SUMMARY PLAN DESCRIPTION

FOR

GRAND VALLEY STATE UNIVERSITY

FLEXIBLE BENEFITS PLAN

January 1, 2018

THIS BOOKLET IS A SUMMARY OF THE PROVISIONS OF OUR PLAN. WHILE EVERY EFFORT HAS BEEN MADE TO HAVE THESE MATERIALS BE AS COMPLETE AND ACCURATE AS POSSIBLE, THE SUMMARY PLAN DESCRIPTION CANNOT BE A FULL RESTATEMENT OF THE PLAN. IF THERE IS ANY CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE ACTUAL TERMS OF OUR PLAN, THE PROVISIONS OF THE PLAN WILL CONTROL.

TABLE OF CONTENTS

Page

GRAND VALLEY STATE UNIVERSITY

FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Grand Valley State University Flexible Benefits Plan (the "**Plan**") provides you the opportunity to pay your premium contribution for coverage under the group health plans (medical, dental and vision) sponsored by Grand Valley State University (referred to in this document as the "**University**" or the "**Employer**") on a pre-tax basis as well as to pay certain uninsured health care and dependent care costs and, if you are eligible, to make contributions to a tax-advantaged health savings account ("**HSA**") on a pre-tax basis. This Summary Plan Description is intended to answer most of your questions regarding the Plan. You should feel free to contact the Plan Administrator if you need additional information.

HOW DOES THE PLAN OPERATE?

You may elect to have the University withhold a portion of your compensation each pay period to make contributions (in most cases on a pre-tax basis) to the following component programs under the Plan:

(i) Premium Payment Program. Your required premium contributions for coverage under the University's group health (medical, dental and vision) plans,

(ii) HSA Contributions Program. Elective contributions to your health savings account if you are an HSA-eligible individual.

(iii) Health FSA Program. Certain uninsured medical expenses, and

(iv) Dependent Care Program. Certain dependent care expenses.

You may elect to make pre-tax and, in some cases, after-tax contributions to the plan from your regular paychecks. As long as the Plan is operated in a nondiscriminatory manner, you will not pay income or employment (FICA) taxes on the amounts you elect to have withheld from your pay as pre-tax contributions. Therefore, over the course of the plan year, you will pay less in taxes and have more take-home pay than if you paid the contributions or expenses solely on an after-tax basis.

If you pay less tax because you elect to participate in the Plan, your Social Security benefits may be reduced slightly. This is because you and the University will pay less FICA tax. Whether or not your Social Security benefits will actually be lower depends on a number of factors such as your current age, your current earnings, and your future

pay levels; however, in most cases the current tax savings will outweigh any slight impact on future Social Security benefits.

PREMIUM PAYMENT PROGRAM

WHAT BENEFITS ARE PROVIDED UNDER THE PREMIUM PAYMENT PROGRAM?

The Premium Payment Program gives you the opportunity to pay your required employee contribution for coverage under the University's group health plans (medical, dental and vision). The amount by which your compensation will be reduced is the amount of the required contribution for the coverage you elect. Your contribution will be made on a pre-tax basis, except that if you purchase coverage for a Household Member under the University's Household Member Program, your contribution for the cost of that coverage will be made on an after-tax basis. You may not use pre-tax contributions to purchase an individual health plan.

WHAT IF I'M COVERED UNDER OTHER HEALTH INSURANCE?

If you are covered under other health insurance (for example, your spouse's employer's plan), you may decline coverage for yourself and/or your family under the University's plan and instead receive additional cash compensation. The amount of the cash compensation will be determined each year by the University and announced at open enrollment time. It will be added to your regular paychecks and will be taxable the same as your regular pay. If you opt out of health coverage and later change your mind, you will have to wait until the beginning of the next plan year to join the plan (except in certain situations discussed under *"Can I Change My Elections During the Plan Year?").* Therefore, if you decline health coverage, you should be very careful to make sure that you have other coverage through a spouse's plan or elsewhere. If you do not have other coverage for yourself and your family, a major illness or injury could be a severe financial hardship.

If you decline coverage under the University's group health plan, you can still participate in this Plan's other component programs.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR THE PREMIUM PAYMENT PROGRAM?

If you were hired as an employee of the University on or after July 1, 2016 and you are regularly scheduled to work at least 30 hours per week, you are eligible to participate in all benefit coverages offered under the Premium Payment Program on the first day you become eligible to participate in the University's group health plan.

If you were hired as an employee of the University on or after July 1, 2016 and you are regularly scheduled to work at least 20 but less than 30 hours per week, you are eligible

to participate in all benefit coverages offered under the Premium Payment Program other than medical coverage.

If you were hired as an employee of the University before July 1, 2016 and you are regularly scheduled to work at least 20 but less than 30 hours per week, you are eligible to participate in all benefit coverages offered under the Premium Payment Program and your cost of medical coverage will be as follows:

* Beginning January 1, 2018, you will pay 20% of the University's cost for the medical coverage you select.

* Beginning January 1, 2019, you will pay 40% of the University's cost for the medical coverage you select.

* Beginning January 1, 2020, you will pay 50% of the University's cost for the medical coverage you select.

Visiting Faculty may participate in the Premium Payment Program for the sole purpose of making premium contributions for medical coverage under the University's group health plan. Benefits-eligible temporary workers may also participate in the Premium Payment Program for the sole purpose of making premium contributions for medical coverage under the University's group health plan after 90 days of employment. All other temporary employees, adjunct faculty, and adjunct EAP are not eligible to participate for any purpose.

If you are covered by a collective bargaining agreement or a phased retirement agreement with the University, other rules related to your eligibility for the Premium Payment Program may apply. You should consult those agreements for additional information.

HOW DO I MAKE A CLAIM UNDER THE PREMIUM PAYMENT PROGRAM?

To receive benefits from the coverages for which you pay premiums under the Premium Payment Program, you should follow the claims and appeal procedure outlined in the summary plan description or benefit booklet for that coverage. If you have any questions about your ability to pay your required contributions for these benefits on a pre-tax basis, you should contact the Plan Administrator.

HSA CONTRIBUTIONS PROGRAM

WHAT BENEFITS ARE PROVIDED UNDER THE HSA CONTRIBUTIONS PROGRAM?

The HSA Contributions Program allows you to elect to make pre-tax contributions to an HSA. An HSA is an account established under the requirements of the Internal

Revenue Code that belongs to you and is maintained by a bank (or other qualified trustee/custodian). The University will forward any HSA contributions that you elect under the HSA Contributions Program for deposit to your HSA account. The University may choose one or more trustees/custodians who will assist in establishing an HSA for you, but your HSA belongs to you. It is completely portable and it goes with you if you change jobs or terminate employment.

You can use amounts in your HSA and the earnings on those amounts to pay for qualifying medical care expenses on a tax-free basis. However, you must pay regular income tax on any withdrawals from your HSA that you do not use to pay qualifying medical care expenses and, with certain exceptions (death, disability or attainment of age 65), you must also pay a 20% penalty as well. For a description of qualifying medical care expenses, consult the materials provided to you by your HSA trustee/custodian or go to www.irs.gov.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR HSA PARTICIPATION?

To be eligible for the HSA Contributions Program you must be an HSA-eligible individual. You are an HSA-eligible individual if you meet all of the following requirements:

(i) you elect coverage under the University's high deductible health plan ("**HDHP**");

(ii) you are not covered by any disqualifying non-HDHP coverage (see *"What Is Disqualifying Non-HDHP Coverage?"*); and

(iii) you cannot be claimed as another person's tax dependent.

WHAT IS DISQUALIFYING NON-HDHP COVERAGE?

Any health plan coverage that pays or reimburses medical expenses before your HDHP deductible is met disqualifies you from contributing to an HSA for that year. Disqualifying non-HDHP coverage includes the following types of health plan coverage:

* Your spouse's non-HDHP plan under which you are covered

* Medicare Parts A, B or D

* A Medicare Advantage Plan

* Medicaid

* Tricare

* Veterans Administration medical benefits received during the preceding three months, unless you have been determined to have a service-related disability

* Indian Health Service medical benefits received during the preceding three months

* A health flexible spending account elected by you or your spouse (or any other family member if you are covered), unless it is a limited-purpose or post-deductible flexible spending account. The University's general purpose Health FSA Program is disqualifying non-HDHP coverage (but see below for a special rule regarding the health FSA grace period).

* Any other coverage that covers all or even a portion of medical expenses that you incur before you have satisfied the deductible threshold

Coverage under the general purpose health FSA during the grace period following the end of the plan year does not disqualify you from making HSA contributions during the grace period but only if (i) you are otherwise an HSA-eligible individual and (ii) you incurred sufficient claims to reduce your health FSA balance to zero by the end of the plan year.

WHAT IS MY EMPLOYER'S ROLE IN MY HSA?

The University will forward your HSA contributions for deposit to your HSA. However, your HSA is not part of the Plan and your HSA is not sponsored by the University.

WILL MY EMPLOYER CONTRIBUTE TO MY HSA?

The University may, but is not required to, make contributions to your HSA. You will be informed of the amount of any Employer contribution when you enroll in this Plan.

DO I HAVE TO MAKE CONTRIBUTIONS TO MY HSA?

No, but you are encouraged to make pre-tax contributions to an HSA so that you will be prepared for out-of-pocket medical expenses you incur under your HDHP.

WHAT ARE THE LIMITS ON CONTRIBUTIONS TO MY HSA?

Your total HSA contributions each year may not exceed the IRS limit for the calendar year in which the contribution is made ($3,450 for single HDHP coverage and $6,900 for double or family HDHP coverage in 2018, adjusted for cost of living annually thereafter). If you are age 55 or older by the end of the plan year, you may contribute an additional $1,000 "catch-up" amount.

Generally, the maximum limit for your HSA contributions is pro-rated on a monthly basis if you are not an HSA-eligible individual for the entire plan year. For example, if you are an HSA-eligible individual for only 9 months of the year, your contribution limit will be 9/12 of the above limits. However, under a special IRS rule, if you become HSA-eligible after the first day of the year and you are still eligible during the last month of that year (December), you may contribute up to the full annual limit for that tax year. But be careful because if your HSA eligibility ends for any reason other than your death or disability prior to December 31 of the next year (for example, because you no longer have HDHP coverage), the contributions that would not have been allowed except for this special IRS rule will be included in gross income and subject to a monetary penalty.

The maximum HSA contribution limit applies to all contributions made by you or on your behalf through this Program and any HSA contributions made outside this Program. Contributions made in excess of the IRS limit are subject to a 6% excise tax, so it is important that you make sure you do not exceed this limit.

WHOSE EXPENSES CAN BE PAID FROM MY HSA?

You may use your HSA to pay eligible medical expenses for yourself, your spouse and any dependent who meets the requirements of a dependent under Section 152 of the Internal Revenue Code for medical plan purposes. Unlike the University's medical plan and Health FSA, medical expenses of your adult child over age 18 are eligible for reimbursement only if your child is also your dependent for medical plan purposes under the Internal Revenue Code.

WHAT HAPPENS TO AMOUNTS LEFT IN MY HSA AT THE END OF THE YEAR?

Your HSA belongs to you as the account owner. Unlike the Health FSA and Dependent Care Programs, amounts remaining in your HSA at the end of the year are yours and will carry forward to the next year. These amounts will not be forfeited.

HOW DO I MAKE WITHDRAWALS FROM MY HSA?

To withdraw money from your HSA, follow the procedures of the trustee/custodian of your HSA. The HSA is not sponsored or maintained by the University and the University has no control over contributions deposited to or disbursements from your HSA; however, if you have any questions about your ability to pay HSA contributions on a pre-tax basis through this Plan, you should contact the Plan Administrator.

HEALTH FSA PROGRAM

WHAT BENEFITS ARE PROVIDED UNDER THE HEALTH FSA?

The Health FSA Program allows you to make pre-tax contributions to a health flexible spending account ("**Health FSA**") and be reimbursed for eligible medical expenses (see

"What Are Eligible Medical Expenses?") incurred by you, your spouse, and your dependents (see *"Who is Considered a Dependent Under the Health FSA?"*) during the plan year and the grace period. The grace period is the period from January 1 through March 15 immediately following the end of the plan year.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR THE HEALTH FSA?

You must be an employee who is eligible to participate in the University's group medical plan in order to be eligible to participate in the Health FSA Program. You will be eligible to participate in the Health FSA Program as soon as you become eligible to participate in the University's medical plan.

Temporary employees, visiting faculty, adjunct faculty, and adjunct EAP are not eligible to participate in the Health FSA Program.

WHAT ARE "ELIGIBLE MEDICAL EXPENSES"?

Medical expenses eligible for reimbursement under this Health FSA Program depend on whether you elect the "general purpose" or "limited purpose" option.

General Purpose FSA (This option should be elected only if you or your spouse do not intend to make HSA contributions during the plan year.)

If you and your spouse do not intend to contribute (or have contributions made on your behalf) to an HSA during the plan year, you should elect the "**general purpose**" option. Eligible medical expenses that can be paid by your general purpose Health FSA include the following, provided they are not payable under any other insurance policy or health care plan:

* Expenses not paid by your health plan, such as deductible or co-payment amounts, co-insurance, expenses over the maximum payable under the plan and medical care expenses that are excluded or otherwise not covered under the plan;

* Dental expenses;

* Orthodontic expenses;

* Vision expenses, including examinations, eyeglasses, contact lenses, laser surgery and seeing-eye dogs;

* Hearing expenses, including examinations and hearing aids;

* Physical examinations;

* Psychoanalysis, psychiatric therapy, learning disability counseling by a licensed professional, inpatient care, treatment and services provided by a licensed psychologist;

* Acupuncture;

* Therapeutic treatment for drug or alcohol addiction, including meals and lodging if necessary for the treatment;

* Medical equipment purchased or rented because of a medical condition, such as wheelchairs, crutches, and orthopedic shoes, or for the repair or replacement of prosthetic devices due to normal wear and tear;

* Prescription drugs and over-the-counter drugs purchased with a physician's prescription;

* Insulin;

* Transportation primarily for, and essential to, medical care; and

* Any other expense that qualifies as a medical care deduction for federal income tax purposes.

Limited Purpose FSA (This option should be elected if you or your spouse intend to make HSA contributions during the plan year.)

The limited purpose option under the Health FSA Program is designed for employees who intend to make contributions to an HSA (or have contributions made on their behalf) during the plan year. In order to assure your eligibility for HSA contributions during the plan year, expenses that can be paid from your limited purpose Health FSA are limited to the following:

* Dental Expenses - Dental expenses, including orthodontics; and

* Vision Expenses - Vision expenses, including examinations, eyeglasses, contact lenses, laser surgery and seeing-eye dogs.

These expenses will be reimbursed only if they are not paid under any other insurance policy or health care plan.

WHAT MEDICAL EXPENSES CANNOT BE PAID UNDER THE HEALTH FSA PROGRAM?

Current tax law prohibits the Health FSA Program from paying or reimbursing the following:

* Expenses incurred prior to the beginning or after the end of the current plan year (except during the grace period);

* Cosmetic surgery or similar procedures unless the surgery or procedure is necessary to ameliorate a deformity due to a congenital abnormality, an injury, or a disfiguring disease;

* Premiums for health insurance coverage;

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

* Any expense incurred while you were not participating in the Health FSA Program; or

* Over-the-counter drugs and medication (other than insulin) purchased without a physician's prescription.

WHOSE EXPENSES CAN BE PAID UNDER THE HEALTH FSA PROGRAM?

You may use your Health FSA to pay eligible medical expenses for yourself, your spouse, your children (until the end of the calendar year in which they attain age 26) and any qualifying dependent. A qualifying dependent must meet the requirements of a dependent under section 152 of the Internal Revenue Code for medical plan purposes.

WHAT IS THE MAXIMUM AMOUNT I CAN CONTRIBUTE TO THE HEALTH FSA PROGRAM?

The maximum amount you may elect to contribute under the Health FSA Program for the 2018 plan year is $2,500 (as may be adjusted in subsequent years for cost of living), regardless of whether you participate in the general purpose or limited purpose option.

IS THERE A LIMIT ON HOW MUCH REIMBURSEMENT I CAN RECEIVE?

The amount of reimbursement available to you at any time during the plan year is the entire amount you have elected to contribute for the plan year, less any previous reimbursement for expenses incurred during the plan year. You must accumulate a minimum of $10 (or the amount remaining in your Health FSA, if less) in reimbursable expenses before filing a claim.

WHAT HAPPENS TO AMOUNTS LEFT IN MY HEALTH FSA AT THE END OF THE YEAR?

If you do not incur sufficient expenses to use all the money in your Health FSA by the end of the plan year, the unused amount can be rolled over for 2 1/2 months. You may

continue to incur expenses to be reimbursed from the amounts rolled over until March 15th of the following plan year. This period from the end of the plan year through the following March 15th is referred to as the "grace period." Any rolled over amount that is not used to reimburse eligible medical expenses incurred during the plan year or grace period will be permanently forfeited. It will not be refunded to you. An expense is considered to be "incurred" when the medical care service is provided, not when it is billed or paid.

You may not use your Health FSA for Dependent Care Program expenses and vice versa. Therefore, in deciding how much of your compensation to direct toward benefits under the Health FSA, **it is very important that you estimate your expected expenses for the upcoming year carefully.** Overestimating your expenses may cause you to forfeit unused amounts. Forfeited amounts are used to offset excess reimbursements and administrative expenses for the Plan.

HOW DO I MAKE A CLAIM UNDER THE HEALTH FSA PROGRAM?

In General

To be reimbursed under the Health FSA Program for medical expenses that you, your spouse or your dependents have incurred, you must file a benefit claim form with the Claims Administrator, together with a bill, receipt, or other satisfactory proof of the medical expense from your medical provider as well as any additional information required by the Claims Administrator, including certification that the expense has not been, and will not be, reimbursed under any other health plan.

If you elected a limited purpose Health FSA, you must include sufficient information to show that the expenses are for dental or vision coverage.

The Claims Administrator will have benefit claim forms available for your use. All claims for expenses incurred during a plan year or grace period must be filed no later than April 30th following the end of the plan year or, if earlier, 90 days following the termination of your employment.

Generally, your claim will either be paid or denied within 30 days of submission. You may elect to have claim payments directly deposited into your bank account. The Claims Administrator can provide you with additional information on this option.

If you elect automatic reimbursement during your initial enrollment period or the annual enrollment period, you do not need to file a benefit claim form for co-pay or deductible expenses you incur under the University's self-funded PPO medical plan. These expenses will be automatically reimbursed when you incur them. If you participate in one of the University's other medical plans (e.g., the HDHP or HMO), you must file a benefit claim form for such expenses. If you are not sure whether this applies to you or a medical expense you incur, you should consult the Claims Administrator.

If a claim is approved, the amount of the expense will be deducted from the balance in your Health FSA. Expenses incurred during the grace period will be deducted first from any amounts temporarily rolled over from the previous plan year.

You (or your representative) have the right to appeal the denial of a claim, in writing to the Claims Administrator, within 60 days after you receive the notice of denial. Your written appeal should state the reasons you believe your claim should not have been denied. Decisions of the Claims Administrator are final and binding. You will be required to repay any expense or cost incurred due to the payment of a benefit that should not have been reimbursed.

WHAT IS A QUALIFIED RESERVIST DISTRIBUTION?

If you are a member of a military reserve component ordered or called to active duty for a period of at least 180 days or for an indefinite time period, you may be eligible for a qualified reservist distribution from your Health FSA of any unspent amounts that you have contributed for the year. To request a distribution, you must submit a written request along with a copy of your orders or call to duty before the last day of the grace period for the plan year (March 15 of the following year).

The Plan Administrator will approve or deny the request by verifying that the period of active duty is for 180 days or more. If the period specified in your order or call is less than 180 days but a subsequent order increases the total period of active duty to 180 days – for example, if you are ordered or called to active duty for 120 days, and your order or call is subsequently extended for an additional 60 days – you will at that time qualify for a qualified reservist distribution.

The amount of the qualified reservist distribution will be the amount you have contributed to your Health FSA for the plan year minus all reimbursements received as of the date of the distribution. The distribution will be made no later than 60 days after the date of your request. The distribution will be included in your taxable income.

DEPENDENT CARE PROGRAM

WHAT BENEFITS ARE PROVIDED UNDER THE DEPENDENT CARE PROGRAM?

The Dependent Care Program allows you to make pre-tax contributions to a Dependent Care Account and be reimbursed from the account on a tax-free basis for Eligible Dependent Care Expenses (see *"What Are Eligible Dependent Care Expenses?"*) incurred during the plan year. It also allows you to receive dependent care services from an on-site day care facility maintained by the University on a tax-free basis if those services qualify as Eligible Dependent Care Expenses. Dependent care services are "incurred" when the care is actually provided. Even if you are required to pay for care in advance, you cannot be reimbursed until the care has been provided.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR THE DEPENDENT CARE PROGRAM?

You must be an employee of the University who regularly works 20 hours or more per week to participate in the Dependent Care Program. If you meet these requirements, you will be eligible to participate in the Dependent Care Program on the date you are hired as an employee of the University.

Temporary employees, visiting faculty, adjunct faculty, and adjunct EAP are not eligible to participate in this Program.

WHAT ARE "ELIGIBLE DEPENDENT CARE EXPENSES"?

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

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

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

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

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

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

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

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

* The value of dependent care services provided at the on-site facility maintained by the University (which the University will report to you based

on the level of use by your qualifying dependent and the fair market value of the services provided); and

* Related expenses in connection with the care of an eligible dependent, such as day care application fees, agency fees and deposits required to obtain care.

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

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

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

WHAT DEPENDENT CARE EXPENSES <u>CANNOT</u> BE REIMBURSED?

There are some dependent care expenses that <u>cannot</u> be reimbursed under this Plan. These include:

* Expenses for an overnight camp;

* Household services that are not related to the care of a dependent;

* Educational expenses (e.g., private school tuition from kindergarten up, summer school, or tutoring programs);

* Forfeited application or agency fees and deposits if care is not provided;

* Food, lodging or clothing; and

* Any expense incurred while you were not participating in the Dependent Care Program.

WHO IS A DEPENDENT UNDER THE DEPENDENT CARE PROGRAM?

For purposes of the Dependent Care Program, a qualified dependent is:

* Your child under the age of 13;

* Your spouse or your tax dependent (age 13 or over) who is physically or mentally incapable of caring for himself or herself and who lives with you for more than one-half the calendar year.

A child whose parents are divorced, separated, or who live apart at all times during the last 6 months of the year and who is either under age 13 or physically or mentally incapable of caring for himself or herself will be treated as a dependent of the parent with whom the child lives for the greater portion of the calendar year, even if the child is the dependent of the other parent for income tax purposes.

For an adult to be considered a qualifying dependent, he or she must spend at least eight (8) hours a day in your home.

WHAT IS THE MAXIMUM AMOUNT OF BENEFITS I CAN RECEIVE UNDER THE DEPENDENT CARE PROGRAM?

The maximum amount of benefits you may receive under your Dependent Care Account each calendar year (including your salary deferrals and the value of care provided at an on-site facility maintained by the University) is the lowest of:

(i) $5,000 ($2,500 if you are married and file separate tax returns),

(ii) your earned income (wages or salary, not including the amount elected under this Program), or

(iii) the earned income of your spouse if you are married at the end of the year. If, during any month in which you have dependent care expenses, your spouse is mentally or physically incapable of self-care and shares your principal place of abode for more than half the year, or your spouse is a full-time student, your spouse will be considered to have earned, for each such month, not less than $250 ($500 if you have two or more dependents). Your spouse will be considered a full-time student if he or she is enrolled full-time during at least five calendar months at an educational institution that offers traditional classroom instruction on a regular basis.

HOW MUCH CAN I BE REIMBURSED?

The amount available to you for reimbursement of an Eligible Dependent Care Expense is limited to the balance in your Dependent Care Account at the time of the claim. You must accumulate a minimum of $10 (or the amount remaining in your Dependent Care Account, if less) in reimbursable expenses before filing a claim. If you elect automatic reimbursement during your initial enrollment period or the annual enrollment period, you do not need to file a claim for services provided to your qualifying dependent at an on-site facility maintained by the University.

WHAT INFORMATION WILL THE IRS REQUIRE?

For amounts received as reimbursement under the Dependent Care Program to be tax free, you must report the correct name, address and taxpayer identification number of your dependent care provider on your federal income tax return. If the dependent care provider is a tax-exempt organization described in Section 501(c)(3) of the Internal Revenue Code, you must report the name and address and write "tax-exempt" in the space in which the taxpayer identification number of the provider generally would be reported.

Your dependent care provider is required to furnish you with the provider's taxpayer identification number, unless the provider is a tax-exempt organization. A provider that fails to comply with this requirement is subject to a monetary penalty.

HOW DOES THIS PROGRAM COORDINATE WITH THE FEDERAL CHILD TAX CREDIT?

The Internal Revenue Code also permits a "tax credit" for certain dependent care expenses, but amounts paid through the Dependent Care Program directly offset the maximum amount to which the tax credit can apply. The actual determination of which option (the tax credit or pre-tax payment) is more beneficial for you depends on a number of other factors such as size of family, marital status, taxable income, itemized deductions, etc. You may want to consult a tax adviser to decide which option is more effective for you.

WHAT HAPPENS TO AMOUNTS LEFT AT THE END OF THE YEAR?

If you have not incurred sufficient expenses by the end of the plan year to use all the money in your Dependent Care Account, the unused amount will be forfeited. It cannot be refunded to you. An expense is considered to be "incurred" when the dependent care service is provided, not when it is billed or paid.

You may not use your Dependent Care Account for Health FSA expenses and vice versa. Therefore, in deciding how much of your compensation to direct toward benefits under the Dependent Care Program, **it is very important that you estimate your expected expenses for the upcoming year carefully.** Overestimating your expenses will cause you to forfeit unused amounts. Forfeited amounts will be used to offset excess reimbursements and administrative expenses for the Plan.

HOW DO I MAKE A CLAIM?

You must file a benefit claim with the Plan Administrator, together with a bill, receipt, or other satisfactory proof of the expense from your dependent care provider together with any additional information required by the Plan Administrator. The Plan Administrator

will have benefit claim forms available for your use. All claims for expenses incurred during a plan year must be filed no later than April 30th following the end of the plan year. Generally, your claim will either be paid or denied within 30 days of submission. You (or your representative) have the right to appeal denial of a claim in writing to the Plan Administrator concerning your appeal within 60 days after receiving the notice of denial. Your written appeal should state the reasons you believe your claim should not have been denied. Decisions of the Plan Administrator are final and binding. You will be required to repay any expense or cost incurred due to the payment of a benefit which should not have been reimbursed.

No legal action may be brought against the Plan until you have exhausted these claims and appeals procedures. If you have exhausted these procedures and you decide to bring legal action against the Plan, you must do so within one year of the date of the final denial or appeal.

ENROLLMENT

HOW DO I ENROLL IN THE PLAN?

Premium Payment Program

When you first become eligible for the Premium Payment Program, you will be automatically enrolled if any of the University-provided coverages you elect require you to make premium contributions. You may obtain more information about this on the University's Health and Wellness website located at http://www.gvsu.edu/healthwellness/.

The University will begin withholding from your pay on a pre-tax basis (or in the case of premiums for a Household Member on an after-tax basis) the amount necessary to pay premium contributions for the coverage you have elected under the University's group health plan.

Although it is rarely desirable to do so, you have the right to decline participation in this Program and pay your premium contributions on an after-tax basis instead. The University will provide you with information on how to decline participation.

If you decide not to participate on a pre-tax basis, or if you initially participate and later change your mind, you must file a form electing to decline pre-tax participation. You cannot change your election after the beginning of the plan year unless you have a change in status described below in *"Can I Change My Elections During the Plan Year?"*

HSA Contributions, Health FSA and Dependent Care Programs

When you first become eligible for the HSA Contributions, Health FSA and Dependent Care Programs, you may elect the benefits you wish to receive by completing and filing an election form with the Plan Administrator. You can do this electronically through the University's Health and Wellness website located at http://www.gvsu.edu/healthwellness. After you have timely filed the election form with the Plan Administrator, you will become a participant on the date specified by the Plan Administrator.

There will then be an annual enrollment period for each subsequent plan year. You must file an election form each year. If you do not do so, you cannot participate during the next plan year unless you have a change in status described below in *"Can I Change My Elections During the Plan Year?"* You cannot make changes to the amount of your Health FSA or Dependent Care elections after the beginning of a plan year unless you have a change in status. However, you may change your HSA contribution election at any time during the Plan Year.

Whether or not you participate in this plan is entirely your decision. If you choose to participate, you must agree to reduce your compensation by the amount you elect on your election form. Each paycheck you receive during the plan year will be reduced in a substantially equal amount.

ELECTION CHANGES

CAN I CHANGE MY ELECTIONS DURING THE PLAN YEAR?

Although elections are generally irrevocable during a plan year, under certain limited circumstances specified below, you will be permitted to make changes for the remaining portion of the plan year.

HSA Contributions Program

You may change the amount of your elective HSA contributions at any time.

All Other Programs

You may change the amount of your election under the Premium Payment, Health FSA, and Dependent Care Programs if you experience a "change in status" (defined below) or any other event that the Plan Administrator determines permits an election change under IRS regulations. However, the election change must be consistent with and necessary or appropriate as a result of the change in status. Generally, this means **the change in status must cause a gain or loss of eligibility for coverage, and your election change must correspond to the gain or loss of coverage**.

A "change in status" includes:

* Change in Employee's Legal Marital Status. Marriage, death of a spouse, divorce, legal separation and annulment.

* Change in Number of Dependents. Birth, adoption, placement for adoption and death of a child.

* Change in Employment Status. For example, termination or commencement of employment by the employee, spouse or dependent; commencement of, or return from, an unpaid leave of absence; a strike or lockout; a change in worksite or any other change in status that effects eligibility for benefits.

* Change in Residence. Change in residence of employee, spouse or dependent that affects eligibility for benefits (for example, relocation outside your HMO's service area).

* Change in Dependent Status. Dependent starts or stops meeting the requirements (such as age, student status, marriage) to be eligible for any coverage under this Plan.

For example, if you become divorced, you could change your premium payment election to eliminate the premium cost for your former spouse who is no longer eligible for health coverage through the University but you could not change your election to eliminate the cost of coverage for your children if they remain eligible under the health plan.

Note that a situation that prevents you from incurring an anticipated expense is not a change in status allowing you to change your elections mid-year. For example, you may not reduce your Health FSA election because you were unable to have an anticipated surgery due to a change in your medical condition or physician availability.

Health FSA Program

If you experience a change in status and wish to reduce or cease contributions to the Health FSA, you may only do this if the change in status is due to the death of your spouse or dependent, your divorce, or the loss of your dependent's legal status as a dependent.

Dependent Care Program

You may change your Dependent Care election in a manner consistent with any of the following occurrences:

* Change in Cost. Cost of dependent care increases or decreases (unless a cost increase is imposed by a relative of yours who provides the care).

* Change in Coverage. For example, you change your day care provider or your child's enrollment in school decreases the hours of required day care service you need.

* Change Under Another Plan. Change in dependent care benefits under another employer plan.

Premium Payment Program

You may change your Premium Payment election for group health coverage under the following circumstances.

* HIPAA Enrollment Rights. You or a dependent become entitled to special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) because you lose coverage under another employer's group health plan, you gain a dependent, become eligible for health plan premium assistance under Medicaid or a state Children's Health Information Program ("CHIP"), or you lose eligibility for Medicare for CHIP.

* Judgment, Decree, or Order. You are ordered to provide health coverage for your child under a judgment, decree, or order resulting from a divorce, legal separation, or change in legal custody (or someone else is ordered to provide the coverage that you previously provided to the child).

* Change in Medicare/Medicaid Eligibility. You, your spouse or a dependent child become enrolled in Medicare or Medicaid and you desire to cancel group health coverage for that individual under this Plan, or you lose Medicare or Medicaid and desire to enroll in the University's group health coverage on a pre-tax basis.

* Change in Employment Status Without Loss of Eligibility. You have a change in employment status that results in a change in work schedule from one in which you were reasonably expected to average 30 hours of service per week to a schedule in which you will be reasonably expected to average fewer than 30 hours of service per week without losing eligibility to participate in the plan; and you certify that you will enroll in another medical plan that provides minimum essential coverage that will become effective no later than the first day of the second month following the month in which you revoke coverage under this Plan.

* Becoming Eligible to Enroll in Coverage Through the Health Insurance Marketplace. You become eligible to enroll in a health plan offered through the Health Insurance Marketplace, either because of a special enrollment right or during the Marketplace's annual open enrollment period, and you certify that your new coverage under such a plan will become effective no later than the day after your coverage under this Plan ends.

The University may automatically adjust the amount of your Premium Payment election if the cost of any coverage you elected under the Premium Payment Program is increased or decreased during the plan year. If the cost change is significant or if the coverage terminates or is significantly reduced, you will be permitted to revoke your election and, instead, elect coverage under another option with similar coverage on a pre-tax basis (if one is offered). In some circumstances you may drop the coverage.

If the University adds a new benefit option, you may change your election to add the new coverage even if you did not previously participate in this Plan. If there is a change in the coverage of your spouse or dependent under another employer's plan, you may make a corresponding election change under this Plan.

WHAT NOTICE IS REQUIRED FOR A MID-YEAR ELECTION CHANGE?

If you wish to change your election for any permitted reason, you must notify the Plan Administrator within 30 days of the event (60 days in the case of a change in your Medicaid or CHIP entitlement). All changes will apply prospectively except that if you gain a new dependent by birth, adoption or placement for adoption, the change will be effective as of the date of the birth, adoption or placement for adoption.

In rare cases, your election may be restricted so that the Plan will satisfy nondiscrimination rules imposed by the Internal Revenue Service.

TERMINATION OR LOSS OF BENEFITS OR COVERAGE

WHAT IF MY EMPLOYMENT ENDS?

All Programs

Generally, your pre-tax contributions to the Plan and any additional Employer contributions will terminate when your employment ends.

Health FSA Program

Unless you elect continuation coverage as described below, you will only be reimbursed for eligible medical expenses incurred before your termination of employment.

Dependent Care Program

You may continue to submit claims for eligible dependent care expenses incurred through the remainder of the plan year in which your employment terminates as long as you still have funds remaining in your account.

Rehire

If your participation in this Plan ends because your employment has terminated, but you are rehired within the same plan year and within 30 days after termination, your prior election will remain in effect. If you are rehired more than 30 days after termination, you may make a new election for the remainder of the plan year.

WHAT IS CONTINUATION COVERAGE?

You may elect to continue coverage under the Health FSA Program after the occurrence of certain events that would otherwise end your participation in the Program (e.g., termination of employment). You will be required to pay up to 102% of your regular payroll deduction contribution for this continuation coverage.

If your employment is terminated (for reasons other than gross misconduct) or your hours are reduced so that you no longer meet the program's eligibility requirements, you may elect to continue contributions and participation in the Health FSA for the remainder of the plan year. Your spouse and/or dependents may elect to continue participation until the end of the plan year if they are no longer eligible for coverage for the following reasons: (i) you die, (ii) you become divorced or legally separated, (iii) you become entitled to Medicare benefits, or (iv) your children cease to be dependents.

In the case of divorce, legal separation or loss of dependent status, continuation coverage is available only if you (or your spouse or dependent) notify the University's Manager of Benefits, in writing, within 60 days after the qualifying event. The Plan Administrator will then provide you (and your spouse and/or dependents) with written

notification of the right to continuation coverage (or the unavailability of such coverage). Assuming continuation coverage is available, you (or your spouse and/or dependent) then have 60 days from the date coverage would normally end or, if later, the date you receive notice of continuation coverage rights to return a signed election to the Plan Administrator indicating the choice to continue coverage under the Program. Otherwise, continuation coverage rights will end.

Continuation coverage will automatically end if a required contribution is not paid on a timely basis, if you (or your spouse and/or dependent) become covered by another group health plan, if the University terminates coverage for all employees or if you (or your spouse and/or dependent) become entitled to Medicare. For further information, consult the Plan Administrator or the continuation coverage notice provided to you by the University.

WHAT HAPPENS IF I TAKE UNPAID FMLA LEAVE?

Premium Payment Program

If you take an unpaid leave of absence under the Family and Medical Leave Act ("**FMLA**"), any contributions for group health coverage will be paid on an after-tax basis since you will not be receiving a paycheck.

HSA Contributions Program

If you take an unpaid FMLA leave, any contributions to your HSA must be made on an after-tax basis while you are on leave since you are not receiving a paycheck (but can be deducted when you file your tax return).

Health FSA Program

For purposes of the Health FSA Program, you may choose to continue coverage or you may revoke your prior election and terminate your coverage. If you choose to continue coverage while on an unpaid FMLA leave, you can continue to submit claims incurred during your leave. The Plan Administrator will explain your payment options.

If your coverage terminates during FMLA leave, when you return from leave you may elect to reinstate your coverage for the rest of the plan year. You will be given two options: (1) make larger payments to make up for those missed while on leave and resume coverage with your original election amount or, (2) continue payments of the original amount and resume coverage with a reduced election amount for the year. You will not be reimbursed for expenses incurred while your coverage was terminated.

Dependent Care Program

If you take an unpaid leave of absence under FMLA, pre-tax contributions will cease while you are on unpaid FMLA leave since you will not be receiving a paycheck.

However, you may continue to submit claims under the Dependent Care Program through the end of the plan year as long as funds remain in your Dependent Care Account.

WHAT IF I TAKE A LEAVE OF ABSENCE FOR MILITARY SERVICE?

Premium Payment Program

If you take an unpaid leave of absence to perform military service that qualifies as military service under the Uniformed Services Employment and Reemployment Rights Act ("**USERRA**"), any premium contributions for coverage while you are on unpaid leave will be paid on an after-tax basis since you will not be receiving a paycheck.

HSA Contributions Program

If you take an unpaid USERRA leave of absence, contributions to your HSA may be made on an after-tax basis if you continue to be an HSA-eligible individual (but can be deducted when you file your tax return).

Health FSA Program

If you take a USERRA leave, you can elect to continue participation in the Health FSA Program for up to 24 months from the day your leave begins or, if earlier, until the day after you are required to apply for or return to reemployment under USERRA. You will pay up to 102% of your regular payroll deduction contribution for this continuation coverage. Continuation coverage will end if you do not return to work within the time period specified under USERRA or if you lose USERRA rights.

Even if you do not elect to continue coverage during a USERRA leave, you have the right to be reinstated when you return, generally without any waiting period.

Dependent Care Program

If you take an unpaid USERRA leave, you may continue to submit claims under the Dependent Care Program through the end of the plan year as long as funds remain in your Dependent Care Account, but pre-tax contributions will cease while you are on unpaid leave since you will not be receiving a paycheck.

If you intend to take a leave of absence for military service, contact the Plan Administrator. You will be provided more detailed information, including your payment options and any notices you are required to provide if you intend to continue coverage under the Plan during your leave of absence.

CAN MY BENEFITS UNDER THE PLAN BE TRANSFERRED TO ANOTHER PERSON?

Generally, your benefits under the Plan cannot be sold, given away, or otherwise transferred or assigned to another person. However, if the Plan Administrator receives a medical child support order from a court or administrative agency directing the Plan Administrator to extend coverage under the Health FSA Program to your dependent child(ren), the Plan Administrator will follow the directions in the order, provided it meets the requirements under federal law for a National Medical Support Notice (NMSN). You will be notified of the Plan Administrator's determination upon review of the order.

ADDITIONAL INFORMATION

DO HIPAA PRIVACY RULES APPLY TO THIS FLEXIBLE BENEFITS PLAN?

Yes, HIPAA privacy and security rules apply to the Health FSA Program under this Plan. Provisions regarding these rules are contained in the Plan document as required. You should review the notice of privacy practices previously given to you by the University for more information on your privacy rights under HIPAA.

WHO IS RESPONSIBLE FOR THE ADMINISTRATION OF THE PLAN?

The Premium Payment Program is self-administered by the University. With respect to that Program, the University has the final discretionary authority to decide all questions of eligibility for participation and benefit payments, to determine all issues of fact, to supply any omission and interpret any ambiguous provision of the Plan. The University has a duty to exercise this authority in a nondiscriminatory and consistent manner.

The Claims Administrator identified below administers the Health FSA and Dependent Care Programs. With respect to these Programs, the University has the final discretionary authority to decide all questions of eligibility for participation and benefit payments, to determine all issues of fact and to supply any omission and interpret any ambiguous provision of the Plan. The University has a duty to exercise this authority in a nondiscriminatory and consistent manner.

CAN THE UNIVERSITY CHANGE OR TERMINATE THIS PLAN?

Although the University intends to continue the Plan indefinitely, it may amend or terminate this Plan (or any of the benefit programs) at any time; however, an amendment or termination will not affect your rights to benefits for any expenses incurred or services provided before the amendment or termination.

WHAT ELSE SHOULD I KNOW?

Employer and Plan Administrator

Grand Valley State University
One Campus Drive
1090 James H. Zumberge Hall
Allendale, Michigan 49401
(616) 331-2220

Employer Identification Number

38-1684280

Plan Number

501

Type of Plan

Section 125 (Flexible Benefits) Plan
- Premium Payment Program
- HSA Contributions Program
- Health FSA Program
- Dependent Care Program

Claims Administrator

The Premium Payment Program and HSA Contributions programs are self-administered by the University. Claims under the Health FSA and Dependent Care Programs are administered under a contract with the University by:

Infinisource Benefit Services, LLC
15 E. Washington Street
P.O. Box 889
Coldwater, MI 49036
(866) 370-3040
fsa@infinisource.com

Plan Year

January 1 – December 31

Service of Legal Process

Service may be made upon the plan administrator or the following individual:

Associate Vice President – Human Resources
Grand Valley State University
One Campus Drive
1090 James H. Zumberge Hall
Allendale, Michigan 49401

2020-1 AMENDMENT SUMMARY OF MATERIAL MODIFICATIONS TO THE GRAND VALLEY STATE UNIVERSITY FLEXIBLE BENEFITS PLAN
Effective January 1, 2020

The Grand Valley State University Flexible Benefits Plan ("Plan") has been amended to implement optional changes to the Health FSA program under the CARES Act. This Summary of Material Modifications is being furnished to all affected employees to inform them of the changes made by the amendment and modifies the Summary Plan Description that has been provided to you. All changes made to the Summary Plan Description by this Plan amendment are effective as of July 1, 2020.

1. **Reimbursable expenses under the Health FSA**. You no longer need a prescription to be reimbursed for over-the-counter drugs and products. You may also be reimbursed for menstrual care products. This change affects the following section of the Summary Plan Description:

*The bullet point list in the answer to the question "**WHAT ARE 'ELIGIBLE MEDICAL EXPENSES'?**" under the section titled "**HEALTH FLEXIBLE SPENDING ARRANGMENT**" is modified to read:*

* Expenses not paid by your health plan, such as deductible or co-payment amounts, co-insurance, expenses over the maximum payable under the plan and medical care expenses that are excluded or otherwise not covered under the plan;

* Dental expenses;

* Orthodontic expenses;

* Vision expenses, including examinations, eyeglasses, contact lenses, laser surgery and seeing-eye dogs;

* Hearing expenses, including examinations and hearing aids;

* Physical examinations;

* Psychoanalysis, psychiatric therapy, learning disability counseling by a licensed professional, inpatient care, treatment and services provided by a licensed psychologist;

* Acupuncture;

* Therapeutic treatment for drug or alcohol addiction, including meals and lodging if necessary for the treatment;

* Medical equipment purchased or rented because of a medical condition, such as wheelchairs, crutches, and orthopedic shoes, or for the repair or replacement of prosthetic devices due to normal wear and tear;

* Insulin;

* Transportation primarily for, and essential to, medical care;

* Over-the-counter medications (e.g., antacids, allergy medication, pain relievers, cold medications);

* Menstrual care products (e.g., tampons, pads, liners, cups, sponges or other similar products); and

* Any other expense that qualifies as a medical care deduction for federal income tax purposes.

*The bullet point list in the answer to the question "**WHAT MEDICAL EXPENSES CANNOT BE PAID UNDER THE HEALTH FSA PROGEAM?**" under the section titled "**HEALTH FLEXIBLE SPENDING ARRANGMENT**" is modified to read*

* Expenses incurred prior to the beginning or after the end of the current plan year (except during the grace period);

* Cosmetic surgery or similar procedures unless the surgery or procedure is necessary to ameliorate a deformity due to a congenital abnormality, an injury, or a disfiguring disease;

* Premiums for health insurance coverage;

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

* Any expense incurred before the effective date of this Health FSA Program, or while you were not participating in the Health FSA Program.

2. **Special mid-year change rules for the Health FSA.** You may change your election under the Health FSA for any reason, through December 31, 2020. This change affects the following section of the Summary Plan Description:

*Within the subsection entitled "HEALTH FSA" the answer to the question "**CAN I CHANGE MY ELECTIONS DURING THE PLAN YEAR?**" is modified to read:*

Health FSA

If you experience a change in status and wish to reduce or cease contributions to the Health FSA, you may only do this if the change in status is due to the death of your spouse or dependent, your divorce, or the loss of your dependent's legal status as a dependent.2.

Notwithstanding the foregoing, you may revoke your election, make a new election, or decease or increase an existing election regarding Health FSA coverage on a prospective basis. You may change your election at any time through December 31, 2020, but you are limited to one change. Your election to decrease your Health FSA contribution cannot result in a total contribution amount for the Plan Year of less than the amount already contributed to your Health FSA for the Plan Year.

3. Any provisions in the Summary Plan Description that are inconsistent with the changes described above are superseded.

THIS NOTICE OF MATERIAL MODIFICATIONS SHOULD BE KEPT WITH YOUR COPY OF THE SUMMARY PLAN DESCRIPTION.

21074752-1