year. In circumstances of divorced or legally separated parents (or parents who live apart at all times during the last six months of the calendar year), a child as provided above and in Code §152(e) and §21(e)(5) will be the "Qualifying Dependent" of the parent having custody for the greater portion of the calendar year.

"Dependent Care Service Provider" means a person who provides care or other services for the care of your Qualifying Dependent and related household services, but shall not include a dependent care center (as defined in Code §21(b)(2)(D)), unless the requirements of Code §21(b)(2)(D) are satisfied and shall not include a related individual described in Code §129(c), Code §21 and the regulations thereunder.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. We will also provide you with a debit or credit card to use to pay for Employer-Related Dependent Care Expenses.

You shall be required to certify that such card shall only be used for Employment-Related Dependent Care Expenses and that any Employment-Related Dependent Care Expense paid with the card has not already been reimbursed by any other plan covering dependent care benefits and that you will not seek reimbursement from any other plan covering dependent care benefits. You shall also retain sufficient documentation for any expense paid with the card, including invoices and receipts, where appropriate. This certification is reaffirmed each time the card is used. The cards shall only be accepted by such service providers as have been approved by the Administrator. The cards shall only be used for Employment-Related Dependent Care Expenses from these providers. The Administrator will provide you with further details.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation for the calendar year; (c) if you are married, your spouse's actual or deemed earned income (a spouse who is a full time student at an educational institution or physically or mentally incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including any information deemed by the Administrator necessary to comply with the applicable substantiation requirements of the Code and Treasury regulations, including but not limited to the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted.

Such purchases by the cards shall be subject to substantiation by the Administrator in accordance with all applicable requirements of the Code and Treasury regulations, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69, as applicable. All

charges shall be conditional pending confirmation and substantiation. If such purchase is later determined by the Administrator to not qualify as an Employment-Related Dependent Care Expense, the Administrator, in its discretion, shall use legally compliant correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. You will need to carefully examine your own tax situation to determine this. For more information about how the child care tax credit works, see IRS Publication No. 503, located at www.irs.gov. Please use this publication with caution because it was meant to help taxpayers figure out if they can claim the dependent care tax credit and not what is reimbursable under a Dependent Care Flexible Spending Account. Some statements in the publication are not correct for determining whether an expense is reimbursable from the Dependent Care Flexible Spending Account. You will not be able to claim a tax benefit for the amounts received by you under the Plan although if you incur expenses in excess of your account and below your limitation for the year, you may be able to claim a credit for the excess amount. You and your tax advisor should calculate the tax savings that are available through use of the credit and compare it to the tax savings you would enjoy by reducing your salary under the Plan. If you have any questions about whether or not an expense is reimbursable, ask the Administrator.

4. Premium Conversion Plan

The "Premium Conversion Plan" means the account established for you pursuant to the Plan to which part of your salary may be allocated and from which your "Premiums" (i.e., your cost for Group Medical Plan and Group Dental Plan benefits) may be paid or reimbursed. The Premium Conversion Plan allows you to reduce your pay in pre-tax dollars to make the required Employee contribution to purchase coverage under the Group Medical Plan and the Group Dental Plan. The amount your compensation is reduced to purchase these benefits will not be subject to federal, state or local income taxes or FICA taxes. Although you may make an election to receive this benefit under this Plan, the Group Medical Plan and Group Dental Plan benefits will be provided by separate plans governed by separate plan documents

Under our Plan, we will establish sub-accounts for you for each different type of coverage that is available. Also, certain limits on the amount of coverage may apply.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

The rights and conditions with respect to the benefits payable from the Group Medical Plan and Group Dental Plan shall be determined therefrom, and incorporated herein by reference. While the election to receive these optional benefits may be made under this Plan, the benefits will be provided by the separate plan or plans sponsored by the Employer offering the benefits described. The types and amounts of benefits available, the requirements for participating, and the other terms and conditions of coverage and benefits are set forth in those plans. The annual contribution for the Participant's premium sharing benefits is equal to the amount as set by the Employer and communicated to the Participants prior to enrollment.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. The provisions of the insurance contracts will control what Group Medical Plan and Group Dental Plan benefits will be paid and when. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

If you have not spent all the amounts in your Dependent Care Flexible Spending Account by the end of the Plan Year, you may continue to incur claims for expenses during the Grace Period. The term "Grace Period" means, with respect to any Plan Year, the time period ending on the 15th day of the third calendar month after the end of such Plan Year, during which Employment-Related Dependent Care Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year. Specifically, you may continue to incur Employer-Related Dependent Expenses during the Grace Period to be paid for by any remaining amounts in the Dependent Care Flexible Spending Account from the immediately prior Plan Year.

Any monies left at the end of the Plan Year and the Grace Period (as applicable) will be forfeited (unless carried over in the case of the Health Flexible Spending Account pursuant to Question 2 of Article IV. Qualifying expenses that you incur late in the Plan Year or during the Grace Period for which you seek reimbursement after the end of such Plan Year and Grace Period will be paid first before any amount is forfeited, but only if you seek reimbursement on a timely basis.

Internal Revenue Service Notice 2020-29 grants employers the ability to provide relief for participants of Code §125 cafeteria plans. That notice is designed to provide temporary flexibility for employers and employees and assist with the national response to the 2019 novel coronavirus outbreak (COVID-19). In accordance with that notice, for unused amounts remaining in the Dependent Care Flexible Spending Account as of the end of the Grace Period ending in 2020, the Plan shall permit you to apply those unused amounts to pay or reimburse Employment-Related Dependent Care Expenses incurred through December 31, 2020.

For the Health Flexible Spending Account, you must submit claims no later than 135 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, claims for reimbursement of Medical Expenses must be submitted within 30 days after termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 60 days after the end of the Plan Year (or within 30 days after the end of the Grace Period for expenses incurred therein). Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act ("FMLA"), to the extent required by the FMLA, your Employer will continue to maintain your Group Medical Plan, Group Dental Plan, and Health Flexible Spending Account coverage on the same terms and conditions as if you were still actively working (that is, your Employer will continue to pay its share of the premium to the extent you opt to continue coverage). Typically, you will have the choice to continue coverage during your FMLA leave, or to revoke coverage. However, in some circumstances, your Employer may require that coverage be continued during your FMLA leave.

If you are taking a paid FMLA leave, your Employer may elect to continue your Group Medical Plan, Group Dental Plan, and Health Flexible Spending Account coverage, so long as Participants on non-FMLA paid leave are required to continue coverage. In this case, you will pay your share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis, if that is what was used before the FMLA leave began).

If you are taking an unpaid leave and your Employer requires all Participants to continue Group Medical Plan, Group Dental Plan, and Health Flexible Spending Account coverage, you may discontinue paying your share of the required premium until you return from leave. Upon returning from leave you must pay your share of any required premiums that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, as you and the Administrator may agree.

If you choose to continue your Group Medical Plan, Group Dental Plan, and Health Flexible Spending Account coverage during the leave, on either a paid or unpaid FMLA leave, then you may continue to pay your share of the premium in the following ways:

(a) You may prepay your contributions due for the FMLA leave period prior to taking your leave. Contributions under the pre-pay option may be made on a pre-tax salary reduction basis or on an after-tax basis (to pre-pay in advance, you must make a special election before such compensation would normally be available to you (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year));

(b) You may pay your contribution during your leave as if you were not on leave. These payments may be made with after-tax dollars, or with pre-tax dollars if you receive compensation during the leave for any allowable unused sick days and vacations days; or

(c) You may pay your contribution by other arrangements agreed upon between you and the Administrator. For example, you and your Employer may agree that the Employer pay for coverage during the leave and then will withhold amounts from your compensation upon your return from leave to "catch-up" on the payment you owe

If your Group Medical Plan, Group Dental Plan, or Health Flexible Spending Account coverage ceases while on FMLA leave (e.g., for revocation or nonpayment of required contributions), you will be entitled to re-enter such benefits, applicable, upon return from such leave on the same basis you were participating in the Plan before the leave, or otherwise required by the FMLA. If your Health Care Flexible Spending Account coverage ceases, you will be entitled to elect whether to be reinstated in the Health Care Flexible Spending Account at the same coverage level as in effect before FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-

rata for the period of FMLA leave during which you did not pay premiums. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health Care Flexible Spending Account coverage will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, your election for nonhealth benefits (such as Dependent Care Flexible Spending Account benefits) will be treated in the same way as under Employer's policy for providing such benefits for Participants on a non-FMLA leave. If that policy permits Participants to discontinue contributions while on leave, Participants will, upon returning from leave, be required to repay the premiums not paid by the Participant during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Administrator and the Participant or as the Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate (unless a mid-year change in election is permitted under Question 5 of Article III) and the premium due for you will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year for any reason other than death, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for Employment-Related Dependent Care Expenses incurred during the remainder of the Plan Year in which such termination occurs from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 60 days after the end of the Plan Year in which termination occurs (or within 30 days after the end of the Grace Period for expenses incurred therein, based on the level of your Dependent Care Flexible Spending Account as of the date of termination.

(c) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article X. Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for Medical Expenses that were incurred before the end of the period for which payments to the Health

Flexible Spending Account have already been made. Your further participation will be governed by COBRA and Article X.

6. What happens if I die?

If you die, your participation in the Plan shall cease. However, your Spouse or Dependents may submit claims for expenses or benefits incurred prior to your death for up to 60 days from the date of your death or until the salary redirection dollars allocated to each specific benefit are exhausted, if earlier). In no event may reimbursements be paid to someone who is not a Spouse or Dependent.

7. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

It is the intent of the Plan, the Health Flexible Spending Account, and the Dependent Care Flexible Spending Account to not discriminate in violation of the Code (including Code §§ 125, 129, and 105(h)) and the Treasury regulations thereunder.

The Code specifically defines the terms "highly compensated employees" and "key employees." However, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. For example, federal tax laws generally state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

If the Administrator deems it necessary to avoid discrimination or possible taxation to key employees or highly compensated employees under this Plan, the Health Flexible Spending Account, and/or the Dependent Care Flexible Spending Account, it may, but shall not be required to, reject any election or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. This action may include, without limitation, a modification of elections by highly compensated employees or key employees, with or without the Employee's consent. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

Northern Michigan University Flexible Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 520 to your Plan.

"Effective Date": The provisions of your amended and restated Plan become effective on July 1, 2020. Your Plan was originally effective on January 1, 1990.

Your Plan's records are maintained on a twelve-month period of time. This is known as the "Plan Year". The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

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

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

3. Plan Administrator and Plan Sponsor Information

The name, address and business telephone number of your Plan Administrator and Plan Sponsor are:

Northern Michigan University
Human Resources Department
1401 Presque Isle Avenue
Marquette, Michigan 49855
Phone: 906-227-1030

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

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Northern Michigan University
Human Resources Department
1401 Presque Isle Avenue
Marquette, Michigan 49855

Note: Service of legal process may also be made on the Plan Administrator.

5. Type of Administration and Plan

The type of plan is a cafeteria plan.

The type of administration is Employer-Administration.

6. Contract / Claims Administrator

Claims for expenses should be submitted to:

WageWorks, Inc.
P.O. Box 14054
Lexington, KY 40512

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

Any claims for benefits under the Group Medical Plan or Group Dental Plan shall be made pursuant the underlying document's claims and review procedure.

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 135 days after the end of the Plan Year (or within 30 days after termination of employment if you terminate employment during the Plan Year). For the Dependent Care Flexible Spending Account, you must submit claims no later than 60 days after the end of the Plan Year (or within 30 days after the end of the Grace Period for expenses incurred therein). Any claims submitted after that time will not be considered.

Claims that are insured or self-funded will be handled in accordance with procedures contained in the insurance policies or contracts. All other general requests should be directed to the Administrator of our Plan. If a dependent care or medical expense claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

X
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), certain employees and their families covered under group health plan benefits under this Plan will be entitled to the opportunity to elect a temporary extension of such health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide group health plan benefits. Whenever "Plan" is used in this section, it means any of the group health plan benefits under this Plan including the Health Flexible Spending Account. Please note that special rules exist with regard to COBRA's application to the Health Flexible Spending Account, as described below.

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available when you lose group health coverage**.** For example, you may be eligible to buy an individual plan through the health insurance marketplace. By enrolling in coverage through the marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, Spouse, or a Dependent child (as set forth in 26 U.S.C. §4980B(g)(1)).

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage. If coverage is reduced or eliminated in anticipation of an event (for example, an employer's eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee's eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), then the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

The taking of leave under the FMLA does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on

the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost).

4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of the applicable premium for COBRA coverage (150% of the applicable premium if coverage is continued due to disability). Other options, like coverage on a spouse's plan or through the marketplace, may be less expensive. Qualified Beneficiaries may have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified Beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the health insurance marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited. You and your Qualified Beneficiaries each will have an independent right to elect COBRA continuation coverage. Covered employees and spouses who are Qualified Beneficiaries may elect COBRA coverage on behalf of all other beneficiaries, and parents may elect COBRA coverage on behalf of their minor children.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment (other than by reason of gross misconduct) or reduction of hours of employment,

(b) death of the employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (e.g., divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the latest of (i) the date on which the relevant Qualifying Event occurs; or (ii) the date on which the covered

employee or Qualified Beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Northern Michigan University
Human Resources Department
1401 Presque Isle Avenue
Marquette, Michigan 49855

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

9. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which timely payment is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of coverage under the Health Flexible Spending Account, coverage ceases on the last day of the Plan Year within which the Qualifying Event occurs.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

10. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

11. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

12. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension may be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

13. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

14. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

15. What is Timely Payment for COBRA continuation coverage?

Timely payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered timely payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

16. How is my participation in the Health Flexible Spending Account affected?

COBRA coverage under the Health Flexible Spending Account will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. An account is underspent if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the Qualifying Event, is equal to or more than the amount of the premiums for Health Flexible Spending Account COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health Flexible Spending Account coverage in force at the time of the Qualifying Event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the Qualifying Event). The use or lose rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year. Unless otherwise elected, all Qualified Beneficiaries who were covered under the Health Flexible Spending Account will be covered together for Health Flexible Spending Account COBRA coverage. Qualified Beneficiaries may not enroll in the Health Care Flexible Spending Account at open enrollment.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

XI
MISCELLANEOUS

Applicable Law

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Michigan. With respect to group health plans, those plans will provide benefits in accordance with COBRA, NMHPA, USERRA, PPACA, the Mental Health Parity Act; the Mental Health Parity and Addiction Equity Act of 2008; the Genetic Information Nondiscrimination Act of 2008; FMLA; HIPAA; WHCRA; and other group health plan laws to the extent required by such laws.

Errors

An error cannot give a benefit to an individual if an individual is not actually entitled to the benefit.

Overpayments

An "overpayment" occurs if the Plan pays an amount not payable under the Plan (e.g., 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 (e.g., a health care provider) on your or your 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 a Dependent, 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 Dependent's ineligibility for Plan benefits will be reduced by the amount of any contributions the Participant paid for coverage for the person while ineligible.

Amendment and Termination

Although the Plan Sponsor intends to continue the Plan indefinitely, it reserves the right to amend or terminate the Plan or to modify the Plan to reduce, increase or modify any and all of the benefits provided under the Plan. Any decision to amend, terminate or modify the Plan shall be made by a written instrument by the governing body of your Employer or by any person or persons authorized by the governing body to take such action. This decision shall be communicated to all participants in writing. In the event the Plan is terminated, all elections and reductions in compensation made under the Plan shall terminate, and allowable reimbursements or payments shall be made in accordance with the next paragraph.

If the Plan terminates, you will be entitled to payment or reimbursement for Employment-Related Dependent Care or Medical Expenses incurred during the Plan Year if you apply for reimbursement or payment on or before the 90th day after the termination date of the Plan. Your reimbursement will not

exceed the remaining balance, if any, in your Dependent Care Flexible Spending Account or your Health Flexible Spending Account for the Plan Year in which the expenses were incurred.

Summary

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Extension of Certain Deadlines Due to COVID-19

On May 4, 2020, guidance issued by the Department of the Treasury and the Department of Labor entitled "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak" was published in the Federal Register at 85 Fed. Reg. 26351 (May 4, 2020) requiring certain group health plans, disability and other employee welfare benefit plans to disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency concerning the novel coronavirus disease (COVID-19) outbreak or such other date announced by the government in a future notification (the "Outbreak Period") for all plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining certain periods and dates including:

- The 30-day period (or 60-day period, if applicable) to request special enrollment under Code §9801(f).
- The 60-day election period for COBRA continuation coverage under Code §4980B(f)(5).
- The date for making COBRA premium payments pursuant to Code §4980B(f)(2)(B)(iii) and (C).
- The date for individuals to notify the plan of a qualifying event or determination of disability under Code §4980B(f)(6)(C).

With respect to group health plans and their sponsors and administrators, the Outbreak Period shall be disregarded when determining the date for providing COBRA election notice under Code §4980B(f)(6)(D).

On May 14, 2020, Department of Health and Human Services released a memorandum concurring with the above referenced guidance and adopting a temporary policy of relaxed enforcement to extend similar time frames otherwise applicable to non-federal governmental group health plans offering coverage under applicable provisions of the Public Health Service Act. To the extent applicable and to the extent required / permitted by this guidance and/or any related subsequently issued guidance, the Plan, effective as of the date required / permitted by such guidance, shall extend such applicable deadlines.