
Agenda

Call to Order
Approval of the June 16, 2020 Minutes
Additions to the Agenda
Limited Public Comment

1. Economic Development Corporation Board – Interviews
2. Greater Lansing Convention and Visitors Bureau – Update from Julie Pingston, President and CEO
3. Ingham County Brownfield Development Authority – Resolution Setting a Public Hearing for an Amended Brownfield Plan for K3 Property LLC, 318 W Kipp Road City of Mason, MI
4. Drain Commissioner
   a. Resolution to Approve Agreement for Work in County Road Right of Way by Bauer Drain Drainage District
   b. Resolution to Approve Agreement for Work in County Road Right of Way by Green Consolidated Drain Drainage District
   c. Resolution to Approve Agreement for Work in County Road Right of Way by Marshall Tile Drain Drainage District
5. 9-1-1 Dispatch Center
   a. Resolution to Authorize the Conversion of the 9-1-1 Radio System Administrator from Part-Time to Three-Quarter Time
   b. Notice of Emergency Purchase Order for Radio Connectivity at the Backup 9-1-1 Center
6. Innovation & Technology
   a. Resolution to Approve the Renewal of Firewall Licenses
   b. Notice of Emergency Purchase Order to Repair Cooling Unit in Mason Datacenter
7. Facilities Department
   a. Resolution to Authorize a Contract Extension with Modernistic for Carpet Cleaning Services at Several County Facilities
   b. Notice of Emergency Purchase Order for Condensing Unit Replacement at the 911 Center
8. Road Department
   a. Resolution to Approve Local Road Agreements with Alaiedon, Aurelius, Bunker Hill, Leroy, Locke, Stockbridge, Vevay, and Wheatfield Townships
   b. Resolution to Authorize the Extension of Resolution #17-235 for Dust Control Solution
   c. Resolution to Authorize the Extension of RFP #17-349, Purchase of Seasonal Corrosion Inhibited Liquid De-Icer Solution

9. Human Resources Department
   a. Resolution to Authorize Buyout of Special Vacation Bonus Hours Earned During Suspension of County Operations for Essential Employees Excluded from Work Share Program Participation
   b. Resolution Adopting the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan
   c. Resolution Adopting an Amended Health Advisory Leave Policy
   d. Resolution to Approve Generic Service Credit Purchase for County Employee: Cindy S. Farley
   e. Resolution to Authorize Extension of the Contract for Sparrow Occupational Health Services
   f. SB 690 First Responder Hazard Pay (Discussion Item) no material

10. Human Services and County Services Committees – Resolution to Declare a Climate Emergency

Announcements
Public Comment
Adjournment

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COUNTY SERVICES COMMITTEE  
June 16, 2020  
Draft Minutes

Members Present: Sebolt, Celentino, Grebner (arrived at 6:30 p.m.), Koenig, Stivers, and Maiville.

Members Absent: Naeyaert.

Others Present: Teri Morton, Bonnie Toskey, Courtney Gabbara, Debbie Edokpolo, Becky Bennett, Sue Graham, Julia Smith-Heck, Jane Southwell, Craig Lyons, Kameya Young, Laura Addai, Heather Bricker, Veronica Logan, and Michael Tanis.

The meeting was called to order by Chairperson Sebolt at 6:30 p.m. in Personnel Conference Room “A” of the Human Services Building, 5303 S. Cedar Street, Lansing, Michigan.

Approval of the June 2, 2020 Minutes

MOVED BY COMM. MAIVILLE, SUPPORTED BY COMM. KOENIG, TO APPROVE THE MINUTES OF THE JUNE 2, 2020 COUNTY SERVICES COMMITTEE MEETING.

THE MOTION CARRIED UNANIMOUSLY. Absent: Commissioners Grebner and Naeyaert

Commissioner Grebner arrived at 6:30 p.m.

Additions to the Agenda

Late –
4. Prosecutor’s Office - Resolution to Honor Angela M. Morgan of the Ingham County Prosecutor’s Office

Limited Public Comment

None.

MOVED BY COMM. MAIVILLE, SUPPORTED BY COMM. GREBNER, TO APPROVE A CONSENT AGENDA CONSISTING OF THE FOLLOWING ACTION ITEMS:

1. Facilities Department
   a. Resolution to Authorize a Purchase Order be Issued to Trane U.S. Inc. for the HVAC Split Unit at the Ingham County Jail’s Transport Supervisor’s Office
   b. Resolution to Authorize an Agreement with Roof Connect for the Roof Repairs at the Ingham County Jail’s Training Center
   c. Notice of Emergency Purchase Order for Chilled and Heated Water Line Repair between the Mason Courthouse and Hilliard Building
2. **Human Resources Department**

3. **Ingham County Board of Commissioners** - Resolution Honoring Ingham County’s Covid-19 Essential Workers

4. **Prosecutor’s Office** - Resolution to Honor Angela M. Morgan of the Ingham County Prosecutor’s Office

THE MOTION CARRIED UNANIMOUSLY. Absent: Commissioner Naeyaert

THE MOTION TO APPROVE THE ITEMS ON THE CONSENT AGENDA CARRIED UNANIMOUSLY. Absent: Commissioner Naeyaert

2. **Human Resources Department**
   c. Closed Session

MOVED BY COMM. CELENTINO, SUPPORTED BY COMM. STIVERS, AT 6:36 P.M., TO MOVE THE MEETING INTO CLOSED SESSION TO DISCUSS LABOR NEGOTIATIONS IN THE FORM OF THE CAPITAL CITY LABOR PROGRAM (CCLP) AND THE INGHAM COUNTY SHERIFF’S OFFICE.

THE MOTION CARRIED UNANIMOUSLY BY ROLL CALL VOTE. Absent: Commissioner Naeyaert

CHAIRPERSON SEBOLT STATED THAT, WITHOUT OBJECTION, THE COMMITTEE WOULD RETURN TO OPEN SESSION AT 7:12 P.M. Absent: Commissioner Naeyaert

MOVED BY COMM. GREBNER, SUPPORTED BY COMM. CELENTINO, TO APPROVE ONE NINETY-DAY EXTENSION OF A SPECIAL LEAVE OF ABSENCE PURSUANT TO ARTICLE 33, SECTION 5 OF THE CCLP SUPERVISOR’S CONTRACT AT THE SHERIFF’S OFFICE FOR SCOTT PHILLIPS.

THE MOTION CARRIED UNANIMOUSLY. Absent: Commissioner Naeyaert

2. **Human Resources Department**
   b. Grievance Hearing

Courtney Gabbara, County Attorney, provided a factual synopsis of the grievance to the County Services Committee.

Ms. Gabbara stated that she would respectfully ask the County Services Committee to uphold the County’s denial of the grievance.
Julia Smith-Heck, Michigan Nurses Association—Nurse Practitioners/Clinic Nurses Unit, stated that they had filed a grievance based on the fact that Immunization Nurses were temporarily reassigned to do work in Disease Control. She further stated that, as the contract stated for a temporary assignment to higher, equal, or lower pay grade, it was an employee who was temporarily reassigned to perform a majority of his or her duties and responsibilities in a position of a higher salary.

Ms. Smith-Heck stated that when the Immunization Nurses had their Step 2 grievance, they went back and forth about if they performed the full duties of a Disease Control Nurse, or partial duties, but 100 percent of the time. She further stated that they had been spending all of their time working, to an extent, in the same capacity as a Disease Control Nurse.

Ms. Smith-Heck stated that they thought the contract was clear that the Immunization Nurses had been temporarily reassigned and were doing work in a different pay grade. She further stated that it was not work that the nurses would normally do in their job description.

Discussion.

Ms. Smith-Heck stated that the Disease Control Nurses had written a letter, dated June 11, 2020, on behalf of the Immunization Nurses. She further stated that they supported the Immunization Nurses, were grateful for their work in Disease Control, and outlined what Immunization Nurses had been doing, which was typically done by Disease Control Nurses 100 percent of the time.

Ms. Smith-Heck stated that some of that work included contact tracing, education, data entry, and interviews.

Heather Bricker, Ingham County Health Department Immunization Nurse, stated that, when they were first reassigned, they were not given an option. She further stated that March 17, 2020 was their first day working under Disease Control, and the next day, they were assigned to work from home.

Ms. Bricker stated that they had received an hour-and-a-half training on a FaceTime call detailing how their jobs were going to be going forward. She further stated that it was very difficult, but the Disease Control Nurses were very supportive of them.

Ms. Bricker stated that, in the clinic, she was giving shots and assessments with questionnaires, but this type of work was different than what she was used to. She further stated that it was very stressful, and some of them worked more than 40 hours a week.

Kameya Young, Ingham County Health Department Immunization Nurse, stated that she had a booklet that contained relevant information to her job, but the Immunization Nurses were not given protocol instructions when they were reassigned. She further stated that was the biggest difference between the jobs.
Ms. Smith-Heck stated that it required them to use their critical thinking skills since immunization was a structured environment. She further stated that she wanted to address that the position of the County was that, in an emergency situation, nurses could be reassigned to do other work, and they did not have issue with that.

Ms. Smith-Heck stated that they understood that this was a Public Health Crisis, but that did not mean that they could forego that pay grade difference as outlined in the contract. She further stated that the contract said that if a person was reassigned, a person was paid at a certain percentage of that pay grade.

Ms. Smith-Heck stated that it had been established that they had been reassigned and were doing the work of Disease Control Nurses. She further stated that, because of that, the Michigan Nurses Association—Nurse Practitioners/Clinic Nurses Unit thought they should be paid that wage.

Commissioner Celentino asked if Ms. Bricker was trained for the additional duties that she was being asked to do.

Ms. Bricker stated that Disease Control Nurses received 6 months of training, but the Immunization Nurses received an hour-and-a-half FaceTime call with one of the Disease Control Nurses who explained what would be asked of them.

Commissioner Celentino asked Ms. Gabbara if that meant the Immunization Nurses were reclassified because they had to be trained to do something they had not done before.

Ms. Gabbara stated that reclassification could only be done when negotiating the upcoming Collective Bargaining Agreement (CBA). She further stated that, in terms of training, one of the tasks the Immunization Nurses were trained to do was contact tracing, and there were volunteers with no medical training and had all types of backgrounds who were being screened through the State of Michigan and currently assisting the County with that task.

Commissioner Celentino asked, if it was a reassignment that required training, if that meant it was additional work.

Ms. Gabbara stated that it was additional work, but it fell within their work capabilities in their current capacity. She further stated that their job description was simply a set of examples of work they would more likely be doing, but it was not an exhaustive list.

Ms. Gabbara stated that, especially in these unprecedented times, they were being called upon to take on more assignments, but it was not more than they thought they could handle based off of their training. She further stated that, in their job description, it said specifically that an Immunization Nurse prepares for and responds to emergencies, such as communicable disease outbreak within a clinic or in the community at large, so this was within their job description.

Debbie Edokpolo, Deputy Health Officer, stated that she appreciated the nurses jumping in and helping the County. She further stated that the Health Department had had about 32 staff members doing contact tracing.
Ms. Edokpolo stated that the nurses did something different than others because of their skillset. She further stated that they continually prepared for emergencies at the Health Department, so they lumped people together based on skillsets and the nurses went where nurses could do things.

Ms. Edokpolo stated that what was asked from them was the assessing and critical thinking since that was what nurses did. She further stated that was why they asked nurses to take the lead in this particular arena with regard to contact tracing.

Ms. Smith-Heck stated that, in the CBA between the County and the MNA-Nurse Practitioners/Clinic Nurses Unit, Article 35 talked about promotions and reclassifications, but Article 10 talked about temporary assignment to a higher, equal, or lower pay grade, and that was what was being discussed. She further stated that this was a directive given by their supervisor to do this work, which was a temporary reassignment to a higher pay grade.

Ms. Smith-Heck stated that they agreed that, in an emergency, people would be reassigned, and they did not have an issue with that.

Ms. Bricker summarized the duties that Immunization Nurses were required to do to the County Services Committee.

Ms. Smith-Heck asked Ms. Edokpolo what part of the contact tracing duties the volunteers did.

Ms. Edokpolo stated that the volunteers had done contact tracing for people who had been exposed to COVID-19, including a family member.

Ms. Smith-Heck asked Ms. Edokpolo if that meant it did not include people who had tested positive for COVID-19.

Ms. Edokpolo stated that, in most cases, only the nurses were doing that. She further stated that she agreed that the information that the nurses had to obtain was different than normal, but she did not believe that it was outside the scope.

Ms. Edokpolo stated that she had been at the County for 30 years, and this had been their process. She further stated that, for example, in 2009 during the H1N1 pandemic, they had other nurses and people who had to be trained to give immunizations, which was new for them.

Ms. Edokpolo stated that she heard them, but this was how they operated. She further stated that, if they started a precedent of moving people into other jobs, there were 32 other people that had to be considered because it was outside of their scope too.

Ms. Gabbara stated that she wanted to point out that this was not a new job, but rather it was about executing a new task within their job. She further stated that, in their capacity as Immunization Nurses, they still screened and followed-up with their patients and provided education, so this was simply a new subject matter that everyone was familiarizing themselves with.
Ms. Gabbara stated that, by saying this was a new task or reclassification, they were taking away authority from the Health Department, and she was not sure that was the precedent they wanted to set today.

Commissioner Koenig asked for more details about the money being asked for.

Ms. Smith-Heck stated that she had calculated that it was $4.00 an hour, and the nurses had worked about 500 hours in this different capacity.

Discussion.

Ms. Gabbara stated that, per figures from the Human Resources Department, the maximum amount for each employee from March 17, 2020 to June 15, 2020 would be $1,700 per person, but that depended on the employee.

Discussion.

Commissioner Koenig asked why it ended on June 15, 2020 since people continued to do contact tracing.

Ms. Gabbara stated that it was just the figure as of today and would continue on.

Commissioner Koenig asked if everyone was doing this from home.

Ms. Edokpolo stated yes.

Commissioner Koenig stated that the County had emergency rules in place for persons who had to work when other employees did not have to work, and they automatically received a paid day of vacation for every day they worked.

Teri Morton, Deputy Controller, stated that it was under the Suspension of Operations Policy.

Commissioner Koenig asked how long that lasted from.

Sue Graham, Human Resources Director, stated that it lasted from March 17, 2020 through April 5, 2020.

Commissioner Koenig asked if that meant anyone on the job benefited from that. She further asked if that value depended on the job.

Ms. Graham stated that it was up to 120 hours for regular hours worked.

Commissioner Koenig stated that, in North Korea and a lot of other places, contact tracing was being done by computers. She further stated that there were other ways to do this that would be helpful to everyone, and so some of this could be done in the future in a computerized fashion.
Commissioner Stivers asked if the total amount that potentially be paid out would be between $12,000 and $17,000.

Ms. Gabbara stated that was the maximum amount.

Commissioner Stivers asked if that was for all six nurses to make them whole today, but there would be more as they continued to work in that function.

Ms. Gabbara stated yes.

Chairperson Sebolt asked what percentage of the overall job of Disease Control Nurse was being performed by the Immunization Nurses.

Ms. Gabbara stated that the only difference was detailed in Exhibit 5, bullet point #8.

Discussion.

Chairperson Sebolt stated that, out of all the job responsibilities of a Disease Control Nurse, the Immunization Nurses were only doing differently that one specific task.

Ms. Gabbara stated yes.

Discussion.

Chairperson Sebolt asked Ms. Smith-Heck if she thought the Immunization Nurses had performed tasks detailed in Exhibit 5, bullet points #8, #9, and #10.

Ms. Smith-Heck stated yes.

Chairperson Sebolt stated that bullet point #10 was in both job descriptions. He asked if that was correct.

Ms. Smith-Heck stated yes.

Chairperson Sebolt stated that, in terms of things that overlapped, he thought that #9 also fell under the Immunization Nurse tasks. He asked if that was correct.

Ms. Smith-Heck stated yes.

Chairperson Sebolt stated that, in theory, Immunization Nurses were performing similar tasks, albeit in different settings, but still tasks that would be normally assigned.

Ms. Smith-Heck stated that not every nurse had the same skillset.

Discussion.
Commissioner Koenig asked if they had people permanently moving into this position, or if they were going to carry on like this.

Ms. Edokpolo stated that the Immunization Clinic had reopened, so the Immunization Nurses were doing scaled down visits and were doing a bit of both. She further stated that their COVID-19 numbers had decreased and they were having fewer positive cases, but she thought that this would continue.

Ms. Edokpolo stated that they might not need the Immunization Nurses as much, and be more reliant on Disease Control Nurses unless they had a turnaround of new waves of the disease.

Jane Southwell, Michigan Nurses Association—Nurse Practitioners/Clinic Nurses Unit President, stated that she was involved in contract negotiations, and so she did not know why this would be in here if it was not pertinent to this situation. She further stated that any full-time nurse that was temporarily reassigned to perform a majority of the duties and responsibilities in a position of a higher pay grade for many than three days shall be paid at the higher pay grade.

Discussion.

Chairperson Sebolt stated that was why he asked his questions, and he was comparing the language of the contracts to the job duties because if it was indeed a majority of the job responsibilities of the higher pay grade, then they should be paid that salary. He further stated that, however, it did not seem like that was what was happening.

Ms. Smith-Heck stated that was their different interpretation. She further stated that they thought it was the amount of time that they spent in the different classification, not that they had to encompass the entire job description, but it said that if they did this work for more than three days, they would get that difference in pay.

Ms. Smith-Heck stated that they did not think it was pertinent to say that they did not go out and visit Tuberculosis patients in their homes. She further stated that they were working in Disease Control 100 percent of the time.

Chairperson Sebolt stated that it said assigned to perform a majority of his or her duties and responsibilities.

Ms. Smith-Heck stated that the Immunization Nurses were only doing Disease Control.

Chairperson Sebolt stated that he thought that meant a majority of the duties and responsibilities of Disease Control Nurses. He further stated that that was how he read it, but he understood that they had a different interpretation of it.

Discussion.

Ms. Smith-Heck stated that it said a majority of his or her duties and responsibilities, but not the majority of the duties and responsibilities of that job description.
Chairperson Sebolt stated yes, but temporarily reassigned to perform a majority of the duties and responsibilities of the Disease Control Nurses.

Ms. Smith-Heck stated that she read it as they were working in Disease Control a majority of the time they were working. She further stated that if they were doing other tasks for half of the day, there would be a different kind of argument, but they were working there 100 percent of the time.

Chairperson Sebolt stated that he can see that reading of the sentence.

Ms. Smith-Heck stated that it was clear as mud.

Chairperson Sebolt stated that it was clear as mud. He asked if, on the other hand, in a year, would they need to pull and assign nurses from other jobs should there be a flu shot that came along.

Ms. Smith-Heck stated that the County also employed Medical Assistants to in-unit immunizations, so it was not strictly a Registered Nurse duty. She further stated that there was a larger amount of staff that could give shots.

Chairperson Sebolt stated that he was envisioning a scenario where people were lining up around the block to get an immunization shot.

Discussion.

Commissioner Stivers asked, in terms of the precedent, if they did interpret the language as the majority of his or her duties in the higher job classification, how many other employees would they be looking at to then go back and see who was moved.

Ms. Edokpolo stated that there were vision and hearing technicians.

Commissioner Stivers asked if those people were spending a majority of their time doing things outside of their initial job descriptions.

Ms. Smith-Heck stated that she did not know what their contracts looked like because MNA did not represent those people.

Commissioner Stivers asked how many people they were referring to.

Chairperson Sebolt stated that he believed it was 25 people.

Ms. Graham stated that, after their lower-step Grievance Hearing, they searched their records for if the County had ever done what Ms. Smith-Heck had requested, and the answer was no. She further stated that they never did a temporary out-of-class reassignment to a higher classification unless a majority of the duties were being done, so it was a County-wide approach.
Ms. Gabbara asked Ms. Graham if that language was included in seven other contracts.

Ms. Graham stated that she was correct. She further stated that language was included in the contract of one of the County’s larger unions, the United Auto Workers (UAW).

Commissioner Koenig asked if the next time this contract was drafted, if they could make it clearer because it was difficult to understand what was intended.

Commissioner Grebner stated that what was intended that it would work in the world that they expected. He further stated that there people in “Position A” who were being assigned to work in “Position B,” but that was not the world that occurred.

Commissioner Grebner stated that people in “Position A” were assigned to work in a newly-created job that the County did not have before.

Ms. Edokpolo stated that, in 2016, they had done contact tracing after an outbreak at the Kellogg Center. She further stated that had an outbreak at Ingham County Medical Care Facility, and they had other people who were helping them do that.

Commissioner Grebner stated that there had not been a job study, so people had been assigned to “Position D,” and if “Position D” was paid at a higher pay grade, the contract intended to pay them at the higher rate, but that position did not exist. He further stated that the question was, had they created a Contact Tracing position, they would not have had to worry that this was like some other job.

Commissioner Grebner stated that, if you wanted to follow the contract logic, the question was, for this newly-created position of Contact Tracing, was that a higher position. He further stated that, for example, it could be higher than the Immunization Nurse position, but less than others.

Discussion.

Ms. Gabbara stated that she understood where he was coming from, but these were tasks that were already being practiced in their work lives pre-pandemic. She further stated that they were simply being tapped by the employer in a new way to address this pandemic.

Commissioner Grebner asked if contact tracing was specific to Immunization Nurses.

Ms. Edokpolo stated that the skillset to do contact tracing was within their wheelhouse.

Commissioner Grebner stated that was why it was “Position B” because it really was a collection of work, and if they had a person doing that collection of work, they would have a job description and would know if they were a Pay Grade 7 or Pay Grade 8, but they did not.

Commissioner Celentino stated the nurses were saying that they did not have a “Position D,” as Commissioner Grebner said, but they were doing new procedures that they had not been doing before.
Commissioner Grebner stated that, under the current contract, if the nurses were doing new procedures but at a lower level, they get paid their current rate, not a higher rate. He further stated that, in other words, it was not that they were doing something new, but it had to be new duties assigned to a higher pay grade.

Commissioner Celentino stated that the nurses were saying that their duties were harder.

Commissioner Grebner stated that it was not enough to say that it was new or different, but it had to be a part of something of a higher skill level than what went into their jobs.

Ms. Edokpolo stated that she did believe that this was in the wheelhouse of a nurse. She further stated that maybe they did not know what COVID-19 was, but this was what a nurse can do.

Ms. Edokpolo stated that she agreed that it was hard work, and if the County said they were going to pay them more, she would fully support that. She further stated that she was not fighting to fight because of what the contract said.

Ms. Edokpolo stated that they had brought in a temporary person in Disease Control to do their work because they had so many positive cases of people with COVID-19, and so they were only doing a piece of what the Disease Control Nurses did, but they were doing it 100 percent of time, so she was leaving that interpretation up to the County Services Committee.

Ms. Edokpolo stated that when you have a skill, you learn how to be able to use that skill. She further stated that they had done it and done it well.

Commissioner Stivers stated that she was going to say a lot of what Ms. Edokpolo said, in terms of the fact that these nurses were doing some of the most critical work of this crisis. She further stated that the amount they were asking for was pennies for the County.

Commissioner Stivers stated that the County was facing budget issues, and needed to be mindful of that, but that had a conversation in Closed Session where they talked about a number that was bigger than this one, and the Commissioners had said it was no-big-deal. She further stated that her only concern was how many other employees the County temporarily reclassified because of the COVID-19 crisis, and if the County could afford that.

Discussion.

Chairperson Sebolt stated that the bigger question was if this sentence was in seven other contracts, and they were redefining what the County interpreted what “majority” means, because until this point, the County had interpreted that to mean a majority of the job responsibilities. He further stated that redefining the sentence to mean a majority of the time would be the key difference moving forward.

Commissioner Koenig asked if the people discussed were full-time nurses and the requests of the employer had been made in writing.
Ms. Smith-Heck stated yes.

Commissioner Koenig asked when Ingham County had the last positive case of COVID-19.

Ms. Edokpolo stated that the last positive case had been the day prior.

Discussion.

Ms. Young stated that, at this point, half of the nurses were doing contact tracing while the rest were back to immunization.

Commissioner Koenig stated that she was with Commissioner Stivers that it was not a lot of money for the County, but it could be if it affected all these other contracts and if it was indefinite going forward.

Ms. Gabbara stated that she wanted to reiterate that there would be a greater impact that would trickle from this situation to other collective bargaining agreements. She further stated that to say that this one task that overlapped with Disease Control Nurses was a temporary reassignment negated some of the responsibilities of the Immunization Nurse.

Ms. Gabbara stated that to say that one task makes it a temporary reassignment would be a mischaracterization of the agreement.

Commissioner Grebner stated that he thought the critical word was not “majority,” but rather “higher.” He further stated that the question was whether this would be a higher classification and he agreed that adding one responsibility would not have ended up in a higher classification, and that was critical to the County and its cost.

Commissioner Koenig stated that this was the kind of thing suited for contract negotiations, rather than this hearing today. She further stated that this should be done in the context of contract negotiations because that was where the solutions would come.

Commissioner Koenig stated that it appeared to her that the Committee would go forward and grant this, if they felt it did not have an impact on all of these other units.

Chairperson Sebolt stated that the Committee could either uphold the prior denial of the grievance, grant the grievance and accept the grievants’ request for relief, or grant or deny the grievance in part and craft an alternative remedy.

Ms. Graham stated that the Committee had five days to render its decision after today’s meeting.

Chairperson Sebolt stated that his preference would be to not have to call a special meeting of the Committee in five days. He further stated that it would be nice to do it tonight and then have 15 days to present an alternative remedy.
Commissioner Celentino asked what the third option would look like.
Chairperson Sebolt stated that counsel would determine where the Committee was leaning without making a decision, but then take into consideration the comments about the impact to employees and talk about an alternative remedy. He further stated that, for example, the Committee could say that the nurses were working above, but they did not fit the majority requirements, so the 10 percent pay was not an adequate pay, but perhaps they could come back with a different percentage that was more appealing to this Committee.

Commissioner Grebner stated that, if they did that, they should nudge them into the direction of offering half or a similar number, so that they did not wonder what they should bring back.

Discussion.

Ms. Smith-Heck stated that, if there was a settlement offer, the Committee would make the offer.

Chairperson Sebolt stated that the Committee would instruct counsel to negotiate that with the Michigan Nurses Association—Nurse Practitioners/Clinic Nurses Unit, and counsel would present options to the Committee. He further stated that instead of the Committee negotiating themselves, counsel would do that on their behalf.

Commissioner Grebner stated that he suspected when people looked at it that employees were not similarly situated, and if they tried to craft a solution here, there would be some loose ends.

Chairperson Sebolt stated that counsel would form a consensus on an appropriate response from the Committee, the parties involved would fine tune the details, and then the Committee would come back on July 21, 2020 to decide.

Discussion.

Ms. Edokpolo stated that, during the pandemic, there were a lot of people who had to work, and not everyone did contact tracing, but people did things that they had to do. She further stated that a lot of people were doing things outside of their job descriptions who were part of the Emergency Operations Center, so the Committee would be setting a precedent if they were saying that someone who worked and did something outside of their job descriptions should be paid for it.

Ms. Edokpolo stated that she was all for it, but that was what the Committee needed to think about. She further stated that there were a lot of people who held things down in the middle of this pandemic.

Commissioner Koenig stated that there were people who did not work at all and still received their full wages. She further stated that it appeared that the Committee was looking for a motion to grant or deny the grievance and to turn it over to counsel to negotiate a settlement.

Commissioner Koenig stated that she thought that there should not be any more fact finding, and nothing that went beyond this room at this time. She further stated that they needed to shift it
over to counsel to manage, as she was nervous when it was said that counsel would get from the Committee what they meant because what they meant was here and now. Commissioner Koenig stated that there should be no other record than this record.

Chairperson Sebolt stated that he agreed.

Ms. Gabbara stated that it sounded like the Committee was forming a consensus requesting that counsel sought a resolution that was evenly-disbursed. She further stated that she wanted to reiterate what Ms. Edokpolo said that this would set a precedent regardless of how the Committee decided.

Commissioner Stivers stated that she did not agree with that. She further stated that she was more in favor of the second option, regardless of the precedent.

Commissioner Stivers stated that she felt that they should fairly compensate every Ingham County employee who stepped up and did necessary work during a time of crisis. She further stated that if that involved paying more, the County could afford it and find a way to make it work.

Ms. Smith-Heck stated that, as far as negotiating a settlement, the reason this was brought before the Committee was because the County and Immunization Nurses could not agree. She further stated that they could probably come to an agreement, but they had not.

Chairperson Sebolt stated that, under the third option, the Committee would say to counsel that they thought, for example, a better agreement would look something like this.

Ms. Gabbara asked if the Commissioners preferred if all parties stepped out of the room in order to deliberate.

Chairperson Sebolt stated that this was a public meeting, so that was not an option.

Commissioner Koenig asked if they were looking to ratify this before July 21, 2020 because she did not know if there was time.

Chairperson Sebolt stated that the new agreement would have to come before the Committee at their next meeting on July 21, 2020.

Discussion.

Chairperson Sebolt stated that they would have to have an agreement within 15 days’ time, which would then be ratified. He further stated that they could grant authority to enter into a settlement agreement, so that the County Services Committee would not necessarily need to review.

Discussion.
Commissioner Stivers stated that it would be a shame to keep these nurses waiting for that long. She further stated it would be a shame to negotiate at a lower rate since they were not asking for much to begin with.

MOVED BY COMM. GREBNER, SUPPORTED BY COMM. KOENIG, TO DEFER FINAL ACTIONS UNTIL THE NEXT COUNTY SERVICES COMMITTEE MEETING, AND TO INSTRUCT STAFF TO REACH AN AGREEMENT WITH THE UNDERSTANDING THAT THE COUNTY SERVICES COMMITTEE SUPPORTED SUBSTANTIAL COMPENSATION FOR THE WORK THAT WAS PERFORMED THAT WAS NOT TYPICAL OF IMMUNIZATION NURSES.

Commissioner Grebner stated that the real question was whether this was a higher classification. He further stated that he did not think they could allow themselves to worry about all of the heroic work that was done within their classifications because a lot of employees did a lot of wonderful things, especially during an emergency, but the County could not pay them extra because they had done their job well.

Chairperson Sebolt asked Ms. Gabbara if counsel had a clear enough understanding.

Ms. Gabbara stated that she was not sure because it did not sound like counsel had a lot of room to negotiate. She further stated that the grievants would prefer a flat denial or agreement, so if this was the consensus, she wondered if it even made sense to push it out to the next Committee meeting because she did not know if there was a middle ground.

Ms. Smith-Heck stated that it depended on what the County offered. She further stated that they had not had much success finding middle ground.

Discussion.

Ms. Gabbara stated that she would defer to however the Committee said it wanted to proceed.

Chairperson Sebolt stated that it was their decision whether or not they wanted to go that route.

Ms. Gabbara stated that if they wanted the actual language in the CBA, it said that the Committee shall reply with its decision no later than five days following said meeting, and if the decision by the County Services Committee was unsatisfactory to the Union, said dispute may be submitted within 15 days of arbitration in accordance with the procedures and rules of the American Arbitration Association.

Commissioner Grebner stated that if the union found itself not liking the situation, it was fine to treat this as a rejection of their agreement, but it was not. He further stated that if they decided that this was unacceptable, they could simply proceed, so he was in favor of offering half a loaf.
Commissioner Koenig stated that the County was better off with an answer because it did affect so many unions and the County going forward, and it would be better to deny the grievance and find an answer. She further stated that the answer would then be binding and not reoccur in seven other contracts.

Discussion.

Ms. Smith-Heck stated that the nurses were not interested in bargaining for other bargaining units.

Commissioner Koenig stated that it created precedent.

Chairperson Sebolt stated that they would all look at the decision tonight.

Ms. Smith-Heck stated that she did not know how many were working in what capacity.

Discussion.

THE MOTION FAILED. Yeas: Koenig, Maiville, Sebolt Nays: Celentino, Grebner, Stivers Absent: Naeyaert

MOVED BY COMM. GREBNER TO DENY THE GRIEVANCE.

THE MOTION FAILED FOR LACK OF SUPPORT.

MOVED BY COMM. STIVERS, SUPPORTED BY COMM. CELENTINO, TO GRANT THE GRIEVANCE AND ACCEPT THE GRIEVANTS’ REQUEST FOR RELIEF.

THE MOTION CARRIED. Yeas: Celentino, Grebner, Stivers, Sebolt Nays: Koenig, Maiville Absent: Naeyaert

Commissioner Maiville asked if the Committee could get an outline of other employees who were taking on other duties, given the State of Emergency. He further asked if the County knew how widespread this was.

Ms. Graham stated that it would be hard pressed to identify hundreds of employees who took on additional tasks due to the uniqueness of the situation. She further stated that two staff people from Human Resources were on the Emergency Coordination Center called daily who had never done that before.

Commissioner Maiville asked if they would be tasks substantially in another pay grade.

Ms. Graham stated that if one task overlapped and it seemed to be a temporary reclassification of a higher pay grade, then yes.

Announcements
None.
Public Comment

None.

Adjournment

The meeting was adjourned at 8:29 p.m.
RESOLUTION ACTION ITEMS:

The Deputy Controller recommends approval of the following resolutions:

3. **Ingham County Brownfield Development Authority – Resolution Setting a Public Hearing for an Amended Brownfield Plan for K3 Property LLC, 318 W Kipp Road City of Mason, MI**

This resolution will set a public hearing shall for August 25, 2020 Board of Commissioners Meeting to hear any interested persons on the adoption of a resolution approving the Amended Plan for Klavon’s Pizzeria & Pub in Mason.

On June 12, 2020 the Ingham County Brownfield Authority reviewed and recommended approval of an amended Brownfield Plan for the Klavon’s Pizzeria & Pub. This project is the redevelopment of an under-utilized site on Kipp Road in Mason. The Ingham County Board of Commissioners is required to hold a public hearing on the proposed amended plan before approval and the Brownfield Plan must be adopted by both the Board of Commissioners and the City of Mason. The Plan will be presented to the County Services Committee on August 18, 2020 and the Finance Committee on August 19, 2020.

4a. **Drain Commissioner – Resolution to Approve Agreement for Work in County Road Right of Way by Bauer Drain Drainage District**
4b. **Drain Commissioner – Resolution to Approve Agreement for Work in County Road Right of Way by Green Consolidated Drain Drainage District**
4c. **Drain Commissioner – Resolution to Approve Agreement for Work in County Road Right of Way by Marshall Tile Drain Drainage District**

These resolutions would approve entering into agreement to grant a license and permission to three drainage districts for purposes of operating, maintaining, and improving drains in road rights-of-way held by the ICRD. This action by the Board of Commissioners is customary now as there is no longer a Road Commission. Managing Director Bill Conklin is in agreement with the attached agreements subject to approval by the County Attorney.

The affected districts are:

The Bauer Drainage District, which includes the cleaning out, relocating, widening, deepening, straightening, tiling, extending, improving, providing structures, adding lands, adding branches and relief drains, and/or relocating along a highway to the Drain.

The Green Consolidated Drain Drainage District, which will consolidate the Green Drain Drainage District, the Schoolcraft Drain Drainage District, the Green #4 Consolidated Drain Drainage District, the Green, NE Delhi Branch Drain Drainage District, the Green, Three Lakes Branch Drain Drainage District, the Jackson Drain Drainage District, the Stimson Drain Drainage District, and the Wooded Valley Drain Drainage District. The project involves consolidation of the drains, and the relocating, extending and adding branches to the Drain, and further for the adding and/or deletion of lands not within the Drainage District to the Drain. No construction or improvements are planned.
The Marshall Tile Drain Drainage District, which includes the cleaning out, relocating, widening, deepening, straightening, tiling, extending, improving, providing structures, adding lands, adding branches and relief drains, and/or relocating along a highway to the Drain.

See memos for details.

5a. **9-1-1 Dispatch Center – Resolution to Authorize the Conversion of the 9-1-1 Radio System Administrator from Part-Time to Three-Quarter Time**

This resolution will approve converting the 9-1-1 Radio System Administrator Position #325066 (UAWH) position from part-time to three-quarter time. The 9-1-1 Center is currently implementing a new Public Safety Radio System, and this position is an integral part of this project. In order to meet the deadlines for this project, the position will need to work more than 20 to 29 hours per week that are allowed for a part-time employee. A three-quarter time position, which may work 30 to 39 hours per week, will be able to meet this need. The additional annual cost of the position conversion would be $30,418 and is available within the 9-1-1 fund. The UAW is supportive of this position change.

See memo for details.

6a. **Innovation & Technology – Resolution to Approve the Renewal of Firewall Licenses**

This resolution will authorize the purchase of firewall hardware configuration and renewal licenses from CDWG in the amount not to exceed $205,000.00. Resolution #17-279 approved the purchase of a NextGen Firewall. This protects Ingham County from having an infected computer rapidly spread its infection unchecked. The licensing on this firewall needs to be renewed in order to continue protecting us effectively. In reviewing the licensing preparing for renewal, it was found that we could make a small change to the hardware configuration that would reduce our costs going forward by approximately $30,000.00 per year. Funds for this purchase are included in the 2020 budget.

See memo for details.

7a. **Facilities Department – Resolution to Authorize a Contract Extension with Modernistic for Carpet Cleaning Services at Several County Facilities**

This resolution will authorize a one year contract extension with Modernistic for carpet cleaning services at several county facilities. The contract with Modernistic expires on August 31, 2020. The Facilities Department would like to exercise a one year contract extension. Modernistic has agreed to hold their current prices. Funds are included in the budget for this service.

7a. **Road Department – Resolution to Approve Local Road Agreements with Alaiedon, Aurelius, Bunker Hill, Leroy, Locke, Stockbridge, Vevay, and Wheatfield Townships**

This resolution will authorize entering into 2019 Local Road Program Agreements with the following Townships: Alaiedon, Aurelius, Bunker Hill, Leroy, Locke, Stockbridge, Vevay, and Wheatfield Townships. This resolution will also authorize the Road Department to contribute matching funds. The table below identifies the project cost, matching funds, and township cost for each Township.
Each year the Road Department shares costs with each Township in Ingham County to fund local road improvements desired by the respective Township, which is known as the Local Road Program. The Road Department has worked with each Township to determine what local road projects are most needed and desired. The townships not listed in this resolution have either had a 2020 local road agreement previously approved by the Board of Commissioners, or have elected not to participate in the program this year, or may have a resolution authorizing an agreement submitted in a later meeting cycle. The Road Department will invoice each Township for their respective contributions. These projects are subject to final approval by each Township. See memo for details.

7b. Road Department – Resolution to Authorize the Extension of Resolution #17-235 for Dust Control Solution

This resolution will approve the offer to extend Resolution #17-235 for 2 years, with Chloride Solutions to supply Mineral well brine with 28% calcium chloride to the Ingham County Road Department properties as directed by the Road and Purchasing Departments.

The Road Department purchases Mineral well brine with a 28% calcium chloride solution for dust control. Each summer the brine solution is delivered for dust control on gravel roads and other various road maintenance operations. Resolution #17-235 approved a three year contract with a two year renewal option with Chloride Solutions of Webberville, Michigan. Funds for this purchase are included in the 2020 adopted budget and the 2021 department request.
7c. **Road Department – Resolution to Authorize the Extension of RFP #17-349, Purchase of Seasonal Corrosion Inhibited Liquid De-Icer Solution**

This resolution will authorize the purchase of Geomelt S7 liquid de-icing solution on an as-needed, unit price basis from Chloride Solutions LLC at a cost not to exceed $29,880.

The Road Department annually purchases approximately 12,000 gallons of liquid de-icing solution for use in winter maintenance operations. Resolution #17-349 approved a three year contract with Chloride Solutions of Webberville, Michigan. Chloride Solutions is offering a two year extension at current pricing. Funds for this purchase will be included in the 2021 and 2022 budget.

See memo for details.

9a. **Human Resources Department – Resolution to Authorize Buyout of Special Vacation Bonus Hours Earned During Suspension of County Operations for Essential Employees Excluded from Work Share Program Participation**

This resolution will authorize the Controller/Administrator to enter into collective bargaining for the purpose of negotiating Letters of Agreement with County Unions for the buyout of accrued special vacation bonus hours earned during the March 17 through April 5, 2020 Suspension of Operations period. Employees designated as excluded from participation in Ingham County’s June 1 – July 25, 2020 Work Share Program would be eligible for the buyout. For those not offered this buyout, or who choose not to take it, these special vacation bonus hours earned by employees will remain banked and available for use by employees during their employment with payout at the time of separation from employment.

See memo for details.

9b. **Human Resources Department – Resolution Adopting the Amended and Restated Ingham County Section 125 Flexible Benefits Plan**

This resolution will adopt the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan in order to meet the requirements of applicable Internal Revenue Code sections. The previous Plan was drafted for an effective date of January 1, 2005 and had 11 Amendments as well as 12 Summaries of Material Modification. Several changes are also incorporated to conform to 2020 practices. The Plan has also been amended to incorporate changes due to recent legislation spurred by COVID-19.

See memo for details.

9c. **Human Resources Department – Resolution Adopting an Amended Health Advisory Leave Policy**

In response to the coronavirus pandemic, the Board of Commissioners adopted Resolution #20-112 approving a Health Advisory Leave (HAL) Policy. Since that time, amendments to this policy are being recommended to further the purpose and intent of the policy to provide relief to employees experiencing hardship during the coronavirus pandemic. The proposed amendments reflected in the attached document would:

1. Permit the HAL Policy to apply where an employee subject to a mandatory work schedule reduction under the Work Share Program and the reduction in hours by Ingham County does not qualify the employee for Work Share benefits under applicable State law.
2. Clarify that “caring for a family member” includes temporary care of an individual which becomes necessary due to visitation restrictions at a nursing home or assisted living facility.
3. Expand the nature of supporting documentation to correspond with the proposed amendments.

See memo for details.

9d. **Human Resources Department** – Resolution to Approve Generic Service Credit Purchase for County Employee: Cindy S. Farley

Resolution #02-101 allows for employees to purchase generic service credit under the Municipal Employees’ Retirement System (MERS). Cindy S. Farley has completed the MERS application and received the cost estimate to purchase zero (0) years, five (5) months under the County’s plan. This resolution will approve this generic service credit purchase.

9e. **Human Resources Department** – Resolution to Authorize Extension of the Contract for Sparrow Occupational Health Services

This resolution will approve a 1-year extension of the current contract for occupational health services with Sparrow Occupational Health Services through September 30, 2021.

Ingham County and Sparrow Occupational Health Services have an existing contract for the provision of occupational health services to employees (physicals, drug screens and occupational injury care) with an expiration date of September 30, 2020. This contract was authorized by Resolution #15-305 which extended the contract through this date. It has been typical practice that we would re-bid a contract after 5 years. Given the current state of affairs a 1-year extension of this contract is being proposed, with plans to issue an RFP for Occupational Health Services during 2021.

Sparrow Occupational Health Services is in agreement with a 1-year extension of the contract and is willing to extend the prices for physicals/drug screens that they are currently charging with the existing contract. Injury care will continue to be billed according to the State of Michigan Workers Compensation Fee Schedule.

See memo for details.

10. **Human Services and County Services Committees** – Resolution to Declare a Climate Emergency

This resolution will declare a climate emergency for Ingham County with the intent to build awareness and urgency to develop sustainable practices in County government, including identifying and implementing environmental programming into its existing commitments.

**OTHER ITEMS:**

1. **Economic Development Corporation Board** – Interviews

2. **Greater Lansing Convention and Visitors Bureau** – Update from Julie Pingston, President and CEO

9f. **Human Resources Department** – SB 690 First Responder Hazard Pay (discussion)
EMERGENCY PURCHASE ORDERS:

Notwithstanding the provisions of the Purchasing Procedures Policy, emergency purchase of goods, works and/or services may be made by the Purchasing Director, under the direction and authorization of the Controller, when an immediate purchase is essential to prevent detrimental delays in the work of any department or which might involve danger to life and/or damage to County property. Section 412.J requires the Purchasing Director and responsible department head to file a report with the County Services Committee which explains the nature of the emergency and necessity of the action taken pursuant to Policy. The following emergency purchase orders have been made.

4b. **9-1-1 Dispatch Center** – Notice of Emergency Purchase Order for Radio Connectivity at the Backup 9-1-1 Center

An emergency purchase order was issued to L3 Harris for a total cost of $5,255.31 which is for the four Yagi antennas and labor that were needed to continue the build-out of the backup 9-1-1 center at the Road Department. A fully operational 9-1-1 backup center is necessary to support all Public Safety Agencies while keeping the 9-1-1 staff safe if we have to vacate the current center. This work is for 4 control stations at the backup 9-1-1 center, which will provide radio connectivity until the Motorola Radio System is installed and tested.

5b. **Innovation & Technology** – Notice of Emergency Purchase Order to Repair Cooling Unit in Mason Datacenter

An emergency purchase order was issued for cooling unit repair in the Mason Datacenter from Myers Plumbing and Heating not to exceed $5,000.00. The Mason datacenter is climate controlled to ensure that critical equipment remains operational. One of the cooling units failed and with rising temperatures and other units operating under higher loads there was great risk for the other units to fail as well causing systems outages across the County.

7b. **Facilities Department** – Notice of Emergency Purchase Order for Condensing Unit Replacement at the 911 Center

An emergency purchase order was issued to Trane for a total cost of $44,982. This was necessary because the 30 ton condensing unit at the 911 Center is failing and has been repaired multiple times causing the system to be shut down. The unit provides cooling to the administrative area, locker rooms, kitchen, and restrooms. Complete failure of the unit would have a negative impact on the indoor air temperature. The purchase order includes the condensing unit, installation labor and all other materials.
TO: Ingham County Board of Commissioners County Services Committee

FROM: Dillon Rush, Lansing Economic Area Partnership (LEAP)

DATE: June 22, 2020

SUBJECT: Set Public Hearing for Amended Brownfield Plan, K3 Property LLC (Klavon’s) in City of Mason for the August 25, 2020 Meeting

BACKGROUND
On June 12, 2020 the Ingham County Brownfield Authority (ICBRA) reviewed and recommended approval of an amended Brownfield Plan for the Klavon’s Pizzeria & Pub in the City of Mason. This project is the redevelopment of an under-utilized site on Kipp Road in Mason. Pursuant to PA 381 of 1996 as amended, the Ingham County Board of Commissioners is required to hold a public hearing on the proposed amended plan before approval. The Brownfield Plan must be adopted by both the Board of Commissioners and the City of Mason.

OTHER CONSIDERATIONS
The Brownfield plan will be presented to the County Services Committee at their meeting on August 18, 2020 and the Finance Committee on August 19, 2020.

RECOMMENDATIONS
I respectfully recommend approval of the attached resolution setting a public hearing for the Klavon’s Pizzeria & Pub in Mason for August 25, 2020 at 6:30 PM.
Agenda Item 3

Introduced by the County Services Committee of the:

TINGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION SETTING A PUBLIC HEARING FOR AN AMENDED BROWNFIELD PLAN FOR K3 PROPERTY LLC, 318 W KIPP ROAD, CITY OF MASON, MI

WHEREAS, the Ingham County Board of Commissioners created the Ingham County Brownfield Redevelopment Authority (ICBRA) in September 2001 (Resolution #01-279) pursuant to PA 381 of 1996, as amended (the Act) in order to promote the redevelopment of environmentally distressed, functionally obsolete, and/or blighted areas of the County; and

WHEREAS, the ICBRA recommends approval an amended Brownfield Plan (the Amended Plan) to redevelop underutilized properties in the City of Mason, Michigan identified with tax ID Numbers 33-19-10-08-476-012 and 33-19-10-08-476-010 (the Property), containing 2.18 acres for a Klavon’s Pizzeria & Pub with private investment of approximately $2,500,000 and the creation of 100-110 jobs; and

WHEREAS, the description of the Property along with any maps and Brownfield (finance) Plan are available for public inspection at the office of the Lansing Economic Area Partnership, 1000 S. Washington Avenue, Suite 201, Lansing, MI 48910, and that all aspects of the brownfield plan are open for discussion at the public hearing; and

WHEREAS, pursuant to the Act, the Ingham County Board of Commissioners is required to hold a public hearing on the approval and adoption of the Brownfield Plan and to publish that notice in accordance with the Act.

THEREFORE BE IT RESOLVED, that a public hearing shall be set for August 25, 2020 at 6:30 PM in the Community Room of the Ingham County Fairgrounds, 700 E. Ash Street, Mason to hear any interested persons on the adoption of a resolution approving the Amended Plan for Klavon’s Pizzeria & Pub in Mason, MI.

BE IT FURTHER RESOLVED, that pursuant to the Act, notice of the public hearing shall be provided to taxing jurisdictions that levy taxes subject to capture under the Act and to the public by causing notice to be published in a newspaper of general circulation in the County before the date set for the public hearing.
To: Memo to County Services Committee

From: Patrick E. Lindemann, Ingham County Drain Commissioner

Re: Agreement for the Future Operation, Maintenance and Improvement of Drain in Road Rights-of-Way by the Bauer Drain Drainage District

Date: July 6, 2020

I am requesting that the Ingham County Board of Commissioners, on behalf of the Ingham County Road Department (“ICRD”), approve entering into an agreement to grant a license and permission to the Bauer Drain Drainage District (the “Drainage District”) for the purposes of operating, maintaining, and improving the Bauer Drain (the “Drain”) in road rights-of-way held by the ICRD. Such action by the Board of Commissioners is customary now as there is no longer a Road Commission. Managing Director Bill Conklin is in agreement with the attached agreement subject to approval by the County Attorney.

On November 12, 2018, I received a petition requesting improvements, including the cleaning out, relocating, widening, deepening, straightening, tiling, extending, improving, providing structures, adding lands, adding branches and relief drains, and/or relocating along a highway to the Drain. The petition submitted for the reason that it is necessary to protect the waters of the state from potential hydrocarbon spills and leaks experienced in the Bauer Drain. On December 10, 2018, the petition was found necessary by a statutory Board of Determination. The project involves maintenance and improvements to the Drain.

Thank you for consideration of my request. I will be in attendance at your July 21, 2020 Committee meeting to answer any questions you might have regarding my request.

It is an honor and a privilege to serve the citizens, municipalities, and businesses of Ingham County.
Agenda Item 4a

Introduced by the County Services Committee of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO APPROVE AGREEMENT FOR WORK IN COUNTY ROAD RIGHT OF WAY BY BAUER DRAIN DRAINAGE DISTRICT

RESOLUTION # ______

Minutes of a regular meeting of the Board of Commissioners of Ingham County, Michigan, held in the Ingham County Courthouse, Mason, Michigan, on _____________ _____, 2020, at 6:30 p.m., local time.

PRESENT: Commissioners

_________________________________________
_________________________________________

ABSENT: Commissioners

_________________________________________
_________________________________________

The following resolution was offered by Commissioner _____________ and supported by Commissioner _____________:

WHEREAS, for the reason that it is necessary to protect the waters of the state from potential hydrocarbon spills and leaks experienced in the Bauer Drain (the “Drain”), a Petition dated November 12, 2018, requesting maintenance and improvements, including the cleaning out, relocating, widening, deepening, straightening, tiling, extending, improving, providing structures, adding branches, extensions and a relief drains, relocating along a highway, adding structures and mechanical devices that will properly purify or improve flow, and/or re-pumping equipment necessary to assist or relieve flow (the “Maintenance and Improvements”) to the Drain was filed with the Drain Commissioner; and,

WHEREAS, an Order of Necessity was entered on December 10, 2018, determining that the Maintenance and Improvements petitioned therefore are necessary and conducive to the public health, convenience or welfare, and that the Drain should be improved and that the Maintenance and Improvements to the Drain are necessary for the protection of the public health in Stockbridge Township and White Oak Township; and,

WHEREAS, the Drainage District is developing plans and specifications for the Maintenance and Improvements to the Drain within the Drainage District, and is in the process of securing easements necessary therefore; and,

WHEREAS, the Maintenance and Improvements are intended to protect the waters of the state from potential hydrocarbon spills and leaks experienced in the Bauer Drain, providing cause for the Petition previously filed, in a manner consistent with now-existing federal and state statutes and regulations, and local ordinances; and,

WHEREAS, said Maintenance and Improvements entail work to be performed in the public road rights-of-way under the control and jurisdiction of the ICRD, for which permission must be obtained from the ICRD pursuant to Section 321 of the Drain Code of 1956, MCL 280.321; and,
WHEREAS, the Drain Commissioner has requested that the ICRD grant such permission to construct the Drain in road rights-of-way under the jurisdiction of the ICRD; and,

WHEREAS, the ICRD and the Drain Commissioner agree to cooperate to assure that drainage from properties and roads is unobstructed and that the roads are left in equal, or better, condition once construction is completed in accordance with the terms of this Agreement.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners, on behalf of the ICRD approves entering into an agreement with the Ingham County Drain Commissioner, on behalf of the Bauer Drain Drainage District, to grant license and permission to said Drainage District, its assigns and successors in interest, for purposes of constructing, improving and maintaining the Drain, and to allow said Drain to be constructed in and occupy any and all granted road rights-of-way held by the ICRD necessary for the construction, improvement and maintenance of the Drain, subject to and conditioned upon construction to be performed and constructed in the roads rights-of-way as permitted by the ICRD.

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners is hereby authorized to sign any necessary contract documents on behalf of the County after approval as to form by the County Attorney.

YEAS: Commissioners 

NAYS: Commissioners 

ABSTAIN: Commissioners 

COUNTY SERVICES:

Yeas: 

Nays: Absent: Approved: 

RESOLUTION DECLARED ADOPTED.

Barb Byrum, Clerk
County of Ingham
STATE OF MICHIGAN  
)  
) SS  
COUNTY OF INGHAM  
)

I, Barb Byrum, the duly qualified and acting Clerk of Ingham County, Michigan (the “County”) do hereby certify that the foregoing is a true and complete copy of a resolution adopted by the Board of Commissioners at a meeting held on ________________, 2020, the original of which is on file in my office. Public notice of said meeting was given pursuant to and in compliance with Act No. 267 of the Public Acts of Michigan of 1976, as amended.

IN WITNESS WHEREOF, I have hereunto affixed my signature this ____ day of ________________, 2020.

________________________________________
Barb Byrum, Clerk
County of Ingham
AGREEMENT FOR WORK IN ROAD RIGHT OF WAY BY BAUER DRAIN DRAINAGE DISTRICT

This Agreement is made and entered into on this ___ day of ____________, 2020, by and between the Bauer Drain Drainage District (the “Drainage District”), a public body corporate, administered by the Ingham County Drain Commissioner (the “Drain Commissioner”) of 707 Buhl St, Mason, MI 48854-0220, and the County of Ingham on behalf of the Ingham County Road Department (hereinafter, the “ICRD”) of 301 Bush Street, P.O. Box 38, Mason, Michigan 48854.

WITNESSETH:

WHEREAS, for the reason that it is necessary to protect the waters of the state from potential hydrocarbon spills and leaks experienced in the Bauer Drain (the “Drain”), a Petition dated November 12, 2018, requesting maintenance and improvements, including the cleaning out, relocating, widening, deepening, straightening, tiling, extending, improving, providing structures, adding branches, extensions and a relief drains, relocating along a highway, adding structures and mechanical devices that will properly purify or improve flow, and/or re-pumping equipment necessary to assist or relieve flow (the “Maintenance and Improvements”) to the Drain was filed with the Drain Commissioner; and,

WHEREAS, an Order of Necessity was entered on December 10, 2018, determining that the Maintenance and Improvements petitioned therefore are necessary and conducive to the public health, convenience or welfare, and that the Drain should be improved and that the Maintenance and Improvements to the Drain are necessary for the protection of the public health in Stockbridge Township and White Oak Township; and,

WHEREAS, the Drainage District is developing plans and specifications for the Maintenance and Improvements to the Drain within the Drainage District, and is in the process of securing easements necessary therefore; and,

WHEREAS, the Maintenance and Improvements are intended to protect the waters of the state from potential hydrocarbon spills and leaks experienced in the Bauer Drain, providing cause for the Petition previously filed, in a manner consistent with now-existing federal and state statutes and regulations, and local ordinances; and,

WHEREAS, said Maintenance and Improvements entail work to be performed in the public road rights-of-way under the control and jurisdiction of the ICRD, for which permission must be obtained from the ICRD pursuant to Section 321 of the Drain Code of 1956, MCL 280.321; and,

WHEREAS, the Drain Commissioner has requested that the ICRD grant such permission to construct the Drain in road rights-of-way under the jurisdiction of the ICRD; and,

WHEREAS, the ICRD and the Drain Commissioner agree to cooperate to assure that drainage from properties and roads is unobstructed and that the roads are left in equal, or better, condition once construction is completed in accordance with the terms of this Agreement.
NOW THEREFORE, it is agreed by and between the parties as follows:

1. The ICRD does hereby grant license and permission to the Drainage District, its assigns and successors in interest, for purposes of constructing, improving and maintaining the Drain, and to allow said Drain to be constructed in and occupy any and all granted road rights-of-way held by the ICRD necessary for the construction, improvement and maintenance of the Drain, subject to and conditioned upon construction to be performed and constructed in the road rights-of-way as permitted by the ICRD and as marked on the map attached hereto as Exhibit A.

2. The Drainage District is solely responsible for, and shall maintain, all Drainage Structures installed within the road right-of-way for storm water drainage purposes, as depicted in the attached Exhibit A.

3. The term “Drainage Structures” as used herein shall mean all storm sewer pipes, open ditches, tiles, culverts, trench drains, planting material, manholes, catch basins, vegetation and bio-retention areas residing within the Drainage District for drainage and storm water management purposes.

4. The ICRD shall not be obligated in the future to repair and maintain any Drainage Structures that are within the road right-of-way that are also within the drainage route and course that have been installed, improved and/or maintained, arising out of or as a result of this Agreement.

5. The Drainage District shall be responsible, without cost to the ICRD, for repairing any portion of a road or ICRD property located within the road rights-of-way, as depicted on the attached Exhibit A, that is damaged during or as a result of construction, repair or maintenance work on the Drain performed by the Drainage District under this Agreement. Such repair shall reasonably restore any damaged portion to the same general condition as it was prior to such damage.

6. Except as specifically set forth herein, this Agreement does not otherwise alter the ICRD’s obligations, or rights to governmental immunity as may be provided by law, for road administration, repair and maintenance of roads and road rights-of-way under its control and jurisdiction as provided by law.

7. Except as specifically set forth herein, this Agreement does not otherwise alter the Drainage District’s obligations for maintenance and repair of the Drain as provided by law.

8. This Agreement shall not be construed as obligating the ICRD or the Drain Commissioner to expend funds in excess of appropriations or assessments authorized by law or otherwise commit the Drain Commissioner or the ICRD to actions for which they lack statutory authority.

9. For the Maintenance and Improvements to be performed pursuant to this Agreement, and for any future maintenance and/or repair work, the Drain Commissioner, on behalf of the Drainage District, shall obtain any and all necessary permits from the ICRD required to perform said construction, maintenance and/or repair work. Any subsequent changes in the Plans and Specifications during construction for work under the roads or within the road
rights-of-way must first receive a permit amendment. Subsequent to completion of construction, the Drainage District shall provide the ICRD with construction record drawings illustrating all Maintenance and Improvements and their details constructed under the roads and within the public road rights-of-way and identifying the Drainage Structures to be maintained by the Drainage District.

10. This Agreement is entered specific to the construction, Maintenance and Improvements and maintenance of the Drain set forth in the above-referenced Plans and Specifications and shall not otherwise be applicable beyond said Drain and Drainage District and does not otherwise modify existing Drain Commissioner and ICRD authorities or transfer any authority, on to the other. The ICRD and the Drain Commissioner do not waive any claims, positions and/or interpretations that may have with respect to the applicability and/or enforceability of any law, regulation or ordinance.

11. This Agreement incorporate by reference the ICRD Right-of-Way Permit Rules and Regulations as revised on June 8, 2006.

12. This Agreement does not confer or grant an easement or other rights or interests in the roads or road right-of-way to the Drain Commissioner or Drainage District other than as necessary for the construction, maintenance and repair of the Drain, unless otherwise stated herein.

13. This Agreement is not intended to create, nor does it create, any third-party rights, but has been entered into for the sole benefit of the parties hereto.

14. The parties signing this Agreement on behalf of each party are, by said signatures, affirming that they are authorized to enter into this Agreement for and on behalf of the respective parties to this Agreement.

[Signatures and Acknowledgments on following pages]
BAUER DRAIN DRAINAGE DISTRICT

By: _____________________________________
    Patrick E. Lindemann
    Ingham County Drain Commissioner

STATE OF MICHIGAN  )
    )SS
COUNTY OF INGHAM  )

The foregoing was acknowledged by me on this ____ day of ____________, 2020, by Patrick E. Lindemann, Ingham County Drain Commissioner on behalf of the Bauer Drain Drainage District.

____________________________________
_______________________, Notary Public
State of Michigan, County of Ingham
My commission expires: ______________
Acting in the County of: ______________

COUNTY OF INGHAM FOR
INGHAM COUNTY ROAD DEPARTMENT

By: _____________________________________
    Bryan Crenshaw
    Chairperson, County Board of Commissioners

STATE OF MICHIGAN  )
    )SS
COUNTY OF INGHAM  )

The foregoing was acknowledged by me on this ____ day of ____________, 2020, by Bryan Crenshaw, Chairperson, County Board of Commissioners, on behalf of the Ingham County Road Department.

___________________________________
_______________________, Notary Public
State of Michigan, County of Ingham
My commission expires: ______________
Acting in the County of: ______________
APPROVED AS TO FORM
FOR THE COUNTY OF INGHAM
COHL, STOKER & TOSKEY, P.C.

By: ______________________________
    Robert D. Townsend

Prepared by and Return to:

Patrick E. Lindemann
Ingham County Drain Commissioner
707 Buhl Avenue
Mason, Michigan 48854-0220
To: Memo to County Services Committee

From: Patrick E. Lindemann, Ingham County Drain Commissioner

Re: Agreement for the Future Operation, Maintenance and Improvement of Drain in Road Rights-of-Way by the Green Consolidated Drain Drainage District

Date: July 6, 2020

I am requesting that the Ingham County Board of Commissioners, on behalf of the Ingham County Road Department (“ICRD”), approve entering into an agreement to grant a license and permission to the Green Consolidated Drain Drainage District (the “Drainage District”) for the purposes of future operating, maintaining, and improving the Green Consolidated Drain (the “Drain”) in road rights-of-way held by the ICRD. Such action by the Board of Commissioners is customary now as there is no longer a Road Commission. Managing Director Bill Conklin is in agreement with the attached agreement subject to approval by the County Attorney.

On March 5, 2019, I received a petition requesting to consolidate the Green Drain Drainage District, the Schoolcraft Drain Drainage District, the Green #4 Consolidated Drain Drainage District, the Green, NE Delhi Branch Drain Drainage District, the Green, Three Lakes Branch Drain Drainage District, the Jackson Drain Drainage District, the Stimson Drain Drainage District, and the Wooded Valley Drain Drainage District, and said drainage districts once consolidated to be known collectively as the Green Consolidated Drain Drainage District (“Drainage District”), and the respective drains, to be known collectively as the Green Consolidated Drain (the “Drain”). On April 23, 2019, the petition was found necessary by a statutory Board of Determination. The project involves consolidation of the drains, and the relocating, extending and adding branches to the Drain, and further for the adding and/or deletion of lands not within the Drainage District to the Drain. No construction or improvements are planned pursuant to the petition and Order of Necessity.

Thank you for consideration of my request. I will be in attendance at your July 21, 2020 Committee meeting to answer any questions you might have regarding my request.

It is an honor and a privilege to serve the citizens, municipalities, and businesses of Ingham County.
Minutes of a regular meeting of the Board of Commissioners of Ingham County, Michigan, held in the Ingham County Courthouse, Mason, Michigan, on _______________ ____, 2020, at 6:30 p.m., local time.

PRESENT: Commissioners ____________________________________________

ABSENT: Commissioners ____________________________________________

The following resolution was offered by Commissioner _______________ and supported by Commissioner _______________

WHEREAS, pursuant to a petition dated March 5, 2019, Delhi Charter Township requested the Drain Commissioner to consolidate the Green Drain Drainage District, the Schoolcraft Drain Drainage District, the Green #4 Consolidated Drain Drainage District, the Green, NE Delhi Branch Drain Drainage District, the Green, Three Lakes Branch Drain Drainage District, the Jackson Drain Drainage District, the Stimson Drain Drainage District, and the Wooded Valley Drain Drainage District, and said drainage districts once consolidated to be known collectively as the Green Consolidated Drain Drainage District (“Drainage District”), and the respective drains, to be known collectively as the Green Consolidated Drain (the “Drain”); and,

WHEREAS, Delhi Charter Township also petitioned for the relocating, extending and adding branches to the Drain, and further petitioned for the adding and/or deletion of lands not within the Drainage District; and,

WHEREAS, an Order of Necessity was entered on April 23, 2019, determining that the consolidation, addition or deletion of lands in the Drainage District and relocation, extension and adding branches to the Drain petitioned therefore are necessary and conducive to the public health, convenience or welfare, and that said drainage districts and drains should be consolidated are necessary for the protection of the public health in Delhi Charter Township and City of Lansing; and,

WHEREAS, no construction or improvements are planned pursuant to the petition and Order of Necessity; and,

WHEREAS, the Drainage District is developing plans and specifications that are necessary for the consolidation of the Drain within the Drainage District, and is in the process of securing easements necessary for relocating, extending and adding branches to the Drain; and,

WHEREAS, the consolidation of drainage districts and drains are intended to provide efficiency of administration of the Drain and for the long-terms savings for landowners and municipalities subject to assessment for the maintenance of the Drain; and,
WHEREAS, said consolidation of drainage districts and drains include drains within the public road rights-of-way under the control and jurisdiction of the ICRD, for which permission must be obtained from the ICRD pursuant to Section 321 of the Drain Code of 1956, MCL 280.321; and,

WHEREAS, the Drain Commissioner has requested that the ICRD grant such permission to maintain the Drain in road rights-of-way under the jurisdiction of the ICRD; and,

WHEREAS, the ICRD and the Drain Commissioner agree to cooperate to assure that drainage from properties and roads is unobstructed and in the event of any maintenance on the Drain that the roads are left in equal, or better, condition once construction is completed in accordance with the terms of this Agreement.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners, on behalf of the ICRD approves entering into an agreement with the Ingham County Drain Commissioner, on behalf of the Green Consolidated Drain Drainage District, to grant license and permission to said Drainage District, its assigns and successors in interest, for purposes of future constructing, improving and maintaining the Drain, and to allow said Drain to be constructed in and occupy any and all granted road rights-of-way held by the ICRD necessary for the future construction, improvement and maintenance of the Drain, subject to and conditioned upon such construction to be performed and constructed in the roads rights-of-way as permitted by the ICRD.

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners is hereby authorized to sign any necessary contract documents on behalf of the County after approval as to form by the County Attorney.

YEAS: Commissioners __________________________________________

NAYS: Commissioners __________________________________________

ABSTAIN: Commissioners _______________________________________

COUNTY SERVICES:

Yeas: __________________________________________

Nays: _______________ Absent: _______________ Approved: ________

RESOLUTION DECLARED ADOPTED.

________________________________________________________________________
Barb Byrum, Clerk
County of Ingham
I, Barb Byrum, the duly qualified and acting Clerk of Ingham County, Michigan (the “County”) do hereby certify that the foregoing is a true and complete copy of a resolution adopted by the Board of Commissioners at a meeting held on ________________, 2020, the original of which is on file in my office. Public notice of said meeting was given pursuant to and in compliance with Act No. 267 of the Public Acts of Michigan of 1976, as amended.

IN WITNESS WHEREOF, I have hereunto affixed my signature this ____ day of ________________, 2020.

__________________________________________
Barb Byrum, Clerk
County of Ingham
This Agreement is made and entered into on this ____ day of __________, 2020, by and between the Green Consolidated Drain Drainage District (the “Drainage District”), a public body corporate, administered by the Ingham County Drain Commissioner (the “Drain Commissioner”) of 707 Buhl St, Mason, MI 48854-0220, and the County of Ingham on behalf of the Ingham County Road Department (hereinafter, the “ICRD”) of 301 Bush Street, P.O. Box 38, Mason, Michigan 48854.

WITNESSETH:

WHEREAS, pursuant to a petition dated March 5, 2019, Delhi Charter Township requested the Drain Commissioner to consolidate the Green Drain Drainage District, the Schoolcraft Drain Drainage District, the Green #4 Consolidated Drain Drainage District, the Green, NE Delhi Branch Drain Drainage District, the Green, Three Lakes Branch Drain Drainage District, the Jackson Drain Drainage District, the Stimson Drain Drainage District, and the Wooded Valley Drain Drainage District, and said drainage districts once consolidated to be known collectively as the Green Consolidated Drain Drainage District (“Drainage District”), and the respective drains, to be known collectively as the Green Consolidated Drain (the “Drain”); and,

WHEREAS, Delhi Charter Township also petitioned for the relocating, extending and adding branches to the Drain, and further petitioned for the adding and/or deletion of lands not within the Drainage District; and,

WHEREAS, an Order of Necessity was entered on April 23, 2019, determining that the consolidation, addition or deletion of lands in the Drainage District and relocation, extension and adding branches to the Drain petitioned therefore are necessary and conducive to the public health, convenience or welfare, and that said drainage districts and drains should be consolidated are necessary for the protection of the public health in Delhi Charter Township and City of Lansing; and,

WHEREAS, no construction or improvements are planned pursuant to the petition and Order of Necessity; and,

WHEREAS, the Drainage District is developing plans and specifications that are necessary for the consolidation of the Drain within the Drainage District, and is in the process of securing easements necessary for relocating, extending and adding branches to the Drain; and,

WHEREAS, the consolidation of drainage districts and drains are intended to provide efficiency of administration of the Drain and for the long-terms savings for landowners and municipalities subject to assessment for the maintenance of the Drain; and,

WHEREAS, said consolidation of drainage districts and drains include drains within the public road rights-of-way under the control and jurisdiction of the ICRD, for which permission must be obtained from the ICRD pursuant to Section 321 of the Drain Code of 1956, MCL 280.321; and,
WHEREAS, the Drain Commissioner has requested that the ICRD grant such permission to maintain the Drain in road rights-of-way under the jurisdiction of the ICRD; and,

WHEREAS, the ICRD and the Drain Commissioner agree to cooperate to assure that drainage from properties and roads is unobstructed and in the event of any maintenance on the Drain that the roads are left in equal, or better, condition once construction is completed in accordance with the terms of this Agreement.

NOW THEREFORE, it is agreed by and between the parties as follows:

15. The ICRD does hereby grant license and permission to the Drainage District, its assigns and successors in interest, for purposes of constructing, improving and maintaining the Drain, and to allow said Drain to occupy any and all granted road rights-of-way held by the ICRD necessary for the construction, improvement and maintenance of the Drain as set for and identified on the map attached hereto as Exhibit A.

16. The Drainage District is solely responsible for, and shall maintain, the Drain and Drainage Structures (as defined in Section 3) installed within the road right-of-way for storm water drainage purposes, as depicted in the attached Exhibit A.

17. The term “Drainage Structures” as used herein shall mean all storm sewer pipes, open ditches, tiles, culverts, trench drains, planting material, manholes, catch basins, vegetation and bio-retention areas residing within the Drainage District for drainage and storm water management purposes.

18. The ICRD shall not be obligated in the future to repair and maintain any Drainage Structures that are within the road right-of-way that are also within the drainage route and course that have been installed, improved and/or maintained, arising out of or as a result of this Agreement.

19. The Drainage District shall be responsible, without cost to the ICRD, for repairing any portion of a road or ICRD property located within the road rights-of-way, as depicted on the attached Exhibit A, that is damaged during or as a result of any construction, repair or maintenance work on the Drain performed by the Drainage District under this Agreement. Such repair shall reasonably restore any damaged portion to the same general condition as it was prior to such damage.

20. Except as specifically set forth herein, this Agreement does not otherwise alter the ICRD’s obligations, or rights to governmental immunity as may be provided by law, for road administration, repair and maintenance of roads and road rights-of-way under its control and jurisdiction as provided by law.

21. Except as specifically set forth herein, this Agreement does not otherwise alter the Drainage District’s obligations for maintenance and repair of the Drain as provided by law.

22. This Agreement shall not be construed as obligating the ICRD or the Drain Commissioner to expend funds in excess of appropriations or assessments authorized by law or otherwise commit the Drain Commissioner or the ICRD to actions for which they lack statutory authority.
23. For any future maintenance and/or repair work, the Drain Commissioner, on behalf of the Drainage District, shall obtain any and all necessary permits from the ICRD required to perform said construction, maintenance and/or repair work.

24. This Agreement is entered specific to the consolidation of the Drain, and future construction, maintenance, repair and improvement of the Drain set forth Exhibit A and shall not otherwise be applicable beyond said Drain and Drainage District and does not otherwise modify existing Drain Commissioner and ICRD authorities or transfer any authority, on to the other. The ICRD and the Drain Commissioner do not waive any claims, positions and/or interpretations that may have with respect to the applicability and/or enforceability of any law, regulation or ordinance.

25. This Agreement incorporate by reference the ICRD Right-of-Way Permit Rules and Regulations as revised on June 8, 2006.

26. This Agreement does not confer or grant an easement or other rights or interests in the roads or road right-of-way to the Drain Commissioner or Drainage District other than as necessary for the consolidation, construction, maintenance and repair of the Drain, unless otherwise stated herein.

27. This Agreement is not intended to create, nor does it create, any third-party rights, but has been entered into for the sole benefit of the parties hereto.

28. The parties signing this Agreement on behalf of each party are, by said signatures, affirming that they are authorized to enter into this Agreement for and on behalf of the respective parties to this Agreement.
GREEN CONSOLIDATED DRAIN DRAINAGE DISTRICT

By: ________________________________
    Patrick E. Lindemann
    Ingham County Drain Commissioner

STATE OF MICHIGAN     )
                      )SS
COUNTY OF INGHAM     )

The foregoing was acknowledged by me on this ___ day of ____________, 2020, by Patrick E. Lindemann, Ingham County Drain Commissioner on behalf of the Green Consolidated Drain Drainage District.

____________________________________
_______________________, Notary Public
State of Michigan, County of Ingham
My commission expires: ______________
Acting in the County of: ______________

COUNTY OF INGHAM FOR
INGHAM COUNTY ROAD DEPARTMENT

By: ________________________________
    Bryan Crenshaw
    Chairperson, County Board of Commissioners

STATE OF MICHIGAN     )
                      )SS
COUNTY OF INGHAM     )

The foregoing was acknowledged by me on this ___ day of ____________, 2020, by Bryan Crenshaw, Chairperson, County Board of Commissioners, on behalf of the Ingham County Road Department.

___________________________________
_______________________, Notary Public
State of Michigan, County of Ingham
My commission expires: ______________
Acting in the County of: ______________
APPROVED AS TO FORM
FOR THE COUNTY OF INGHAM
COHL, STOKER & TOSKEY, P.C.

By: ______________________________
      Robert D. Townsend

Prepared by and Return to:

Patrick E. Lindemann
Ingham County Drain Commissioner
707 Buhl Avenue
Mason, Michigan 48854-0220
To: Memo to County Services Committee

From: Patrick E. Lindemann, Ingham County Drain Commissioner

Re: Agreement for the Future Operation, Maintenance and Improvement of Drain in Road Rights-of-Way by the Marshall Tile Drain Drainage District

Date: July 6, 2020

I am requesting that the Ingham County Board of Commissioners, on behalf of the Ingham County Road Department (“ICRD”), approve entering into an agreement to grant a license and permission to the Marshall Tile Drain Drainage District (the “Drainage District”) for the purposes of operating, maintaining, and improving the Marshall Tile Drain (the “Drain”) in road rights-of-way held by the ICRD. Such action by the Board of Commissioners is customary now as there is no longer a Road Commission. Managing Director Bill Conklin is in agreement with the attached agreement subject to approval by the County Attorney.

On July 30, 2018, I received a petition requesting improvements, including the cleaning out, relocating, widening, deepening, straightening, tiling, extending, improving, providing structures, adding lands, adding branches and relief drains, and/or relocating along a highway to the Drain. The petition submitted is intended to address drainage problems and periodic flooding experienced in the Drainage District. On June 5, 2019, the petition was found necessary by a statutory Board of Determination. The project involves maintenance and improvements to the Drain.

Thank you for consideration of my request. I will be in attendance at your July 21, 2020 Committee meeting to answer any questions you might have regarding my request.

It is an honor and a privilege to serve the citizens, municipalities, and businesses of Ingham County.
Introduced by the County Services Committee of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO APPROVE AGREEMENT FOR WORK IN COUNTY ROAD RIGHT OF WAY BY MARSHALL TILE DRAIN DRAINAGE DISTRICT

RESOLUTION # ________

Minutes of a regular meeting of the Board of Commissioners of Ingham County, Michigan, held in the Ingham County Courthouse, Mason, Michigan, on ______________ _____. 2020, at 6:30 p.m., local time.

PRESENT:  Commissioners

__________________________________________________________

__________________________________________________________

ABSENT:  Commissioners

__________________________________________________________

The following resolution was offered by Commissioner ________________ and supported by Commissioner ________________:

WHEREAS, as a result drainage problems and flooding in the Marshall Tile Drain Drainage District (“Drainage District”), a Petition dated July 30, 2018, requesting improvements, including the cleaning out, relocating, widening, deepening, straightening, tiling, extending, improving, providing structures, adding lands, adding branches and relief drains, and/or relocating along a highway, (the “Improvements”) to the Marshall Tile Drain (the “Drain”) was filed with the Drain Commissioner; and,

WHEREAS, an Order of Necessity was entered on June 5, 2019, determining that the Improvements petitioned therefore are necessary and conducive to the public health, convenience or welfare, and that the Drain should be improved and that the Improvements to the Drain are necessary for the protection of the public health in Aurelius Township; and,

WHEREAS, the Drainage District is developing plans and specifications for the Improvements to the Drain within the Drainage District, and is in the process of securing easements necessary therefore; and,

WHEREAS, the Improvements are intended to relieve drainage problems and periodic flooding, providing cause for the Petition previously filed, in a manner consistent with now-existing federal and state statutes and regulations, and local ordinances; and,

WHEREAS, said Improvements entail work to be performed in the public road rights-of-way under the control and jurisdiction of the Ingham County Road Department (“ICRD”), for which permission must be obtained from the ICRD pursuant to Section 321 of the Drain Code of 1956, MCL 280.321; and,

WHEREAS, the Drain Commissioner has requested that the ICRD grant such permission to construct the Drain in road rights-of-way under the jurisdiction of the ICRD; and,
WHEREAS, the ICRD and the Drain Commissioner agree to cooperate to assure that drainage from properties and roads is unobstructed and that the roads are left in equal, or better, condition once construction is completed in accordance with the terms of this Agreement to be executed.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners, on behalf of the ICRD approves entering into an agreement with the Ingham County Drain Commissioner, on behalf of the Marshall Tile Drain Drainage District, to grant license and permission to said Drainage District, its assigns and successors in interest, for purposes of constructing, improving and maintaining the Drain, and to allow said Drain to be constructed in and occupy any and all granted road rights-of-way held by the ICRD necessary for the construction, improvement and maintenance of the Drain, subject to and conditioned upon construction to be performed and constructed in the roads rights-of-way as permitted by the ICRD.

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners is hereby authorized to sign any necessary contract documents on behalf of the County after approval as to form by the County Attorney.

YEAS: Commissioners

NAYS: Commissioners

ABSTAIN: Commissioners

COUNTY SERVICES:

Yeas: ___________________________________________________________________

Nays: ______________ Absent: __________ Approved: __________
I, Barb Byrum, the duly qualified and acting Clerk of Ingham County, Michigan (the “County”) does hereby certify that the foregoing is a true and complete copy of a resolution adopted by the Board of Commissioners at a meeting held on ________________, 2020, the original of which is on file in my office. Public notice of said meeting was given pursuant to and in compliance with Act No. 267 of the Public Acts of Michigan of 1976, as amended.

IN WITNESS WHEREOF, I have hereunto affixed my signature this ____ day of ________________, 2020.

________________________________________
Barb Byrum, Clerk
County of Ingham
AGREEMENT FOR WORK IN ROAD RIGHT OF WAY BY MARSHALL TILE DRAIN DRAINAGE DISTRICT

This Agreement is made and entered into on this ___ day of ____________, 2020, by and between the Marshall Tile Drain Drainage District (the “Drainage District”), a public body corporate, administered by the Ingham County Drain Commissioner (the “Drain Commissioner”), 707 Buhl St, Mason, MI 48854-0220, and the County of Ingham on behalf of the Ingham County Road Department (hereinafter, the “ICRD”), 301 Bush Street, P.O. Box 38, Mason, Michigan 48854.

WITNESSETH:

WHEREAS, as a result drainage problems and periodic flooding experienced in the Marshall Tile Drain (the “Drain”), a Petition dated July 30, 2018, requesting improvements, including the cleaning out, relocating, widening, deepening, straightening, tiling, extending, providing structures, adding branches and a relief drains, relocating along a highway, adding structures and mechanical devices that will properly purify or improve flow, adding pumping equipment necessary to assist or relieve flow (the “Improvements”) to the Drain was filed with the Drain Commissioner; and,

WHEREAS, an Order of Necessity was entered on June 5, 2019, determining that the Improvements petitioned therefore are necessary and conducive to the public health, convenience or welfare, and that the Drain should be improved and that the Improvements to the Drain are necessary for the protection of the public health in Aurelius Township; and,

WHEREAS, the Drainage District is developing plans and specifications for the Improvements to the Drain within the Drainage District, and is in the process of securing easements necessary therefore; and,

WHEREAS, the Improvements are intended to relieve drainage problems and periodic flooding, providing cause for the Petition previously filed, in a manner consistent with now-existing federal and state statutes and regulations, and local ordinances; and,

WHEREAS, said Improvements entail work to be performed in the public road rights-of-way under the control and jurisdiction of the ICRD, for which permission must be obtained from the ICRD pursuant to Section 321 of the Drain Code of 1956, MCL 280.321; and,

WHEREAS, the Drain Commissioner has requested that the ICRD grant such permission to construct the Drain in road rights-of-way under the jurisdiction of the ICRD; and,

WHEREAS, the ICRD and the Drain Commissioner agree to cooperate to assure that drainage from properties and roads is unobstructed and that the roads are left in equal, or better, condition once construction is completed in accordance with the terms of this Agreement.

NOW THEREFORE, it is agreed by and between the parties as follows:
29. The ICRD does hereby grant license and permission to the Drainage District, its assigns and successors in interest, for purposes of constructing, improving and maintaining the Drain, and to allow said Drain to be constructed in and occupy any and all granted road rights-of-way held by the ICRD necessary for the construction, improvement and maintenance of the Drain, subject to and conditioned upon construction to be performed and constructed in the road rights-of-way as permitted by the ICRD and as marked on the map attached hereto as Exhibit A.

30. The Drainage District is solely responsible for, and shall maintain, all Drainage Structures installed within the road right-of-way for storm water drainage purposes, as depicted in the attached Exhibit A.

31. The term “Drainage Structures” as used herein shall mean all storm sewer pipes, open ditches, tiles, culverts, trench drains, planting material, manholes, catch basins, vegetation and bio-retention areas residing within the Drainage District for drainage and storm water management purposes.

32. The ICRD shall not be obligated in the future to repair and maintain any Drainage Structures that are within the road right-of-way that are also within the drainage route and course that have been installed, improved and/or maintained, arising out of or as a result of this Agreement.

33. The Drainage District shall be responsible, without cost to the ICRD, for repairing any portion of a road or ICRD property located within the road rights-of-way, as depicted on the attached Exhibit A, that is damaged during or as a result of construction, repair or maintenance work on the Drain performed by the Drainage District under this Agreement. Such repair shall reasonably restore any damaged portion to the same general condition as it was prior to such damage.

34. Except as specifically set forth herein, this Agreement does not otherwise alter the ICRD’s obligations, or rights to governmental immunity as may be provided by law, for road administration, repair and maintenance of roads and road rights-of-way under its control and jurisdiction as provided by law.

35. Except as specifically set forth herein, this Agreement does not otherwise alter the Drainage District’s obligations for maintenance and repair of the Drain as provided by law.

36. This Agreement shall not be construed as obligating the ICRD or the Drain Commissioner to expend funds in excess of appropriations or assessments authorized by law or otherwise commit the Drain Commissioner or the ICRD to actions for which they lack statutory authority.

37. For the Improvements to be performed pursuant to this Agreement, and for any future maintenance and/or repair work, the Drain Commissioner, on behalf of the Drainage District, shall obtain any and all necessary permits from the ICRD required to perform said construction, maintenance and/or repair work. Any subsequent changes in the Plans and Specifications during construction for work under the roads or within the road rights-of-way...
must first receive a permit amendment. Subsequent to completion of construction, the Drainage District shall provide the ICRD with construction record drawings illustrating all Improvements and their details constructed under the roads and within the public road rights-of-way and identifying the Drainage Structures to be maintained by the Drainage District.

38. This Agreement is entered specific to the construction, improvements and maintenance of the Drain set forth in the above-referenced Plans and Specifications and shall not otherwise be applicable beyond said Drain and Drainage District, and does not otherwise modify existing Drain Commissioner and ICRD authorities or transfer any authority, on to the other. The ICRD and the Drain Commissioner do not waive any claims, positions and/or interpretations that may have with respect to the applicability and/or enforceability of any law, regulation or ordinance.

39. This Agreement incorporate by reference the ICRD Right-of-Way Permit Rules and Regulations as revised on June 8, 2006.

40. This Agreement does not confer or grant an easement or other rights or interests in the roads or road right-of-way to the Drain Commissioner or Drainage District other than as necessary for the construction, maintenance and repair of the Drain, unless otherwise stated herein.

41. This Agreement is not intended to create, nor does it create, any third-party rights, but has been entered into for the sole benefit of the parties hereto.

42. The parties signing this Agreement on behalf of each party are, by said signatures, affirming that they are authorized to enter into this Agreement for and on behalf of the respective parties to this Agreement.

[Signatures and Acknowledgments on following pages]
MARSHALL TILE DRAIN DRAINAGE DISTRICT

By: ____________________________________
    Patrick E. Lindemann
    Ingham County Drain Commissioner

STAT OF MICHIGAN   )
  )SS
COUNTY OF INGHAM   )

The foregoing was acknowledged by me on this _____ day of ______________, 2020,
by Patrick E. Lindemann, Ingham County Drain Commissioner on behalf of the Marshall Tile
Drain Drainage District.

___________________________________
_______________________, Notary Public
State of Michigan, County of Ingham
My commission expires: ______________
Acting in the County of: ______________

COUNTY OF INGHAM FOR
INGHAM COUNTY ROAD DEPARTMENT

By: _____________________________________
    Bryan Crenshaw
    Chairperson, County Board of Commissioners

STAT OF MICHIGAN   )
  )SS
COUNTY OF INGHAM   )

The foregoing was acknowledged by me on this _____ day of ______________, 2020,
by Bryan Crenshaw, Chairperson, County Board of Commissioners, on behalf of the
Ingham County Road Department.

___________________________________
_______________________, Notary Public
State of Michigan, County of Ingham
My commission expires: ______________
Acting in the County of: ______________
APPROVED AS TO FORM
FOR THE COUNTY OF INGHAM
COHL, STOKER & TOSKEY, P.C.

By: ______________________________
    Robert D. Townsend

Prepared by and Return to:

Patrick E. Lindemann
Ingham County Drain Commissioner
707 Buhl Avenue
Mason, Michigan 48854-0220
TO: Board of Commissioners Law & Courts, County Services and Finance Committees
FROM: Teri Morton, Deputy Controller
DATE: July 2, 2020

SUBJECT: Resolution to Authorize the Conversion of the 9-1-1 Radio System Administrator from Part-Time to Three-Quarter Time
For the meeting agendas of July 16, 21 and 22

BACKGROUND
Staffing at the 9-1-1 Dispatch Center includes a part-time Radio System Administrator. The 9-1-1 Center is currently implementing a new Public Safety Radio System, and this position is an integral part of this project. A part-time employee is allowed to work between 20 and 29 hours per week. In order to meet the deadlines for this project, more work hours will need to be performed by this position. A three-quarter time position, which may work 30 to 39 hours per week on average, will be able to meet this need.

ALTERNATIVES
Without the increase in hours for this position, there may be project delays, or the need to contract for expert services, which would be more costly and less efficient than increasing the hours of the current position.

FINANCIAL IMPACT
The additional annual cost of the position conversion would be $30,418 and is available within the 9-1-1 fund.

OTHER CONSIDERATIONS
For the incumbent employee, there would not only be the benefit of increased wages, but also of the availability of increased fringe benefits. It is requested that this position be increased to three-quarter time indefinitely. Once the Public Safety Radio System is fully implemented, the position will be returned to its part-time status by resolution of the Board of Commissioners. The UAW is supportive of this position change.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution.
Introducing the Law & Courts, County Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE THE CONVERSION OF THE 9-1-1 RADIO SYSTEM ADMINISTRATOR FROM PART-TIME TO THREE-QUARTER TIME

WHEREAS, the 9-1-1 Center is currently implementing a new Public Safety Radio System, and the part-time 9-1-1 Radio System Administrator is an integral part of this project; and

WHEREAS, a part-time employee is allowed to work between 20 and 29 hours per week and in order to meet the deadlines for this project, more work hours will need to be performed by this position; and

WHEREAS, a three-quarter time position, which may work 30 to 39 hours per week on average, will be able to meet this current need; and

WHEREAS, the additional annual cost of the position conversion would be $30,418, and is available within the 9-1-1 fund; and

WHEREAS, the UAW has reviewed and is in support of this proposal.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners approves converting the 9-1-1 Radio System Administrator Position #325066 (UAWH) from part-time to three-quarter time.

BE IT FURTHER RESOLVED, that this change shall be effective the first pay period after the adoption of this Resolution.

BE IT FURTHER RESOLVED, that when the Public Safety Radio System is fully implemented, a resolution will be brought before the Board of Commissioners to return to this position to part-time.

BE IT FURTHER RESOLVED, that the Controller/Administrator is authorized to make any necessary budget adjustments and changes to the position allocation list consistent with this resolution.
MEMORANDUM

TO: Resolution Committee

FROM: Terri Thornberry, Director Ingham County 9-1-1 Communications

DATE: June 18, 2018

SUBJECT: Emergency Purchase Order for Radio Connectivity at the Backup 911 Center

Ingham County desperately needs a 9-1-1 backup center fully operational to support all Public Safety Agencies while keeping the 9-1-1 staff safe if we have to vacate the current center.

This memo is to inform you of an emergency purchase order which is needed to continue the build-out of the backup 9-1-1 center at the Roads Department. Attached is a quote from L3 Harris.

The total order is for antenna work and equipment to install four (4) UHF for control stations at the backup 9-1-1 center. These four control stations will provide radio connectivity until the Motorola Radio System is installed and tested.

An emergency purchase order was issued to L3 Harris for a total cost of $5,255.31 which is for the four Yagi antennas and labor.

Funds for this purchase are available in Line Item 26132500 979000 30911.

Both the Controller and Purchasing Director approved this purchase.

Respectfully,

Terri Thornberry,
Ingham County 9-1-1 Director
TO: Board of Commissioners, County Services Committee, and Finance Committee

FROM: Deb Fett, CIO

DATE: 7/07/2020

SUBJECT: Resolution – Firewall License Renewal
For the meeting agendas of July 21st, July 22nd, and July 28th, 2020

BACKGROUND
Resolution #17-279 approved the purchase of a NextGen Firewall which protects Ingham County from having an infected computer rapidly spread its infection unchecked. The licensing on this firewall needs to be renewed in order to continue protecting us effectively. In reviewing the licensing preparing for renewal, it was found that we could make a small change to the hardware configuration that would reduce our costs going forward by approximately $30,000.00 per year. This seems to be a worthwhile change to make given the budget strain we are facing.

ALTERNATIVES
We do have the option of not renewing our licenses and not be protected against security issues. We also could renew our licenses as they are currently configured and pay the higher rates going forward. Although these are potential options, neither would be in the County’s best interests.

FINANCIAL IMPACT
The funding for the total of $203,341.60 for the hardware and 3 years of license renewal is covered in the 2020 budget and will come from the County’s Innovation and Technology Department’s Network Software Fund #636-25810-932033.

STRATEGIC PLANNING IMPACT
This Resolutions supports Goal D – Information Technology, specifically Strategy 2 – Annually budget for countywide IT projects including updates to existing software applications.

OTHER CONSIDERATIONS
A firewall is the first line of defense for our internal assets and needs to be kept up to date constantly. ITD will continue to do our utmost to ensure that we have not only the safest option but also the most cost effective.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the hardware and renewal solution from CDWG not to exceed $205,000.00.
Introduced by County Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO APPROVE THE RENEWAL OF FIREWALL LICENSES

WHEREAS, Ingham County needs to protect our data and our network from cyber threats; and

WHEREAS, our current firewall solution license expire in October, 2020; and

WHEREAS, Innovation and Technology has been able to reconfigure our current setup to reduce our license cost going forward; and

WHEREAS, the licenses will be for 3 years and will be purchased under the State of Michigan MiDeal contract.

THEREFORE BE IT RESOLVED, that the Board of Commissioners do hereby authorize the purchase of the firewall hardware configuration and renewal licenses from CDWG in the amount not to exceed $205,000.00.

BE IT FURTHER RESOLVED, that the total cost will be paid out of the county’s Network Fund #63625810-932033.

BE IT FURTHER RESOLVED, that the Controller/Administrator is authorized to make any necessary budget adjustments.

BE IT FURTHER RESOLVED, that the Chairperson of the Ingham County Board of Commissioners is authorized to sign any contract documents consistent with this resolution and approved as to form by the County Attorney.
TO: County Services Committee
FROM: Deb Fett, CIO
DATE: June 19, 2020
SUBJECT: Emergency Purchase Order to Repair Cooling Unit in Mason Datacenter

This memo is to inform you of an emergency order that was made prior to receiving board approval.

Our Mason datacenter is climate controlled to ensure that our critical equipment remains operational. There are redundant cooling units but one of the cooling units failed this week. With the rising temperatures and the other units operating under higher loads there was great risk for the other units to fail as well causing systems outages across the County. Innovation and Technology worked with the Facilities department to get the quote and schedule repair after obtaining Emergency PO approval from the Controller’s office and the Purchasing Director.

Funds for the repair from Myers Plumbing and Heating not to exceed $5,000.00 are available through the Innovation and Technology Contractual Services fund #63695800-818000.
TO: Board of Commissioners, County Services & Finance Committees

FROM: Rick Terrill, Facilities Director

DATE: July 7, 2020

RE: Resolution Authorizing a Contract Extension with Modernistic for Carpet Cleaning Services at Several County Facilities

For the meeting agendas of: July 21 & 22

BACKGROUND
The contract with Modernistic expires on August 31, 2020. The Facilities Department would like to exercise a one year contract extension. Modernistic has agreed to hold their current prices.

ALTERNATIVES
The alternative would be to put this out for bid.

FINANCIAL IMPACT
Funds are available in the appropriate 931100 maintenance contractual line items.

OTHER CONSIDERATIONS
Would be to not clean the carpets for the remainder of the year.

RECOMMENDATION
Based on the information presented, the Facilities Department respectfully recommends approval of the attached resolution to support a contract extension for one year with Modernistic for carpet cleaning services at several county facilities.
Introduced by the County Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE A CONTRACT EXTENSION WITH MODERNISTIC FOR CARPET CLEANING SERVICES AT SEVERAL COUNTY FACILITIES

WHEREAS, Ingham County currently has a contract with Modernistic for carpet cleaning services; and

WHEREAS, the current contract will expire on August 31, 2020; and

WHEREAS, a two year extension option was included in the contract and the Facilities Department would like to exercise a one year extension; and

WHEREAS, Modernistic has agreed to hold their current prices; and

WHEREAS, funds are available in the appropriate 931100 maintenance contractual line items.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners authorizes a one year contract extension with Modernistic, 4310 Creyts Road, Lansing, Michigan, 48917, for carpet cleaning services at several county facilities.

BE IT FURTHER RESOLVED, the Ingham County Board of Commissioners authorizes the Board Chairperson to sign any necessary documents that are consistent with this resolution and approved as to form by the County Attorney.
TO: County Service Committee
FROM: Rick Terrill, Facilities Director
DATE: July 9, 2020
SUBJECT: Condensing Unit Replacement at the 9-1-1 Center

This memo is to inform you of an emergency purchase that was made prior to receiving approval from the County Services and Finance Committees.

The 30 ton Carrier’s condensing unit at the 9-1-1 Center which provides cooling to the administrative area, locker rooms, kitchen, and restrooms is failing. The unit has been repaired multiple times causing the system to be shut down.

Due to the negative impact this will have on the indoor air temperature if the unit fails, an Emergency Purchase Order was issued to Trane for a total cost of $44,982.00 which includes the unit, installation labor and all other materials.

Funds for this purchase are available in Line Item 261-32500-978000-9F23 with additional finding transferred from the 9-1-1 Fund Balance.

Both the Interim Controller and Purchasing Director approved this purchase.

Respectfully,

Rick Terrill
Facilities Director
To: County Services & Finance Committees
From: William Conklin, Managing Director
Ingham County Road Department
Date: June 18, 2020
RE: Resolutions for 2020 Local Road Program Agreements with Alaiedon, Aurelius, Bunker Hill, Leroy, Locke, Stockbridge, Vevay, and Wheatfield Townships

BACKGROUND
Each year the Road Department shares costs with each Township in Ingham County to fund local road improvements desired by the respective Township, which is known as the Local Road Program. Attached is a proposed resolution for authorizing 2020 Local Road Program Agreements with the referenced Townships to perform, and share costs for local road improvements in the respective Townships. The Road Department has worked with each Township listed above to determine what local road projects are most needed and desired. The resolution includes a table of the proposed road improvements and estimated funding. The other townships not listed in this resolution have either had a 2020 local road agreement previously approved by the Board of Commissioners, or have elected not to participate in the program this year, or may have a resolution authorizing an agreement submitted in a later meeting cycle.

FINANCIAL CONSIDERATION
The total of the road department match indicated in the resolution is included in the adopted 2020 road fund budget. The work listed in the table is proposed to be done by Road department crews. The estimated costs are for materials only as the Road department does not charge the townships for road department labor, which is also already fully budgeted in the 2020 road fund budget.

RECOMMENDATION
Approval of the attached resolution is therefore recommended.
Introduced by the County Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO APPROVE LOCAL ROAD AGREEMENTS WITH ALAIEDON, AURELIUS, BUNKER HILL, LEROY, LOCKE, STOCKBRIDGE, VEVAY, AND WHEATFIELD TOWNSHIPS

WHEREAS, 2020 Local Road Program Agreements are proposed for the following Townships with details of the proposed road improvement and funding provided in the table below: Alaiedon, Aurelius, Bunker Hill, Leroy, Locke, Stockbridge, Vevay, and Wheatfield Townships; and

WHEREAS, the Road department has worked with each Township to determine what local road projects are most needed and desired; and

WHEREAS, the Road Department is willing to cause said improvements to be undertaken by road department crews, to contribute road department labor without charge on the projects performed by Road department crews, and to pay for portions of the cost of said improvements from the County Road Fund as indicated for each Township in the table below; and

WHEREAS, total Road Department funding match amount indicated in the table below is included in the adopted/amended 2020 Road Department budget; and

WHEREAS, in the event the final cost of any of the projects is more than the estimates provided in the table below, for any final costs less than twice the maximum Road Department match amount set forth in the table below, the additional cost will be split evenly between the respective Township and the Road department, and for any final costs greater than the twice the maximum Road Department match amount set forth in the table below, the additional cost will be paid entirely by the respective Township; and

WHEREAS, in the event the final cost of any of the projects is less than the estimates provided in the table below, for any final cost amount greater than twice the maximum Road Department match amount set forth in the table below, the savings will first accrue to the Township, and then for any final costs below twice the maximum Road Department match amount set forth in the table below, the savings will be split evenly between the respective Township and the Road Department; and

WHEREAS, the respective Townships are willing to pay the respective Township’s portion of the cost of said improvements as shown in the table below and as further detailed above, provided, however, that the respective Township excess payments will not exceed 10 percent (10%) of the Township contribution amounts established in the respective Agreements, unless the respective Township agrees otherwise, or may reduce the scope of described road improvement projects per the respective Township’s available budget.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners authorizes entering into 2020 Local Road Program Agreements with the following Townships with details of the proposed road improvement and funding provided in the table below: Alaiedon, Aurelius, Bunker Hill, Leroy, Locke, Stockbridge, Vevay, and Wheatfield Townships.
BE IT FURTHER RESOLVED, that the Road Department is authorized to contribute match funds to the respective Township projects per the amounts shown in the table below and/or as may be necessary for any final project costs differing from estimates as provided above.

BE IT FURTHER RESOLVED, that the Road Department shall invoice each Township as provided above and in the table below for their respective contributions, and.

BE IT FURTHER RESOLVED, that the Road Department shall cause the improvements identified in the table below to be performed by Road Department crews without charge to the respective projects for road department staff labor as indicated in the table below during the construction season of the 2020 calendar year subject to final approval by, or as modified by, each Township.

BE IT FURTHER RESOLVED, that the Ingham County Board of Commissioners authorizes the Board Chairperson to sign all necessary agreements consistent with this resolution and approved as to form by the County Attorney.

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</thead>
<tbody>
<tr>
<td>Alaiedon</td>
<td>$0.00</td>
<td>$45,000.00</td>
<td>$45,000.00</td>
<td>Asphalt wedging of Evry Road where necessary—particularly Howell to Lamb Roads. Chip-sealing: Lamb Road, Hagadorn to Meridian Roads, 4.75 miles; Simmons Road, Lamb to Holt Roads, 1 mile.</td>
<td>$145,000.00</td>
<td>$100,000.00</td>
<td>$45,000 max.</td>
</tr>
<tr>
<td>Aurelius</td>
<td>$0.00</td>
<td>$33,300.00</td>
<td>$33,300.00</td>
<td>Bunker Road, Aurelius to Effert Roads, 1 mile, full cap maintenance paving.</td>
<td>$50,000.00</td>
<td>$25,000.00</td>
<td>$25,000 (Half up to max $33,300)</td>
</tr>
<tr>
<td>Bunker Hill</td>
<td>$33,300.00</td>
<td>$33,300.00</td>
<td>$66,600.00</td>
<td>Williams Road, Pitchburg to Fogg Roads, 1.75 miles, full cap maintenance paving; Holland Road, Friermuth to Parman Roads, and DeCamp Road, Haynes to Friermuth Roads, total of 2 miles, asphalt wedge and spot maintenance paving to extent of budget. All roads to be chip-sealed first for “Texas Underseal” without charge by ICRD under maintenance.</td>
<td>$133,200.00</td>
<td>$66,600.00</td>
<td>$66,600 max.</td>
</tr>
<tr>
<td>Leroy</td>
<td>$0.00</td>
<td>$33,300.00</td>
<td>$33,300.00</td>
<td>Maintenance paving where necessary on Frost Road between Meech Road and M-52 and Noble Road between Meech Road and M-52, plus on other Leroy Township local roads to be determined to extent of budget.</td>
<td>$83,300.00</td>
<td>$50,000.00</td>
<td>$33,300 max.</td>
</tr>
<tr>
<td>Locke</td>
<td>$0.00</td>
<td>$33,300.00</td>
<td>$33,300.00</td>
<td>Maintenance paving on Bell Oak Road - 1/2 mi east of M-52 and on Corey Road - 1/2 mi between Bell Oak &amp; Hoxie Roads.</td>
<td>$50,000.00</td>
<td>$25,000.00</td>
<td>$25,000 (Half up to max $33,300)</td>
</tr>
<tr>
<td>Stockbridge</td>
<td>$9,916.69</td>
<td>$33,300.00</td>
<td>$43,216.69</td>
<td>Maintenance paving and asphalt wedging where necessary on Shepper Road, south township/county line to M-106, 2 miles, and on Green Road, M-52 to Kane Road (east township/county line), 1.6 miles.</td>
<td>$50,000.00</td>
<td>$25,000.00</td>
<td>$25,000 (Half up to max $43,216.69)</td>
</tr>
<tr>
<td>Vevay</td>
<td>$41,488.72 Estimated after completing 2019 work in 2020.</td>
<td>$45,000.00</td>
<td>$86,488.72</td>
<td>Full cap maintenance paving on Lyon Road, College to Tuttle Roads, 1 mile, and on Coy Road, Hull to Eden Roads, 1 mile.</td>
<td>$90,000.00</td>
<td>$45,000.00</td>
<td>$45,000 (half up to max available match after completing 2019 work)</td>
</tr>
<tr>
<td>Wheatfield</td>
<td>$0.00</td>
<td>$33,300.00</td>
<td>$33,300.00</td>
<td>Full cap maintenance pave Clark Road, Howell to Waldo Roads, 1 mile, and spot maintenance paving where most necessary on Waldo Road, Meridian to Bray Roads, 3 miles, to extent of budget.</td>
<td>$66,600.00</td>
<td>$33,300.00</td>
<td>$33,300 max.</td>
</tr>
</tbody>
</table>
TO:         County Services and Finance Committees
FROM:      Tom Gamez, ICRD Director of Operations
DATE:        June 25, 2020
SUBJECT: Extension of Resolution #17-235: Mineral well brine solution for dust control.

BACKGROUND
The purpose of this correspondence is to support the extension of approved Resolution #17-235 Dust control, for two additional years. This two-year renewal option is in the original Resolution #17-235.

The Road Department purchases Mineral well brine with a 28% calcium chloride solution for dust control. Each summer the brine solution is delivered for dust control on gravel roads and other various road maintenance operations.

ALTERNATIVES
Mineral well brine with a 28% calcium chloride solution is the least costly option for dust control. Other products on the market can cost up to ten times more, with a similar performance. The Road Dept. believes Mineral well brine is the best product for our needs, due to being cost effective and an efficient product for dust control.

FINANCIAL IMPACT
Bids for the Road Department’s needs of dust control solutions, with 28% liquid calcium chloride were solicited by the Purchasing Department in ITB #108-17 and received in sealed bid proposals for suppling dust control solution, for 3 years and with a 2-year renewal option, beginning from date of approved Purchasing departments purchase order execution.

A local vendor, Chloride Solutions of Webberville, Michigan is the lowest qualifying bidder, with unit prices under $.25 per gallon and a quantity not to exceed $57,500 per each year of the agreement on dust control supplies with the 2-year renewal option.

The Road Department’s adopted 2020 and 2021 budgets will includes controllable expenditures and funds for dust control supplies. The Road Department will have sufficient funds budgeted for the two years.

RECOMMENDATION
It is the recommendation of the Purchasing and Road Department to approve the request to extend the current purchase order with Chloride Solution, for two additional years by extending Resolution #17-235.
ADOPTED – JUNE 13, 2017
AGENDA ITEM NO. 17

Introduced by the County Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION AUTHORIZING THE PURCHASE OF DUST CONTROL SOLUTIONS AND SERVICES

RESOLUTION # 17 – 235

WHEREAS, the Road Department uses a service to provide and apply approximately 250,000 gallons of 28% calcium chloride solution for dust control on the 80 miles of gravel county roads during the dry months of the year; and

WHEREAS, the Road Department’s adopted 2017 budget includes funds for this expense in controllable expenditures and will have sufficient funds budgeted for the second and third years of this contract; and

WHEREAS, bids for the Road Department’s supply of liquid calcium chloride solutions were solicited by the Purchasing Department in ITB #108-17 and received sealed bid proposals for these services for the next 3 year period, beginning from date of service contract execution; and

WHEREAS, Chloride Solutions of Webberville, Michigan 48892 was the lowest qualifying bidder, with unit price per gallon and a quantity not to exceed $57,500 per each year of the agreement for dust control services on a 3 year contract with an 2 year renewal option; and

WHEREAS, it is therefore the recommendation of the Road and Purchasing Departments to enter into a contract with Chloride Solutions of Webberville, Michigan, for 28% calcium chloride solution delivered to the Road Department storage tanks or applied on gravel county roads.

THEREFORE BE IT RESOLVED, the Ingham County Board of Commissioners accepts the bid and authorizes entering into a 3 year contract with a 2 year renewal option, with Chloride Solutions 672 N. M-52 Webberville, Michigan 48892 to supply 28% calcium chloride, delivered and applied on Ingham County roads as directed by the Road Department.

BE IT FURTHER RESOLVED, that the Road Department and the Purchasing Department are hereby authorized to execute purchase orders consistent with this resolution.

COUNTY SERVICES: Yeas: Celentino, Crenshaw, Grebner, Koenig, Sebolt, Maiville
Nays: None  Absent: Nolan  Approved 6/06/2017

FINANCE: Yeas: Grebner, McGrain, Hope, Anthony, Schafer, Naeyaert
Nays: None  Absent: Tennis  Approved 6/07/2017
Extension: pricing

Date: May 28, 2020

Customer: Ingham County Road Dept. bus: 517.676.9722
Bobbie Mayes bmayes@ingham.org
301 Bush Street
Mason, MI 48854

Two-year Extensions: Chloride brine used for dust control applications and Geomelt S7 winter salt enhancer, from Packet #108-17 and Proposal #146-17, respectively. Stable pricing for two year extension.

- Mineral brine water delivered to Eastern Garage @ $0.20/gal.
- Mineral brine water applied to roads >6,000 gal. @ $0.24/gal.
- Mineral brine water applied to roads <3,000 gal. @ $0.25/gal.
- Mineral brine water applied to roads >9,500 gal. @ $0.21/gal.

Liquid De-icer for salt treatment: Geomelt S7 @ $0.86/gal.

Terms: check payment within 15 days of completion/delivery

Prepared By: David Barczak, Sales Engineer
Approved By: Brian Hitchcock: CEO
~ Fax: 517-521-4503 ~ Telephone: 517-980-0291 ~
~ Email: david@chloridesolutions.com~
Chloride Solutions, LLC
672 N. M-52
Webberville, MI. 48892
TO:  Tom Gamez, Director of Operations ICRD
FROM: James Hudgins, Director of Purchasing
DATE: May 9, 2017
RE: Memorandum of performance for ITB No. 108-17: Liquid Calcium Chloride Solution

Per your request, the Purchasing Department sought bids from experienced and qualified vendors for the purpose of furnishing liquid calcium chloride solution for dust control on gravel roads for the Ingham County Road Department for a period of three years with an option for a two-year extension.

The RFP was advertised in the Lansing State Journal, New Citizens Press and posted on the Ingham County Purchasing Department’s website.

The Purchasing Department can confirm the following:

<table>
<thead>
<tr>
<th>Function</th>
<th>Overall Number of Vendors</th>
<th>Number of Local Vendors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendors invited to propose</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Vendors responding</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

The summary of the vendors’ costs grid is on the next page:

You are now ready to complete the final steps in the process: 1) Evaluate the submissions based on the criteria established in the ITB; 2) confirm funds are available; 3) submit your recommendation of award along with your evaluation to the Purchasing Department; 4) write a memo of explanation; and, 5) prepare a resolution for Board approval.

This Memorandum is to be included with your memo and resolution submission to the Resolutions Group as acknowledgement of the Purchasing Department’s participation in the purchasing process.

If I can be of further assistance, please do not hesitate to contact me by e-mail at jhudgins@ingham.org or by phone at 676-7309.
<p>| Vendor Name: Michigan Chloride Sales, LLC |
| Local Vendor: No, St Louis MI |
| <strong>DELIVERED TO EASTERN DISTRICT GARAGE STORAGE TANK</strong> |</p>
<table>
<thead>
<tr>
<th>Product Concentration</th>
<th>Price/gallon – Year 1</th>
<th>Price/gallon – Year 2</th>
<th>Price/gallon – Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>28%</td>
<td>$0.19</td>
<td>$0.20</td>
<td>$0.21</td>
</tr>
<tr>
<td>32%</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
</tr>
<tr>
<td>38%</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
</tr>
</tbody>
</table>

*Applied to any location within Ingham County per Road Department direction.

<p>| Vendor Name: Great Lakes Chloride, Inc. |
| Local Vendor: No, Grand Haven MI |
| <strong>DELIVERED TO EASTERN DISTRICT GARAGE STORAGE TANK</strong> |</p>
<table>
<thead>
<tr>
<th>Product Concentration</th>
<th>Price/gallon (&gt;6,000 gallons) Year 1</th>
<th>Price/gallon (&lt;3,000 gallons) Year 1</th>
<th>Price/gallon (&gt;6,000 gallons) Year 2</th>
<th>Price/gallon (&lt;3,000 gallons) Year 2</th>
<th>Price/gallon (&gt;6,000 gallons) Year 3</th>
<th>Price/gallon (&lt;3,000 gallons) Year 3</th>
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<tbody>
<tr>
<td>28%</td>
<td>$0.31</td>
<td>No Bid</td>
<td>$0.32</td>
<td>No Bid</td>
<td>$0.33</td>
<td>No Bid</td>
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<tr>
<td>32%</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
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<tr>
<td>38%</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
</tr>
</tbody>
</table>

*approximate annual usage of 250,000 gallons

<p>| Vendor Name: Chloride Solutions LLC |
| Local Vendor: Yes, Webberville, MI |
| <strong>DELIVERED TO EASTERN DISTRICT GARAGE STORAGE TANK</strong> |</p>
<table>
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<tr>
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<tr>
<td>28%</td>
<td>$0.18</td>
<td>$0.19</td>
<td>$0.20</td>
</tr>
<tr>
<td>32%</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
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<tr>
<td>38%</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
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</table>

*Applied to any location within Ingham County per Road Department direction.

<p>| Vendor Name: Chloride Solutions LLC |
| Local Vendor: Yes, Webberville, MI |
| <strong>DELIVERED TO EASTERN DISTRICT GARAGE STORAGE TANK</strong> |</p>
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<tr>
<th>Product Concentration</th>
<th>Price/gallon (&gt;6,000 gallons) Year 1</th>
<th>Price/gallon (&lt;3,000 gallons) Year 1</th>
<th>Price/gallon (&gt;6,000 gallons) Year 2</th>
<th>Price/gallon (&lt;3,000 gallons) Year 2</th>
<th>Price/gallon (&gt;6,000 gallons) Year 3</th>
<th>Price/gallon (&lt;3,000 gallons) Year 3</th>
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<td>28%</td>
<td>$0.22</td>
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<td>No Bid</td>
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*approximate annual usage of 250,000 gallons
INTRODUCED

INTRODUCED BY THE COUNTY SERVICES AND FINANCE COMMITTEES OF THE:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION AUTHORIZING THE EXTENSION OF RESOLUTION #17-235
FOR DUST CONTROL SOLUTION

WHEREAS, the Road Department purchases approximately 250,000 gallons of Mineral well brine with a 28% calcium chloride solution for dust control for approximately 80 miles of county gravel roads during the dry months of the year; and

WHEREAS, the Road Department’s 2020 and 2021 budgets shall include funds for this expense in controllable expenditures and will have sufficient funds budgeted for the second year of the Purchasing Department approved purchase order; and

WHEREAS, bids for the Road Department’s supply of dust control solutions were solicited by the Purchasing Department in ITB #108-17 and received in sealed bid proposals for a 3 year period, with a 2-year renewal option; and

WHEREAS, Chloride Solutions of Webberville, Michigan 48892 was the lowest qualifying bidder, with unit price per gallon and a quantity not to exceed $57,500 per each year of the purchase order for dust control needs for 3 years with an 2 year renewal option; and

WHEREAS, it is therefore the recommendation of the Purchasing Department to extend the current purchase order with Chloride Solutions of Webberville, Michigan, for Mineral well brine with 28% calcium chloride solution delivered to the Road Department storage tanks and gravel roads.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners approves the offer to extend Resolution #17-235 for 2 year, with Chloride Solutions 672 N. M-52 Webberville, Michigan 48892 to supply Mineral well brine with 28% calcium chloride to the Ingham County Road Department properties as directed by the Road and Purchasing Department.

BE IT FURTHER RESOLVED, that the Road Department and the Purchasing Department are hereby authorized to execute a purchase orders consistent with this resolution.
TO: County Services and Finance Committees

FROM: Tom Gamez, Director of Operations ICRD

DATE: June 24, 2020

SUBJECT: Extension of Resolution #17-349: De-Icing Corrosion Inhibited Solution.

BACKGROUND
The purpose of this correspondence is to support the attached resolution to extend the purchase order for Geomelt S7 De-icing Solution from Chloride Solutions LLC. located in Webberville, Michigan, for two additional years.

The Road Department annually purchases approximately 12,000 gallons of liquid de-icing solution for use in winter maintenance operations.

Bids for liquid de-icing solution were solicited and evaluated by the Ingham County Purchasing Department per Invitation to Bid (ITB) #146-17 in 2017, and it is their recommendation, with the concurrence of Road Department staff, to extend the approved resolution #17-349 and purchase liquid de-icing solution on an as-needed, unit price basis from Chloride Solutions LLC.

ALTERNATIVES
The lowest bidder, Michigan Chloride Sales was disqualified – their product (Mineral well brine) failed to meet the required anti corrosion specifications for de-icing. Mineral well brine is a liquid chloride solution without the corn steep or equivalent anti corrosion additives.

FINANCIAL IMPACT
The Road Department’s adopted 2021 budget shall include controllable expenditures funds for this and other maintenance material purchases. The Road Department will also have sufficient funds budgeted for the second year of this extended purchase order.

OTHER CONSIDERATIONS
A local County vendor, Chloride Solutions LLC of Webberville Michigan, with their product of Geomelt S7, is the lowest qualifying bid witch meets the standards required from ITB #146-17. The De-Icing Solution is to be delivered to all three-district garage locations.

Therefore, approval of the attached resolution is recommended to authorize a 2-year extension of RFP #146-117 with Chloride Solutions LLC. 672 N. M-52 Webberville, MI 48892, at a cost not to exceed $29,880.

It is therefore the recommendation of the Purchasing Department, with the concurrence of Road Department, to extend Resolution #146-17 for the De-icing solutions, with Chloride Solutions LLC, for 2021 and 2022.
TO: Tom Gamez, Director of Operations ICRD
FROM: James Hudgins, Director of Purchasing
DATE: August 29, 2017
RE: Memorandum of performance for ITB No. 146-17: De-Icing Corrosion Inhibited Solution

Per your request, the Purchasing Department sought bids from experienced and qualified vendors for the purpose of furnishing de-icing solution to all three Ingham County Road Department garages for a period of three years with an option for a two-year extension.

The RFP was advertised in the Lansing State Journal, City Pulse and posted on the Ingham County Purchasing Department’s website.

The Purchasing Department can confirm the following:

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<th>Function</th>
<th>Overall Number of Vendors</th>
<th>Number of Local Vendors</th>
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<tbody>
<tr>
<td>Vendors invited to propose</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>Vendors responding</td>
<td>3</td>
<td>1</td>
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The following grid is a summary of the vendors’ costs:

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<th>VENDOR NAME</th>
<th>LOCAL PREFERENCE</th>
<th>GRAND TOTAL ALL 3 LOCATIONS FOR 3 YEARS</th>
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<tr>
<td>Michigan Chloride Sales LLC</td>
<td>No, St. Louis MI</td>
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<tr>
<td>Chloride Solutions LLC</td>
<td>Yes, Webberville, MI</td>
<td>$29,880.00</td>
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<tr>
<td>Great Lakes Chloride Inc.</td>
<td>No, Grand Haven, MI</td>
<td>$34,920.00</td>
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You are now ready to complete the final steps in the process: 1) Evaluate the submissions based on the criteria established in the ITB; 2) confirm funds are available; 3) submit your recommendation of award along with your evaluation to the Purchasing Department; 4) write a memo of explanation; and, 5) prepare a resolution for Board approval.

This Memorandum is to be included with your memo and resolution submission to the Resolutions Group as acknowledgement of the Purchasing Department’s participation in the purchasing process.

If I can be of further assistance, please do not hesitate to contact me by e-mail at jhudgins@ingham.org or by phone at 676-7309.
Extension: pricing

Date: May 28, 2020

Customer: Ingham County Road Dept. bus: 517.676.9722
Bobbie Mayes bmayes@ingham.org
301 Bush Street
Mason, MI 48854

Two-year Extensions: Chloride brine used for dust control applications and Geomelt S7 winter salt enhancer, from Packet #108-17 and Proposal #146-17, respectively. Stable pricing for two year extension.

Mineral brine water delivered to Eastern Garage @ $0.20/gal.
Mineral brine water applied to roads >6,000 gal. @ $0.24/gal.
Mineral brine water applied to roads <3,000 gal. @ $0.25/gal.
Mineral brine water applied to roads >9,500 gal. @ $0.21/gal.

Liquid De-icer for salt treatment: Geomelt S7 @ $0.86/gal.

Terms: check payment within 15 days of completion/delivery

Prepared By: David Barczak, Sales Engineer
Approved By: Brian Hitchcock: CEO

~ Fax: 517-521-4503 ~ Telephone: 517-980-0291 ~
~ Email: david@chloridesolutions.com~
Chloride Solutions, LLC
672 N. M-52
Webberville, MI. 48892
ADOPTED – SEPTEMBER 26, 2017
AGENDA ITEM NO. 18

Introduced by the County Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE THE PURCHASE OF SEASONAL REQUIREMENT OF LIQUID
DE-ICER CORROSION INHIBITED SOLUTION

RESOLUTION # 17 – 349

WHEREAS, the Road Department annually purchases approximately 12,000 gallons of liquid de-icing solution for use in winter maintenance operations; and

WHEREAS, the Purchasing Department recently released bid packet #146-17 and received sealed, competitive bid proposals for De-Icing Corrosion Inhibited Solution for a 3 year period, beginning from date of agreement execution; and

WHEREAS, bids for liquid de-icing solution were solicited and evaluated by the Purchasing Department, and it is their recommendation, with the concurrence of the Road Department staff, to award this agreement to the lowest qualified bidder and purchase liquid de-icing solution on an as-needed, unit price basis from Chloride Solutions LLC; and

WHEREAS, the Road Department’s adopted 2017 budget includes controllable expenditures, funds for this and other maintenance material purchases. The Road Department will have sufficient funds budgeted for the second and third years of this agreement.

THEREFORE BE IT RESOLVED, the Board of Commissioners accepts the bid, and authorizes the purchase of Geomelt S7 liquid de-icing solution on an as-needed, unit price basis from Chloride Solutions LLC. 672 N. M-52 Webberville, Mi. 48892.

BE IT FURTHER RESOLVED, the Purchasing Department is hereby authorized to execute purchase orders with Chloride Solutions LLC, to purchase De-Icing Corrosion Inhibited Solution as needed and budgeted, on behalf of the County.

COUNTY SERVICES: Yea: Celentino, Crenshaw, Grebner, Nolan, Koenig, Sebolt, Maiville
Nays: None Absent: None Approved 9/19/2017

FINANCE: Yea: Grebner, McGrain, Hope, Anthony, Schafer, Naeyaert
Nays: None Absent: Tennis Approved 9/20/2017
INTRODUCED BY THE COUNTY SERVICES AND FINANCE COMMITTEES OF THE:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION AUTHORIZING THE EXTENSION OF RFP #17-349, PURCHASE OF SEASONAL CORROSION INHIBITED LIQUID DE-ICER SOLUTION

WHEREAS, the Road Department annually purchases approximately 12,000 gallons of liquid de-icing solution for use in winter maintenance operations; and

WHEREAS, bids for liquid de-icing solution were solicited and evaluated by the Ingham County Purchasing Department per Invitation to Bid (ITB) #146-17, and it is their recommendation, with the concurrence of Road Department staff, to extend this bid and purchase liquid de-icing solution on an as-needed, unit price basis from Chloride Solutions LLC.; and

WHEREAS, the Road Department’s adopted 2021 budget includes controllable expenditures, funds for this and other maintenance material purchases; and

WHEREAS, the Road Department will have sufficient funds budgeted for the second year of this extended purchase order.

THEREFORE BE IT RESOLVED, that the Board of Commissioners accepts the bid, and authorizes the purchase of Geomelt S7 liquid de-icing solution on an as-needed, unit price basis from Chloride Solutions LLC. 672 N. M-52 Webberville, MI 48892; and

BE IT FURTHER RESOLVED, that the Purchasing Department is hereby authorized to execute purchase orders with Chloride Solutions LLC, to purchase De-Icing Corrosion Inhibited Solution as needed and budgeted, on behalf of the County.
TO: Board of Commissioners County Services and Finance Committees  
FROM: Sue Graham, Human Resources Director  
DATE: July 13, 2020  
SUBJECT: Resolution to Authorize Buyout of Special Vacation Bonus Hours Earned During Suspension of County Operations for Essential Employees Excluded From Work Share Program Participation  
For the meeting agendas of July 21 (County Services) and July 22 (Finance)

BACKGROUND  
The COVID-19 pandemic has caused significant disruption in the normal conduct of life for many Ingham County employees and their families which may result in significant financial hardship. Executive Orders issued by Michigan Governor Gretchen Whitmer in response to the COVID-19 pandemic to protect the health and safety of the public have ordered multiple closures, including the closure of schools, businesses, and other places of employment. Essential employees working during the suspension of operations (March 17 – April 5, 2020) earned special vacation bonus hours as a premium for working during this period of time. Many of these same essential employees were designated as excluded from participation in Ingham County’s Work Share Program from June 1 – July 25, 2020.

Accordingly, buyout of accrued special vacation bonus hours would provide financial relief to these employees and their families. For employees of the Ingham County Sheriff’s Office designated as excluded from participation in Ingham County’s Work Share Program from June 1 – July 25, 2020, the proposed buyout is the full number of such hours. For other Ingham County employees designated as excluded from participation in Ingham County’s Work Share Program from June 1 – July 25, 2020, the proposed buyout is the number of such hours voluntarily elected by employees to be bought out. The opportunity for the Sheriff’s Office is not at the election of the individual employee due to an ongoing and collective limitation on the ability to take vacation time in light of staffing levels in a 24/7 operation.

ALTERNATIVES  
The Ingham County Board of Commissioners may elect to adopt the proposed resolution in whole, in part or not at all. Special vacation bonus hours earned by employees will remain banked and available for use by employees during their employment with payout at the time of separation from employment if the proposed resolution is not adopted in whole, in part or not at all.

FINANCIAL IMPACT  
Buyout of special vacation bonus hours at the present time will result in an additional lump sum, one-time payment to Ingham County Sheriff’s Office employees. The present hourly rate for payout to these employees is likely to be lower than the future hourly rate for payout. Voluntary buyout of special vacation bonus hours at the present time will also result in an additional lump sum, one-time payment to other Ingham County employees. The present hourly rate for payout to these employees is also likely to be lower than the future hourly rate to payout. The voluntary nature of the buyout for these employees may result in fewer employees participating with fewer hours bought out.
STRATEGIC PLAN CONSIDERATIONS
The approval of a Resolution to Authorize Buyout of Special Vacation Bonus Hours Earned During Suspension of County Operations for Essential Employees Excluded From Work Share Program Participation is in furtherance of the following strategic goal(s) and task(s) included in the Strategic Plan:

Goal F. Human Resources and Staffing: Attract and retain exceptional employees who reflect the community they serve and who prioritize public service. Strategy 1: Attract and retain employees who value public service.

OTHER CONSIDERATIONS
None.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached Resolution to Authorize Buyout of Special Vacation Bonus Hours Earned During Suspension of County Operations for Essential Employees Excluded From Work Share Program Participation.
RESOLUTION TO AUTHORIZE BUYOUT OF SPECIAL VACATION BONUS HOURS EARNED DURING SUSPENSION OF COUNTY OPERATIONS FOR ESSENTIAL EMPLOYEES EXCLUDED FROM WORK SHARE PROGRAM PARTICIPATION

WHEREAS, the COVID-19 pandemic has caused significant disruption in the normal conduct of life for many Ingham County employees and their families which may result in significant financial hardship; and

WHEREAS, Executive Orders issued by Michigan Governor Gretchen Whitmer in response to the COVID-19 pandemic to protect the health and safety of the public have ordered multiple closures, including the closure of schools, businesses, and other places of employment; and

WHEREAS, essential employees working during the suspension of operations (March 17 – April 5, 2020) earned special vacation bonus hours as a premium for working during this period of time; and

WHEREAS, many essential employees were designated as excluded from participation in Ingham County’s Work Share Program June 1 – July 25, 2020; and

WHEREAS, buyout of accrued special vacation bonus hours would provide financial relief to these employees and their families as well as address an ongoing and collective limitation on the ability of Sheriff’s Office employees to take vacation time in light of staffing levels in a 24/7 operation.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners hereby authorizes the buyout of accrued special vacation bonus hours earned by employees of the Ingham County Sheriff’s Office provided they were designated as excluded from participation in Ingham County’s Work Share Program June 1 – July 25, 2020.

BE IT FURTHER RESOLVED, that the Ingham County Board of Commissioners hereby authorizes the voluntary buyout of accrued special vacation bonus hours earned by other Ingham County employees at their request provided they were designated as excluded from participation in Ingham County’s Work Share Program June 1 – July 25, 2020.

BE IT FURTHER RESOLVED, that the Ingham County Board of Commissioners hereby authorizes the Controller/Administrator to enter into collective bargaining for the purpose of negotiating Letters of Agreement with County Unions for the buyout of accrued special vacation bonus hours as authorized above and providing that buyout amounts are to be paid out at a mutually acceptable time as established during collective bargaining.

BE IT FURTHER RESOLVED, that the Controller/Administrator is authorized to make the necessary adjustments to the budget consistent with this resolution.

BE IT FURTHER RESOLVED, that the Chairperson of the Ingham County Board of Commissioners is authorized to sign any necessary contract agreement(s) upon approval as to form by the County Attorney.
TO: Board of Commissioners County Services and Finance Committee  
FROM: Sue Graham, Human Resources Director  
DATE: July 13, 2020  
SUBJECT: Resolution Adopting the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan  
For the meeting agendas of July 21 (County Services) and July 22 (Finance)

BACKGROUND
The Ingham County Section 125 Flexible Benefit Plan (Plan) and SPD have been amended and restated to incorporate all previous Amendments and Summaries of Material Modifications. (The previous Plan was drafted for an effective date of January 1, 2005 and had 11 Amendments as well as 12 Summaries of Material Modification). These restated documents also incorporate the following changes to conform to 2020 practices:

- Updated the cash in lieu of medical coverage amounts;
- Updated employer contributions for 2020 to HSAs to $600 single/$1200 family;
- Updated 2020 Health FSA maximum salary reduction as $2700;
- Updated provision that requests for mid-year change in elections must be provided within 30 days of the event;
- Updated signor of Plan documents to include Jared Cypher, Interim Controller (the documents must be executed prior to August 1, 2020 for compliance per legal counsel);
- Added two new mid-year election changes allowed under the Affordable Care Act:
  - Revocation of coverage due to enrollment in a qualified health plan through the marketplace,
  - Revocation of coverage due to a reduction of hours even if eligibility under the County’s plan is not affected; and

Additionally, due to recent legislation spurred by COVID-19, the Plan has been amended to incorporate the following changes:

- The health FSA may reimburse over-the-counter medicine and menstrual care products, effective January 1, 2020 by reference to the applicable Internal Revenue Code sections;
- The carryover provision is increased to 20% of the maximum health FSA amount allowed under Code section 125(i) (i.e., $550 for the 2020 plan year); and
- Mid-year change in elections may now be made on a prospective basis for the health FSA and dependent care FSA accounts without the need to meet the traditional change in election rules for the remainder of the 2020 calendar year (a participant may not reduce their election below claims already reimbursed).

ALTERNATIVES
If the Resolution Adopting the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan is not adopted, the Plan will not meet the requirements of applicable Internal Revenue Code sections and employees will not have the benefit of certain changes resulting from recent legislation spurred by COVID-19.
FINANCIAL IMPACT
Adopting the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan will not result in additional cost to Ingham County.

STRATEGIC PLAN CONSIDERATIONS
The adoption of the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan is in furtherance of the following strategic goal(s) and task(s) included in the Strategic Plan:

Goal F. Human Resources and Staffing: Attract and retain exceptional employees who reflect the community they serve and who prioritize public service. Strategy 1: Attract and retain employees who value public service.

OTHER CONSIDERATIONS
Adoption of the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan will meet the requirements of applicable Internal Revenue Code sections.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached Resolution Adopting the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan.
Ingham County

Section 125 Second Amended and Restated Flexible Benefit Plan
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**Article 10**

**Record Keeping and Administration**

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**HIPAA Privacy and Security for Health Care Flexible Spending Account**

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Ingham County
Section 125 Second Amended and Restated Flexible Benefit Plan

Preamble

Ingham County established this Plan to provide its Employees a choice between cash and certain statutory nontaxable benefits. This Plan is intended to qualify as a “cafeteria plan” under Internal Revenue Code (the "Code") section 125 and is to be interpreted in a manner consistent with the requirements of Code section 125. This Plan is designed to permit an eligible Employee to pay, on a pre-tax salary reduction basis, for his or her share of contributions for benefits under the Group Health Plan (including major medical insurance), the Health Care Flexible Spending Account, the Dependent Care Flexible Spending Account, a Health Savings Account ("HSA"), or for other benefits. The HSA funding feature described in the HSA Component is not intended to establish an Employee Retirement Income Security Act of 1974 ("ERISA") plan.

Portions of this document are also intended to satisfy the written plan requirements of the regulations under Code section 105(b) (relating to Health Care Flexible Spending Account) and Code section 129(d)(1) (relating to Dependent Care Programs). For purposes of clarity, the details of these separate plans and programs are combined in this document with the cafeteria plan provisions in order to fully describe the benefits under the cafeteria plan. However, it is the intent of Ingham County to have three separate written plans or programs consisting of the following:

1. **Cafeteria Plan.** The Cafeteria Plan shall include all of the terms set forth in this document.

2. **Dependent Care Flexible Spending Account.** The Dependent Care Flexible Spending Account under Code section 129 includes the following Articles of this document: Articles 1, 2, 4, 6, 9, 10, 12, 13 and 14. These Articles shall form a separate written program for all purposes of the Code.

3. **Health Care Flexible Spending Account.** The Health Care Flexible Spending Account under Code section 105(b) includes the following Articles of this document: Articles 1, 2, 4, 7, 8, 9, 10, 11, 12, 13 and 14. These Articles shall form a separate written plan document for all purposes of the Code.

**Article 1**

**Definitions**

When used in this Plan, the following words shall have the following meanings, unless the context clearly indicates otherwise:

1.1 “**Account**” means the Dependent Care Flexible Spending Account described in Article 6 and the Health Care Flexible Spending Account described in Article 7. In some contexts, the term “Account(s)” may also include the record of HSA Contributions described in Article 5.
1.2 "Administrator or "Plan Administrator" means the Ingham County or another person or entity designated by the Board of Directors to administer the Plan.

1.3 "Adverse Benefit Determination" means: (a) any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and (b) in the case of a plan providing disability benefits, also any rescission (i.e., a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage) of disability coverage with respect to a Participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect of any particular benefit at that time).

1.4 "Affiliate" means an employer that is sufficiently affiliated with the Employer to be able to participate in the same benefit plan or plans pursuant to the Code and ERISA.

1.5 "Board of Directors" means Plan Sponsor's governing body.

1.6 "Breach Notification Rules" shall mean the Standards and Implementation Specifications for Notification in the Case of Breach of Unsecured Protected Health Information under 45 C.F.R. Part 160 and Part 164, Subparts A and D, and as may be amended from time to time.

1.7 "Claimant" means any Participant who seeks to file a claim pursuant to the terms of this Plan.

1.8 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X, as amended from time to time. References in the Plan to any COBRA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.9 "Code" means the Internal Revenue Code of 1986, as amended. References in the Plan to any Code section shall include reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces the Code section.

1.10 "Compensation" means the base compensation of the Participant paid by the Employer during a Plan Year prior to any reductions under the salary reduction agreement. Compensation shall not include overtime, commissions or bonuses.

1.11 "Concurrent Care Claim" means a claim for an ongoing course of treatment to be provided over a period of time or number of treatments.
1.12 “Dependent” generally means a Participant’s Spouse and any person who is a dependent of the Participant within the meaning of Code section 152, (however, for health benefits, a Dependent generally means any person who is a dependent as defined as set forth in Code sections 105(b), 106 and the regulations and other authority thereunder). The definition of “Dependent” for purposes of Section 1.54 and Article 7 only includes an adult child until the end of the calendar month in which the child turns 26 years of age. A “child” for this purpose is as defined in Code section 152(f)(1); however, the definition of “child” for this purpose shall not include a child of the Participant's child. For purposes of Sections 1.13 and 1.15 and Article 6, “Dependent” means any individual who is either a dependent of the Participant (who is a qualifying child within the meaning of Code section 152) who is under the age of 13, or a Participant’s spouse or dependent (as defined in Code section 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 the Participant 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 section 152(e) and section 21(e)(5) will be the "Dependent" of the parent having custody for the greater portion of the calendar year. It is the intent of this provision to comply with the provisions of ERISA Section 609(c). Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any NMSN, even if the child does not meet the definition of “Dependent.”

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

1.14 “Dependent Care Flexible Spending Account” means the account described in Section 6.2.

1.15 “Dependent Care Service Provider” means a person who provides care or other services for the care of a Dependent of the Participant and related household services, but shall not include a dependent care center (as defined in Code section 21(b)(2)(D)), unless the requirements of Code section 21(b)(2)(D) are satisfied and shall not include a related individual described in Code section 129(c), Code section 21 and the regulations thereunder.
1.16 **“Earned Income”** means earned income as defined in Code section 32(c) as modified by Code section 129.

1.17 **“Effective Date”** of this Plan is January 1, 2005. This Plan has been amended several times since then. The Effective Date of this most recent amendment and restatement is August 1, 2020.

1.18 "**Electronic Protected Health Information (EPHI)"** means PHI that is transmitted by electronic media or maintained in electronic media, as specifically defined in the Security Rules.

1.19 **“Employee”** means any person that the Employer classifies as a common law employee and who is on the Employer’s W-2 payroll, but does not include (a) leased employees (including individuals defined as leased employees in Code section 414(n)), contract workers, independent contractors, temporary employees or seasonal employees for the period such individual is so classified by the Employer, whether or not any such individual is on the Employer’s W-2 payroll or is determined by a court, regulatory agency or others to be a common law employee of the Employer; (b) individuals who perform services for Employer 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 the Employer; (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.

1.20 **“Employer”** means Ingham County and any successor which shall maintain this Plan. Any Affiliate which elects to participate in the Plan and receives the consent of its own board of directors and the Board of Directors to do so, shall also be deemed the Employer with respect to its eligible Employees.

1.21 **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended from time to time. References in the Plan to any ERISA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.22 **“FMLA”** means the Family and Medical Leave Act of 1993, as amended from time to time. References in the Plan to any FMLA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.23 **“General-Purpose Health Care Flexible Spending Account Reimbursement”** means reimbursement for expenses defined in Section 1.54(a).

1.24 **“GINA”** means the Genetic Information Nondiscrimination Act of 2008, as amended from time to time.

1.25 **“Group Health Plan”** means the Ingham County Group Health Plan sponsored by the Employer for Employees.
1.26  “Health Care Flexible Spending Account” means the account described in Section 7.2, which consists of three options: the General-Purpose Health Care Flexible Spending Account Option; the Limited-Purpose Health Care Flexible Spending Account Option; and the Post-Deductible Health Care Flexible Spending Account Option.

1.27  “Health Reimbursement Arrangement” or “HRA” means a health reimbursement arrangement as defined in IRS Notice 2002-45.

1.28  “Health Savings Account” or “HSA” means a health savings account established under Code section 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

1.29  “High Deductible Health Plan” or “HDHP” means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code section 223(c)(2), as described in materials provided separately by the employer. The HDHP may or may not be the sole Group Health Plan eligible for pre-tax salary reduction funding hereunder.

1.30  “Highly Compensated Employee” means any person who is a “highly compensated participant” or “highly compensated individual” as defined in Code section 125(e), a “highly compensated individual” as defined in Code section 105(h), or a “highly compensated employee” as defined in Code section 129(d).

1.31  “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH Act, and as may otherwise be amended from time to time, and their implementing regulations. References in the Plan to any HIPAA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.32  “HITECH Act” means Subtitle D of the Health Information Technology for Economic and Clinical Health Act as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, and as may be amended from time to time.

1.33  “HMO” as used in Article 11, means a federally qualified health maintenance organization (HMO), an organization recognized as an HMO under state law, or a similar organization regulated for solvency under state law in the same manner and to the same extent as such HMO.

1.34  “HSA-Eligible Individual” means an individual who is eligible to contribute to an HSA under Code section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer (including the General-Purpose Health Care Flexible Spending Account option solely as the result of a carryover of unused amounts in a Health Care Flexible Spending Account from the prior Plan Year).

1.35  “Individually Identifiable Health Information” means the information that is a subset of health information, including demographic information collected from an individual, and: (a) is created or received by a health care provider, health plan, employer or health care
clearinghouse; and (b) (1) relates to (i) the past, present or future physical or mental health or condition of an individual; (ii) the provision of health care to an individual; or (iii) the past, present, or future payment for the provision of health care to an individual; and (2) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

1.36 “Key Employee” means any person who is a Key Employee, as defined in Code section 416(i)(1), and the Treasury regulations thereunder.

1.37 “Limited-Purpose Health Care Flexible Spending Account Reimbursement” means reimbursement for expenses defined in Section 1.54(b).

1.38 “MHPAEA” means the Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time. References in the Plan to any MHPAEA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.39 “Named Fiduciary” means the Ingham County for the Health Care Flexible Spending Account for purposes of ERISA section 402(a).


1.41 “Participant” means an Employee who has satisfied the eligibility requirements of Article 2 and who is participating in the Plan pursuant to the terms of the Plan or any continuation requirements of state or federal law. Participants include (a) those who elect to reduce their salary to pay for one or more of the group plan benefits, HSA benefits, Health Care Flexible Spending Account benefits, or Dependent Care Flexible Spending Account benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their contributions under the group plan (if any) with after-tax dollars outside of this Plan and who have not elected any HSA benefits, Health Care Flexible Spending Account benefits, or Dependent Care Flexible Spending Account benefits.

1.42 “Plan” means the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan set forth in this document and all subsequent amendments. The term “Plan” shall also mean the separate written Dependent Care Flexible Spending Account which consists of several of the Articles of this document as set forth in the Preamble. The term “Plan” shall also mean the separate written Health Care Flexible Spending Account, which consists of several of the Articles of this document as set forth in the Preamble.

1.43 “Plan Sponsor” means Ingham County.

1.44 “Plan Year” means the 12-month period ending on each December 31.

1.45 “Post-Deductible Health Care Flexible Spending Account Reimbursement” means reimbursement for expenses defined in Section 1.54(c). Specifically, Qualifying Medical Care Expenses incurred prior to satisfaction of the applicable deductible required under the HDHP will not be reimbursed.
1.46 "Post-service Claim" means any claim for a benefit under a group health plan that is not a Pre-service Claim.

1.47 “PPACA” means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and as may be further amended from time to time. References in the Plan to any PPACA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.48 "Pre-service Claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

1.49 “Privacy Rules” means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act, and as may otherwise be amended from time to time.

1.50 “Protected Health Information (PHI)” means Individually Identifiable Health Information, except as provided below in this definition, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information (a) in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (b) in records described at 20 U.S.C. 1232g(a)(4)(B)(iv); (c) in employment records held by a covered entity in its role as employer; and (d) regarding a person who has been deceased for more than 50 years.

1.51 “Qualified Beneficiary” means the term “qualified beneficiary” as defined in 26 U.S.C. §4980B(g)(1).

1.52 "Qualified Reservist Distributions" means a taxable distribution of amounts remaining in the Health Care Flexible Spending Account for certain members of a reserve component as described in Section 7.5.

1.53 “Qualifying Event” means those events specified in Section 8.3.

1.54 “Qualifying Medical Care Expenses” for:

(a) General-Purpose Health Care Flexible Spending Account benefits, means expenses incurred during the Coverage Period by a Participant, or by the Spouse or Dependent of the Participant, for medical care as defined in Code section 213(d) and, effective January 1, 2020, as allowed under Code sections 105(b) and 106(f). These expenses are only reimbursable as allowed under Code section 125 and the regulations and guidance thereunder, but only to the extent that the Participant or other persons incurring the expense are not reimbursed for the expense through insurance or otherwise. If only a portion of the Medical Care Expense has been reimbursed elsewhere, the Plan may reimburse the remaining portion of the expense if it otherwise meets this definition. Furthermore, a Participant may not be reimbursed for “qualified long-term care services” as defined in Code section 7702B(c) or any premium payments for health care coverage. With the exception of advance payments for orthodontia, Qualifying Medical Care
Expenses are incurred at the time the services to which the expense relates are rendered, regardless of when the Participant is charged for the services;

(b) Limited-Purpose Health Care Flexible Spending Account benefits, means the expenses described in Section 1.54(a), but are limited to coverage expenses for vision care, dental care, or preventive care (as defined in Code section 223(c)) only;

(c) Post-Deductible Health Care Flexible Spending Account benefits, means the expenses described in Section 1.54(a), but are limited to expenses for services incurred after the High Deductible Health Plan deductible has been met.

1.55 "Security Rules" means the Security Standards and Implementation Specifications at 45 C.F.R. Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act, and as may otherwise be amended from time to time.

1.56 "Spouse" means an individual who is legally married to a Participant as determined under applicable Michigan state law and who is treated as a spouse under the Code.

1.57 “Summary Health Information (SHI)” means information, that may be Individually Identifiable Health Information and (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and (b) from which the information described at 45 C.F.R. §164.514(b)(2)(i) has been deleted, except that such geographic information described in 45 C.F.R. §164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

1.58 "Urgent Care Claim" means, as further defined in 29 C.F.R. 2560.503-1(m)(1), any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or (b) in the opinion of the physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Article 2

Eligibility and Participation

2.1 Eligibility Requirements. Unless otherwise provided in a collective bargaining agreement, each Employee who meets all of the following requirements shall be eligible to participate in the Plan:

(a) The Employee is eligible for the Employer's Group Health Plan.

(b) The Employee is 18 years of age.
(c) The Employee is a permanent employee and regularly scheduled to work at least 20 hours per week (unless otherwise specified for permanent employment in the collective bargaining agreement, if applicable).

(d) The Employee is not a temporary Employee.

In addition, to participate in the HSA Component, the Employee must be an HSA-Eligible Individual. Eligibility for HSA benefits shall also be subject to the additional requirements, if any, specified in the HDHP.

2.2 Commencement of Participation. With regard to the benefits described in Sections 4.1(a), 4.1(b), 4.1(d), and 4.1(e), an Employee will become a Participant on the later of the Effective Date of this Plan or the date the Employee becomes eligible to participate pursuant to Section 2.1. However, with regard to new Employees who are eligible as of their date of hire, participation in this Plan is retroactive to their date of hire (but not prior to the Effective Date of the Plan) if they make their election within thirty (30) days after their hire date. This provision does not apply to any Employee who terminates employment and is rehired within 30 days or to an Employee who returns from an unpaid leave of absence of less than 30 days. Moreover, the salary reduction amounts for retroactive coverage can only be made from compensation not yet available on the date of the election.

With regard to the other benefits under this Plan described in Sections 4.1(c), participation will begin the first day of the Plan Year following the date the Employee becomes eligible, or the Effective Date of this Plan, if later.

Although Dependents cannot participate in the Plan, they may benefit from the Participant's participation to the extent they are eligible for the underlying benefits.

2.3 Cessation of Participation. Generally, a Participant will cease to be a Participant as of the earlier of the date the Plan terminates, the day the Employee ceases to be an Employee, the date the Employee ceases to meet the eligibility requirements, or the date the Participant revokes his or her election as permitted under the terms of this Plan. While coverage ceases for the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account on the date of the event, underlying group health care coverage will cease at the end of the month in which the event occurs. If the Participant does not choose to continue participation in the Plan, termination of participation will automatically revoke the Participant’s elections and benefits as of the dates specified in the insurance or other benefit plans. To the extent required by COBRA or by any other state or federal law, a former Participant or the Qualified Beneficiaries will be permitted to continue the group health plan and/or Health Care Flexible Spending Account benefits provided under this Plan. Distributions from a Participant's HSA (whether before or after termination of employment) and all other matters relating to a Participant's HSA are outside of this Plan and are to be handled by the Participant and his or her trustee/custodian in accordance with the agreement between them. See Article 5.

2.4 Reinstatement of Former Participant. A former Participant who again satisfies the eligibility requirements of Section 2.1 shall become a Participant at the time provided in Section 2.2.
If a Participant terminates his or her employment for any reason, including, but not limited to, disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated in this Plan. The Employee will not be allowed to make a new election. If an Employee, whether or not a Participant, terminates employment and is not rehired within 30 days or ceases to be an Eligible Employee for any other reason, including, but not limited to, a reduction in hours, the Employee must complete the eligibility requirements described in Section 2.1 before again becoming eligible to participate in the Plan. An HSA benefit election will only be reinstated if an individual is an HSA-Eligible Individual.

2.5 Family and Medical Leave Act Leaves of Absence.

(a) Health Benefits. If the Employer is subject to the FMLA and a Participant takes a qualifying leave under that Act, then to the extent required by the FMLA, the Employer will continue to maintain the Participant’s medical, dental, vision and prescription coverage and Health Care Flexible Spending Account coverage on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the premium.

An Employer may elect to continue all medical, dental, vision and prescription coverage and Health Care Flexible Spending Account coverage for Participants while they are on paid FMLA leave, provided Participants on non-FMLA paid leave are required to continue coverage. If so, the Participant’s share of the premiums shall be paid by the method normally used during any paid leave, e.g., on a pre-tax salary reduction basis, if that was the method used before FMLA leave.

If the Employer requires all Participants to continue medical dental, vision and prescription coverage and Health Care Flexible Spending Account coverage during an unpaid FMLA leave, the Participant may elect to discontinue payment of the Participant’s required premiums until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the premiums not paid by the Participant during the leave. Payment shall be withheld from the Participant’s Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Administrator and the Participant.

In the event of unpaid or paid FMLA leave where coverage is not required to be continued, a Participant may elect to continue his or her medical, dental, vision or prescription coverage and Health Care Flexible Spending Account coverage during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the premium in one of the following ways:

(1) with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

(2) with pre-tax dollars, by having such amounts withheld from the Participant’s ongoing compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation. To pre-pay the premium, the Participant must make
If a Participant’s medical, dental, vision or prescription coverage or Health Care Flexible Spending Account coverage ceases while on FMLA leave, e.g., for revocation or nonpayment of required contributions, the Participant is entitled to re-enter the medical, dental, vision or prescription coverage or Health Care Flexible Spending Account, as applicable, upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. Participants whose medical, dental, vision or prescription coverage or Health Care Flexible Spending Account coverage terminated during the leave are entitled to be automatically reinstated, provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. Notwithstanding the preceding sentence, with regard to Health Care Flexible Spending Account coverage, a Participant whose coverage ceases 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 the 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 the Participant did not pay premiums. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant’s Compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health Care Flexible Spending Account will be equal to the amount withheld prior to the period of FMLA leave.

(b) Nonhealth Benefits. If a Participant takes a qualifying leave under the FMLA, entitlement to nonhealth benefits (such as Dependent Care Flexible Spending Account benefits), is to be determined by the Employer’s policy for providing such benefits when the Participant is on non-FMLA leave. If such policy permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the premiums not paid by the Participant during the leave. Payment shall be withheld from the Participant’s Compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health Care Flexible Spending Account or by the Administrator otherwise deems appropriate.

2.6 Non-FMLA Leaves of Absence. If a Participant takes an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate in the Plan and the premium due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator.
Article 3

Cash in Lieu of Medical Coverage

3.1 Election to Waive Medical Coverage and Receive Cash. Unless otherwise provided in a collective bargaining agreement, a Participant who is eligible to receive medical coverage from the Employer may elect to receive a monthly cash payment in lieu of provided medical coverage under the Group Health Plan, provided that the Participant meets the requirements of Section 3.2. The amount of the monthly cash payment is in lieu of medical coverage is $131.22 for single coverage, $222.22 for two person coverage or $249.66 for family coverage. These amounts are subject to change on an annual basis and will be communicated to the Participants during the open enrollment period. If the Participant experiences a change in election event described in Article 9, the Participant will be permitted as the Group Health Plan allows, to revoke this election and make a new election. Upon revocation, the cash payment shall cease.

3.2 Restrictions on Election to Waive Medical Coverage and Receive Cash. In order to receive the cash payment when waiving Group Health Plan coverage, a Participant must provide reasonable evidence at least one time each Plan Year that:

(a) The Participant is (or will be) enrolled in alternative "minimum essential coverage" from another employer-sponsored group health plan (other than Ingham County, unless as otherwise specified in a collective bargaining agreement) for the Plan Year (or that portion of the Plan Year) to which the cash waiver applies; and

(b) Each member of the Participant's "expected tax family" is (or will be) enrolled in alternative minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) for the Plan Year (or that portion of the Plan Year) to which the cash waiver applies.

"Minimum essential coverage" is any insurance plan that meets the Affordable Care Act requirement for having health coverage and is described in Code section 5000A(f) (other than coverage in the individual market, whether or not obtained through the Marketplace).

A Participant's "expected tax family" includes all individuals for whom the Participant reasonably expects to claim a personal exemption deduction under Code section 151 for the taxable year or years that begin or end in or with the Plan Year to which the cash waiver applies.

Additionally, Employer will not make the cash waiver payment if it knows or has reason to know that the Participant, or any member of the Participant's expected tax family, does not (or will not) have alternative minimum essential coverage during the eligible Plan Year. If after the start of the Plan Year, the alternative coverage subsequently terminates for the Participant and/or any member of the Participant's expected tax family, the Participant must immediately notify Employer, at which time the cash waiver payment will cease.
3.3 **Revocation of Election Upon Loss of Other Medical Coverage.** A Participant who elects to waive medical coverage and who subsequently loses coverage from another source: (a) must immediately notify Employer, at which time the cash waiver payment will cease; and (b) may be permitted to change an election pursuant to Article 9 of the Plan and, to the extent permitted under the Employer’s Group Health Plan, to prospectively revoke his or her election by providing proof of the loss of alternative coverage and occurrence of a change in election event to the Administrator.

3.4 **Description of the Terms of the Group Health Plan.** The coverage referred to in Section 3.1 is the coverage that is provided by Employer’s Group Health Plan. The medical benefits will not be provided by this Plan, but by the Group Health Plan and the insuring or third-party administrator agreements entered into by Employer with the respective benefit providers. The types and amounts of benefits available, the participation requirements, and the other terms and conditions of coverage are as set forth in the Group Health Plan and any related insuring or third-party administrator agreements. In the event of a conflict in terms between this Plan and the Group Health Plan, the terms of the Group Health Plan shall control.

3.5 **Election Procedure.** Prior to the beginning of the Plan Year, the Administrator shall provide one or more written election forms to each Participant and to each other Employee who is expected to become a Participant at the beginning of the Plan Year. Each Participant who elects to waive medical coverage and receive a cash payment shall so specify on the election form. Each election form must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the Plan Year.

3.6 **New Participants.** As soon as practicable before an Employee becomes a Participant under Sections 2.2 or 2.4, the Administrator shall provide the written election forms described in Section 3.5 to the Employee. If the Employee desires to elect a cash payment pursuant to Section 3.1 for the balance of the Plan Year, he or she shall so specify on the election forms. The election forms must be completed and returned to the Administrator no later than the beginning of the first pay period for which the Participant’s election will apply.

3.7 **Failure to Elect.** A Participant who fails to provide a written election form to the Administrator on or before the specified due date for each Plan Year shall not receive the cash payment discussed in Section 3.1.

3.8 **Changes by Administrator.** If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated Employees or to Key Employees, the Administrator shall take appropriate action, under rules uniformly applicable to similarly-situated Participants. This action may include, without limitation, a modification of elections by Highly Compensated Employees or Key Employees with or without the Employee’s consent.

3.9 **Revocation of Election by the Participant During the Plan Year.** Elections made or deemed to be made under Article 3 of the Plan shall be irrevocable by the Participant during the Plan Year, subject to the provisions of Article 9 and Section 3.10.
3.10 **Automatic Termination of Election.** Elections made under this Article (or deemed to be made) shall automatically terminate on the date on which the Participant no longer meets the requirements of Section 3.2, or on the date on which the Participant ceases to be a Participant in the Plan, subject to any medical care continuation coverage requirements of state or federal law and subject to the provisions of Articles 8 and 9 of this Plan.

3.11 **Maximum Employer Contributions.** The maximum amount of Employer contributions under this Article 3 of the Plan for any Participant shall be equal to the cash payment elected by a Participant who waives medical coverage as provided in this Article.

3.12 **Limitation on the Availability of Cash in Lieu of Nontaxable Benefits Payment.** To the extent Employer’s Group Health Plan contract requires a certain level of Employee participation, the election of the cash benefit available under this Article 3 shall be limited to a first-come-first-served basis. The Administrator, in its sole discretion, shall make the determinations regarding the application of this limitation.

**Article 4**

**Purchase of Benefits Through Salary Reduction**

4.1 **Benefit Options.** This Plan allows Participants to make elections among permitted taxable benefits and qualified nontaxable benefits offered through the Plan for the Plan Year. Subject to the limitations set forth in this Plan (and unless otherwise provided in a collective bargaining agreement), a Participant may elect to purchase the following benefits through salary reduction:

(a) **Premium Sharing:** The Employee portion of the cost of the particular type of medical, prescription, vision, or dental coverage under the Employer’s Group Health, Group Vision and/or Dental Plan elected by the Participant for the Participant and/or the Participant’s Dependents, as described in the benefit booklets distributed with respect to each separate benefit plan. The separate benefit plans and all related documents are incorporated 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.

(b) **Health Savings Account** benefits pursuant to Article 5. HSA benefits cannot be elected with Health Care Flexible Spending Account benefits unless the Limited-Purpose Health Care Flexible Spending Account and/or the Post-Deductible Health Care Flexible Spending Account options are selected. In no event shall benefits under the Plan be provided in the form of deferred compensation. For the Plan Year 2020, the Employer will contribute to the HSA in the amount of $600.00 for HSA-Eligible Individuals who elected single HDHP coverage and $1,200.00 for HAS-Eligible Individuals who elected family HDHP coverage, which will be directly deposited into the Account. These amounts are subject to change for future years and will be communicated to Plan Participants.
A Participant who is covered by the General-Purpose Health Care Flexible Spending Account option solely as the result of a carryover of unused amounts in a Health Care Flexible Spending Account from the prior Plan Year may not contribute to an HSA even for months in the Plan Year after the Health Care Flexible Spending Account no longer has any amounts available to pay or reimburse medical expenses.

However, a Participant who participates in the General-Purpose Health Care Flexible Spending Account option in a Plan Year and elects, for the following Plan Year, to participate in the Limited-Purpose Health Care Flexible Spending Account and/or Post-Deductible Health Care Flexible Spending Account options may elect to have any amounts from the General-Purpose Health Care Flexible Spending Account option carried over to the Limited-Purpose Health Care Flexible Spending Account and/or Post-Deductible Health Care Flexible Spending Account options in accordance with Section 7.14. In such case, such Participant is eligible to contribute to an HSA for the following Plan Year if the individual is otherwise eligible under Code section 223(c)(1)(A). During the 90-day run-out period for the General Purpose Health Care Flexible Spending Account option, the unused Health Care Flexible Spending Account amounts may be used to reimburse any allowed section 213(d) medical expenses incurred prior to the end of the General-Purpose Health Care Flexible Spending Account option Plan Year. Any claims covered by the Limited-Purpose Health Care Flexible Spending Account and/or Post Deductible Health Care Flexible Spending Account options must be timely reimbursed up to the amount elected for the Limited-Purpose Health Care Flexible Spending Account and/or Post Deductible Health Care Flexible Spending Account options Plan Year; any claims in excess of the elected amount may be reimbursed after the 90-day run-out period when the amount of any carryover is determined.

(c) Accident, dental and cancer benefits;

(d) Dependent Care Flexible Spending Account benefits pursuant to Article 6.

(e) Health Care Flexible Spending Account benefits pursuant to Article 7, including election of one of the following options:

(1) General-Purpose Health Care Flexible Spending Account benefits;

(2) Limited-Purpose Health Care Flexible Spending Account benefits;

or

(3) Post-Deductible Health Care Flexible Spending Account benefits.

The Limited-Purpose and the Post-Deductible Health Care Flexible Spending Account options may be selected together.

Although the Employer also maintains an HRA, the salary reduction has no interaction with the HRA and does not provide any funding toward the HRA. Thus, the mere fact that an individual participates in any of the above benefits funded pursuant to a salary reduction election does not result in attributing the salary reduction to the HRA. An "HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.
The Coverage Period for each of the above described benefits elected is the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year coinciding with and following the date participation commences, as described in Section 2.2; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to and including the date participation terminates, as described in Section 2.3. A different Coverage Period may be established by the Administrator and communicated to Participants.

4.2 Method of Purchasing Benefits. Prior to the commencement of each Plan Year, the Administrator shall provide one or more written election forms and salary reduction agreements to each Participant and to each other Employee expected to become a Participant at the beginning of the Plan Year. Participants who desire to purchase one or more of the optional benefits described in Section 4.1 shall so specify on the appropriate election forms, which forms shall include a salary reduction agreement. Except as provided in Section 4.3 with respect to new Participants, elections to purchase benefits shall be effective on the first day of the Plan Year. Each election form must be completed and returned to the Administrator on or before the date specified by the Administrator, which date shall be prior to the first day of the first pay period with respect to which the Participant’s salary reduction agreements will apply.

The Employer may contribute a portion of the cost for the optional benefits as provided in the election forms. There are no Employer contributions for the Health Care Flexible Spending Account benefits, HSA benefits, or the Dependent Care Flexible Spending Account benefits.

4.3 New Participants. As soon as practicable before an Employee becomes a Participant under Section 2.2, the Administrator shall provide the written election forms and salary reduction agreements described in Section 4.2 to the Employee. If the Employee desires one or more optional benefit coverages described in Section 4.1 for the balance of the Plan Year, he or she shall so specify on the election forms and shall agree to a reduction in his or her compensation. The election forms must be completed and returned to the Administrator prior to the first day of the first pay period with respect to which the Participant’s salary reduction agreement will become effective, as stated in the election form.

4.4 Failure to Make Timely Election. A new Participant who fails to return a completed election form to the Administrator on or before the specified due date shall automatically be enrolled in employee-only coverage under PHP Standard Plan and may not change this election unless an event occurs that justifies a mid-year election change, such as an event described in Article 9. A returning Participant who fails to return a completed election form to the Administrator on or before the specified due date for any subsequent Plan Year shall be deemed to have made the same election as was in effect with respect to that Participant for the prior Plan Year with regard to the Premium Sharing benefits in Section 4.1(a) only and may not change this election unless an event occurs such as an event described in Article 9. The Participant shall also be deemed to have agreed to a reduction in his or her compensation for the subsequent Plan Year equal to the cost of the optional benefits the Participant is deemed to have elected for that Plan Year. Elections for HSAs, accident, dental and cancer benefits, and the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account benefits and all other benefits must be affirmatively made each year.
4.5 Modifications of Elections by Administrator. If the Administrator determines before or during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated Employees or Key Employees, the Administrator shall take appropriate action, under rules uniformly applicable to similarly-situated Participants. This action may include, without limitation, a modification of elections by Highly Compensated Employees or Key Employees, with or without the Employee’s consent.

4.6 Revocation of Election by the Participant During the Plan Year. Elections made under the Plan shall be irrevocable by the Participant during the Plan Year, subject to the provisions of Article 9.

4.7 Automatic Termination of Election. Elections made under this Article (or deemed to be made) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, subject to any medical care continuation coverage requirements of state or federal law, and any provisions of this Plan which allow continuation of benefits.

4.8 Maximum Employer Contributions. The maximum amount of Employer contributions that may be made under this Article of the Plan for any Participant shall be the total of maximums the Participant may elect to receive through salary reduction pursuant to Sections 4.1.

4.9 Limitations on Contributions and Benefits for Certain Participants. No more than twenty-five percent (25%) of the total benefits provided under this Plan during any Plan Year may be paid to or for Participants who are key employees within the meaning of Code Section 416(i)(1) on any day during the Plan Year.

Article 5

HSA Component

5.1 HSA Benefits. A Participant can elect to participate in the HSA component by electing to pay the contributions on a pre-tax salary reduction basis to the Participant's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA benefits offered under this Plan). As described in Article 9, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next pay period following the date that the election change was filed. HSA benefits cannot be elected with Health Care Flexible Spending Account benefits unless the Limited-Purpose Health Care Flexible Spending Account and/or the Post-Deductible Health Care Flexible Spending Account options are selected.

5.2 Contributions for Cost of Coverage for HSA; Maximum Limits. The annual contribution for a Participant’s HSA benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $7,100.00 annual benefit amount is elected, then the annual contribution amount is also $7,100.00). In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant’s High Deductible
Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made ($3,550.00 for single and $7,100.00 for family are the statutory maximum amounts for 2020).

An additional catch-up contribution ($1,000 for 2009 and thereafter) may be made for Participants who are HSA-Eligible Individuals who are age 55 or older and are not yet entitled to Medicare.

In addition, the maximum annual contribution (including the catch-up contribution) shall be:

(a) reduced by any matching (or other) Employer contribution made on the Participant’s behalf; and

(b) prorated for the number of months in which the Participant is an HSA-Eligible Individual, except as provided in the following sentence. If a Participant is HSA-Eligible Individual during the month of December (even if he or she was not an HSA-Eligible Individual the entire taxable year), the Participant may still contribute the maximum limit as described above; however, the Participant must then remain an HSA-Eligible Individual until the last day of the twelfth month following the last month of the taxable year in order to avoid taxation and penalties.

5.3 Recording Contributions for HSA. As described in Section 5.5, the HSA is not an employer-sponsored employee benefit plan. It is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Participant, not by the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax salary reductions. Such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA contributions an Employee makes via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in a HSA.

5.4 Tax Treatment of HSA Contributions and Distributions. The tax treatment of the HSA (including contributions and distributions) is governed by Code section 223.

5.5 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan. HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant’s HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan. The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of “qualified eligible medical expenses” as set forth in Code section 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax salary reduction contributions to an
HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

Article 6

Dependent Care Flexible Spending Account Benefits

6.1 Maximum Amount of Dependent Care Coverage. The maximum amount of Dependent Care Flexible Spending Account which a Participant may receive in any calendar year under this Plan shall be the lesser of (a) the Participant’s Earned Income for the calendar year after all reductions in compensation, including the reduction related to Dependent Care Flexible Spending Account, or (b) the actual or deemed Earned Income of the Participant’s spouse for the Plan Year, or (c) $5,000 (reduced to $2,500 in the case of a separate return filed by a married person as defined in Code section 21(e)). In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself, such spouse shall be deemed to have Earned Income of not less than $250 per month if the Participant has one Dependent and $500 per month if the Participant has two or more Dependents.

6.2 Establishment of Dependent Care Flexible Spending Accounts. The Employer will establish and maintain on its books a Dependent Care Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive dependent care assistance for the Plan Year, but will not create a separate fund or otherwise segregate assets for this purpose. The account will merely be a record keeping account with the purpose of keeping track of contributions and determining forfeitures.

6.3 Crediting of Dependent Care Flexible Spending Accounts. There shall be credited to a Participant’s Dependent Care Flexible Spending Account for each Plan Year, as of each date compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such compensation in accordance with the Participant’s election and salary reduction agreement under Section 4.2 of the Plan. All amounts credited to each such Dependent Care Flexible Spending Account shall be the property of the Employer until reimbursements or payments are made pursuant to Sections 6.7 or 6.10.

6.4 Debiting of Dependent Care Flexible Spending Accounts. A Participant’s Dependent Care Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any reimbursement or payment under Sections 6.7 or 6.10 to or for the benefit of the Participant for Dependent Care Expenses incurred during such Plan Year. Amounts debited to each such Dependent Care Flexible Spending Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this Section, under a “first-in/first-out” approach.

6.5 Forfeiture of Dependent Care Flexible Spending Accounts. The amount credited to a Participant’s Dependent Care Flexible Spending Account for any Plan Year shall be used only to reimburse the Participant or directly pay for Dependent Care Expenses incurred after the Participant began participation in the Dependent Care Flexible Spending Account and during the Plan Year only if the Participant applies for reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in the Participant’s Dependent Care Flexible
Spending Account for any Plan Year after all reimbursements or payments have been are made under this Plan, the balance shall not be carried over to pay for to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year and shall not be available to the Participant in any other form or manner, but shall remain the property of the Employer which can in part be used to defray reasonable administrative expenses. In addition, any unclaimed benefit payments at the end of the Plan Year in which the Expense was incurred shall be forfeited and applied as above. Pursuant to this Section, the Participant shall forfeit all rights with respect to the balance of the Dependent Care Flexible Spending Account.

6.6 Application for Payment of Dependent Care Expenses. Except as otherwise provided in Sections 6.10 and 6.11 with regard to the use of Employer provided debit or credit cards to pay for Dependent Care Expenses, a Participant who has elected to receive dependent care assistance for a Plan Year may apply to Employer for reimbursement of Dependent Care Expenses incurred by the Participant during the Plan Year by submitting an application in writing to the Employer, in such form as the Employer may prescribe, setting forth:

(a) the amount, date and nature of the expense with respect to which a benefit is requested;

(b) the name of the person, organization or entity to which the expense was or is to be paid and the taxpayer identification number (Social Security Number, if an individual);

(c) the name of the person on whose behalf Dependent Care Expenses have been incurred and the Dependent’s relationship to the Participant;

(d) the amount recovered, or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense.

The application shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amounts of the expenses, together with any additional documentation which the Employer may request.

6.7 Reimbursement or Payment of Dependent Care Expenses. Except as otherwise provided in Sections 6.10 and 6.11 with regard to the use of Employer provided debit or credit cards to pay for Dependent Care Expenses, the Employer shall reimburse the Participant from the Participant’s Dependent Care Flexible Spending Account for Dependent Care Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with Section 6.6. The Employer may, at its option, pay any such Dependent Care Expenses directly to the Dependent Care Service Provider in lieu of reimbursing the Participant. No reimbursement or payment under this Section of Expenses incurred during a Plan Year shall at any time exceed the balance of the Participant’s Dependent Care Flexible Spending Account for the Plan Year at the time of the reimbursement or payment. The amount of any Dependent Care Expense not reimbursed or paid as a result of the preceding sentence shall be carried over and reimbursed or paid only if and when the balance in such Account permits the reimbursement or payment within the same Plan Year.

6.8 Report to Participants on or before January 31 of each Year. On or before January 31 of each year, the Administrator shall furnish to each Participant who has received
dependent care assistance during the prior calendar year a written statement showing the amount of such assistance paid during such year with respect to the Participant.

6.9 **Termination of Participation.** In the event that a Participant who has elected dependent care assistance ceases to be a Participant in this Plan for any reason, the Participant’s salary reduction agreement relating to dependent care assistance shall terminate. Additionally, the Participant's debit or credit card shall be automatically canceled upon termination pursuant to Section 6.10. The total amount credited to the former Participant’s Dependent Care Flexible Spending Account at the time of termination of participation shall be available to the former Participant for reimbursements through the remainder of the Plan Year in which she or he terminated participation. However, the former Participant must apply for reimbursement on or before the 90th day after the close of the Plan Year in which the termination of participation occurred. In essence, the Plan will allow the former Participant to spend down the remaining balance in his or her Account until the end of the Plan Year. Only claims incurred during that Plan Year may be reimbursed. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Dependent Care Flexible Spending Account for the Plan Year.

6.10 **Payment of Dependent Care Expenses with Employer Provided Debit Card.** Employer has provided Participants with the opportunity to access funds in their Dependent Care Flexible Spending Accounts through the use of debit cards. Each Participant who is issued a card must certify upon enrollment in the Dependent Care Flexible Spending Account, and each Plan Year thereafter, that the card will only be used for Dependent Care Expenses, that the Participant and Spouse, if any, are “gainfully employed,” that the expenses paid with the debit card are for the “care” of the Dependent who is a “Qualifying Individual,” and that the expense has been incurred as the service has been provided. The Participant further certifies that any expense paid with the card has not been otherwise reimbursed and that the Participant will not seek reimbursement under any other plan covering these benefits. These certifications are reaffirmed each time the card is used. The Participant agrees to retain sufficient documentation for any expense paid with the card, including invoices and receipts, where appropriate. The card is automatically canceled when the Participant ceases to participate in the Dependent Care Flexible Spending Account.

The Participant’s use of the card is limited to the existing dollar amount of coverage available in his or her Dependent Care Flexible Spending Account set forth in this Article. When the Participant uses the card at the point of sale, the dependent day care provider is paid the full amount of the charge (assuming there is sufficient coverage within the Dependent Care Flexible Spending Account and that the service has already been rendered) and the Participant’s maximum available coverage remaining is reduced by that amount.

**EXAMPLE:**

At the beginning of the Plan Year or upon enrollment in the Dependent Care Flexible Spending Account, the Participant pays initial expenses to the Dependent Care Service Provider and substantiates the initial expenses by submitting to the Plan Administrator a statement from the Dependent Care Service Provider substantiating the dates and amounts for the services provided. After the Plan Administrator receives the substantiation (but not before the date the services are provided), the Plan makes available through the debit card an amount equal to the lesser of:
(a) The previously incurred and substantiated expense; or
(b) The Participant's total salary reduction amount to date.

The card may be used to pay for subsequently incurred Dependent Care Expenses. The amount available through the card may be increased in the amount of any additional Dependent Care Expenses only after the additional expenses have been incurred.

6.11 Substantiation Procedures for Payment of Dependent Care Expenses with Employer Provided Debit Card. Every claim made with the card must be substantiated. To provide assurance that only Dependent Care Expenses are reimbursed, Employer has established the following procedures for substantiating claimed dependent care expenses after the use of the card:

(a) Automatic Substantiation: Payments with the card that are made in the following manner are automatically substantiated, without the need to turn in receipts or other documentation.

(1) Recurring Transactions: Employer permits automatic reimbursement, without further review, of recurring expenses that match expenses previously substantiated and approved as to provider and time period if the amount is equal to or less than previously substantiated expenses (e.g., for a Participant who uses the same day care provided and incurs the same expense, or less, each month). Similarly, Dependent Care Expenses previously substantiated and approved through nonelectronic methods may also be treated as substantiated without further review.

(b) Manual Substantiation: Employer’s procedures provide that all charges to the card, other than recurring expenses as described above (i.e., new provider or increase in amount), are treated as conditional pending confirmation of the charge. Thus, Employer requires that additional third-party information, such as dependent day care provider receipts, describing (1) the service, (2) the date of the service and (3) the amount, be submitted for review and substantiation.

(c) Correction Procedures for Improper Payments: In case some of the claims that have been paid under the Employer’s card arrangement are subsequently identified as not Dependent Care Expenses, the debit card will be de-activated until the improper payment is recovered. Additionally, Employer has adopted all of the following correction procedures with respect to the improper payments:

(1) First, upon identifying an improper payment, Employer requires the Participant to pay back to the Plan an amount equal to the improper payment.

(2) Second, where this proves unsuccessful, Employer has the amount of the improper payment withheld from the Participant’s wages or other compensation to the extent consistent with applicable law.

(3) Third, if the improper payment still remains outstanding, Employer utilizes a claims substitution or offset approach to resolve improper claims. For example, if a
Participant has received an improper reimbursement of $200 and subsequently submits a substantiated claim incurred during the same coverage period, no reimbursement is made until the improper payment is fully recouped.

(4) If these correction efforts prove unsuccessful, or are otherwise unavailable, the Participant remains indebted to Employer for the amount of the improper payment. In that event and consistent with its business practices, Employer treats the payment as it would any other business indebtedness.

Article 7

Health Care Flexible Spending Account Benefits

7.1 Maximum Amount of Health Care Flexible Spending Account Benefits. The maximum amount of Health Care Flexible Spending Account benefits which a Participant may elect through salary reduction in any Plan Year under this Plan, even if more than one Health Care Flexible Spending Account option is selected, shall be $2,700.00 (may be adjusted by the Employer for future years and will be communicated to Plan Participants on an annual basis).

7.2 Establishment of Health Care Flexible Spending Accounts. The Employer will establish and maintain on its books a Health Care Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year, but will not create a separate fund or otherwise segregate assets for this purpose. The Account will merely be a record keeping account with the purpose of keeping track of contributions and determining forfeitures. This Account will also delineate the type of Health Care Flexible Spending Account elected by the Participant (i.e. General-Purpose, Limited-Purpose or Post-Deductible) and will reimburse accordingly.

7.3 Crediting of Health Care Flexible Spending Accounts. At the beginning of each Plan Year (or for New Participants at the beginning of participation) there shall immediately be credited to a Participant’s Health Care Flexible Spending Account an amount equal to the total reduction, if any, to be made in the Participant’s compensation for the Plan Year in accordance with the Participant’s election and salary reduction agreement under Section 4.2 of the Plan. All amounts credited to each such Health Care Flexible Spending Account shall be the property of the Employer until reimbursements or payments are made pursuant to Sections 7.7 or 7.10.

7.4 Debiting of Health Care Flexible Spending Accounts. A Participant’s Health Care Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any payment or reimbursement under Sections 7.7 or 7.10 to or for the benefit of the Participant for Qualifying Medical Care Expenses incurred during the Plan Year. Except as otherwise provided in Section 7.14, amounts debited to each Health Care Flexible Spending Account shall be treated as payments of the earliest amounts credited to the Account and not yet paid under a “first-in/first-out” approach.

7.5 Forfeiture of Health Care Flexible Spending Accounts. Except as otherwise provided in this Section, the amount credited to a Participant’s Health Care Flexible Spending Account for any Plan Year shall be used only to reimburse the Participant or directly pay for
Qualifying Medical Care Expenses incurred during the period of his or her participation in the Plan Year and only if the Participant applies for reimbursement on or before the earlier of: (a) the 90th day following the date the Participant terminates participation in the Plan (unless he or she continues to participate pursuant to COBRA as of the last day of the Plan Year); or (b) the 90th day following the close of the Plan Year. If any balance remains in the Participant’s Health Care Flexible Spending Account for a Plan Year after all reimbursements or payments have been paid, up to $550.00 [as adjusted pursuant to Section 7.14] of such remaining balance may be carried over to reimburse the Participant or pay directly for Qualifying Medical Care Expenses incurred during the immediately following Plan Year. Any remaining balance in excess of $550.00 [as adjusted pursuant to Section 7.14] shall not be carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner. Such excess balance instead shall remain the property of the Employer to defray reasonable administrative expenses. Any remaining excess balance must be allocated among Participants on a reasonable and uniform basis. In addition, any unclaimed benefit payments at the end of the Plan Year in which the Expense was incurred shall be forfeited and applied as above. Pursuant to this Section, the Participant shall forfeit all rights with respect to the balance of the Health Care Flexible Spending Account.

IMPORTANT EXCEPTION REGARDING QUALIFIED RESERVIST DISTRIBUTIONS: If, however, the Participant is a member of a reserve component (as defined in section 101 of title 37, United States Code) and is ordered or called to active duty for a period in excess of 179 days or for an indefinite period, then the Participant may take a Qualified Reservist Distribution in cash. A “Qualified Reservist Distribution” is a taxable distribution of the unused amounts remaining in the Health Care Flexible Spending Account (excluding any carryover amount otherwise permitted under Section 7.14), which equals the amount contributed to the Account through payroll deductions as of the date of the Qualified Reservist Distribution request minus the reimbursements received from the Account as of the date of the request. The request must be made during the period beginning on the date of such order or call to active duty and ending on the last day of the Plan Year and must be accompanied by a copy of the order or call to active duty. The Employer must then pay the Qualified Reservist Distribution within a reasonable time, but not more than sixty (60) days after the request was made.

A Participant who takes a Qualified Reservist Distribution will automatically terminate participation in the Health Care Flexible Spending Account and may only regain participation status by meeting the eligibility and participation requirements set forth in Sections 2.1 and 2.2 and meeting the requirements of Article 9.

7.6 Application for Payment of Qualifying Medical Care Reimbursements. Except as otherwise provided in Sections 7.10 and 7.11 with regard to the use of Employer provided debit or credit cards to pay for Qualifying Medical Care Expenses, a Participant who has elected to receive medical care expense reimbursements for a Plan Year may apply to Employer for reimbursement of Qualifying Medical Care Expenses incurred by the Participant during the Plan Year by submitting an application in writing to the Employer, in such form as the Employer may prescribe, setting forth:

(a) the amount, date and nature of the expense with respect to which a benefit is requested;
(b) the name of the person, organization or entity to which the expense was or is to be paid and the taxpayer identification number (or Social Security Number, if an individual);

(c) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant; and

(d) the amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense.

Such application shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amounts of such expenses, together with any additional documentation which the Administrator may request.

7.7 **Reimbursement or Payment of Qualifying Medical Care Expenses.** Except as otherwise provided in Sections 7.10 and 7.11 with regard to the use of Employer provided debit or credit cards to pay for Qualifying Medical Care Expenses, the Employer shall reimburse the Participant from the Participant’s Health Care Flexible Spending Account for Qualifying Medical Care Expenses incurred during the Plan Year for which the Participant submits a written application and documentation in accordance with Section 7.6. The Employer may, at its option, pay any such Qualifying Medical Care Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant. Reimbursements shall be made available to the Participant throughout the Plan Year without regard to the amount of salary reductions allocated to the Participant’s Health Care Flexible Spending Account at any point in time. No reimbursement or payment under this Section of expenses incurred during a Plan Year shall at any time exceed the total balance of the Participant’s Health Care Flexible Spending Account for the Plan Year.

7.8 **Report to Participants on or Before January 31 of Each Year.** On or before January 31 of each year, the Administrator shall furnish to each Participant who has received medical care expense reimbursements during the prior calendar year a written statement showing the amount of Qualifying Medical Care Expenses which were paid or reimbursed during the Plan Year with respect to each Participant.

7.9 **Termination of Participation.** In the event that a Participant who has elected the Health Care Flexible Spending Account ceases to be a Participant in this Plan for any reason, the Participant’s salary reduction agreement relating to the Health Care Flexible Spending Account and election to receive reimbursements shall terminate. Additionally, the Participant's debit or credit card shall be automatically canceled upon termination pursuant to Section 7.10. The total amount remaining in the Health Care Flexible Spending Account shall be available to the former Participant for reimbursement of Qualifying Medical Care Expenses incurred prior to the termination of participation. (Only expenses incurred during the period of participation in the Plan may be reimbursed.) However, the former Participant must apply for reimbursement on or before the 90th day after the Participant’s termination of participation. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Health Care Flexible Spending Account for the Plan Year in which the expenses were incurred. However, former Participants and Qualified Beneficiaries may be able to continue coverage under the Health Care Flexible Spending
Account pursuant to COBRA. Additionally, the former Participant may elect to pay for these COBRA benefits through the end of the Plan Year with pre-tax dollars by voluntarily reducing his/her last paycheck.

7.10 Payment of Qualifying Medical Care Expenses with Employer Provided Debit Card. Employer has provided Participants with the opportunity to access funds in their Health Care Flexible Spending Accounts through the use of debit cards. Each Participant who is issued a card must certify in writing upon enrollment in the Health Care Flexible Spending Account, and each Plan Year thereafter, that (a) the card will only be used for Qualifying Medical Care Expenses of the Participant and his or her Spouse and Dependents; (b) that any expense paid with the card has not been otherwise reimbursed and that the Participant will not seek reimbursement under any other plan covering health benefits; and (c) that the Participant will 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 card is automatically canceled when the Participant ceases to participate in the Health Care Flexible Spending Account.

The Participant’s use of the card is limited to the maximum dollar amount of coverage available in his or her Health Care Flexible Spending Account set forth in Section 7.1, reduced by amounts debited as described in Section 7.4. The card is also only effective at merchants and service providers authorized by Employer relating to health care. When the Participant uses the card at the point of sale, the merchant or service provider is paid the full amount of the charge (assuming there is sufficient coverage within the Health Care Flexible Spending Account) and the Participant’s maximum available coverage remaining is reduced by that amount.

7.11 Substantiation Procedures for Payment of Qualifying Medical Care Expenses with Employer Provided Debit Card. Every claim made with the card must be substantiated. To provide assurance that only Qualifying Medical Care Expenses are reimbursed, Employer has established the following procedures for substantiating claimed medical expenses after the use of this card:

(a) Automatic Substantiation: For expenses incurred at medical care providers (as identified by the Merchant Category Code) and at stores with the Drug Stores and Pharmacies Merchant Category Code (if 90% of the store's gross receipts for the prior taxable year consisted of items which qualify as medical care expenses under Code section 213(d)), payments with the card that are made in the following manner are automatically substantiated, without the need to turn in receipts or other documentation.

(1) Co-Payment Transactions: If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the major medical plan of the Participant or is an exact multiple of not more than five times the dollar amount of the co-payment, the charge is fully substantiated without the need for submission of a receipt or further review. The same holds true for combinations of up to five co-payments in the case of tiered co-payments as long as they are exact matches of multiples or combinations. The co-payment schedule under the major medical plan must be independently verified by the Employer.

(2) Recurring Transactions: Employer also permits automatic reimbursement, without further review, of recurring expenses that match expenses previously
approved as to amount, provider, and time period (e.g., for a Participant who refills a prescription drug on a regular basis at the same provider for the same amount).

(3) Real-Time Transactions: If the merchant, service provider or other independent third-party (e.g., Pharmacy Benefit Manager), at the time and point of sale, provides information to verify to Employer (including electronically by e-mail, the internet, intranet or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review (i.e., “real-time substantiation”).

(b) Inventory Information Approval System: An inventory information approval system may be used to substantiate payments made using a debit card, including payments at merchants and service providers that are not described in paragraph (a) of this Section. Debit card transactions using this system are fully substantiated without the need for submission of a receipt by the employee or further review.

(1) When an employee uses the card, the payment card processor's or participating merchant's system collects information about the items purchased using the inventory control information (for example, stock keeping units (SKUs)). The system compares the inventory control information for the items purchased against a list of items, the purchase of which qualifies as expenses for medical care under Code section 213(d) (including nonprescription medications);

(2) These medical expenses are totaled and the merchant's or payment card processor's system approves the use of the card only for the amount of medical expenses eligible for coverage under the Health Care Flexible Spending Account;

(3) If the transaction is only partially approved, the Participant is required to tender additional amounts, resulting in a split-tender transaction;

(4) If, after matching inventory information, it is determined that only some of the items purchased are Code section 213(d) medical expenses, the transaction is approved only as to those medical expenses. In this case, the merchant or service-provider must request additional payment from the Participant for the items that do not satisfy the definition of medical care under Code section 213(d);

(5) The merchant or service-provider must also request additional payment from the Participant if he or she does not have sufficient Health Care Flexible Spending Account coverage to purchase the medical items;

(6) Any attempt to use the card at non-participating merchants or service-providers will fail;

(7) Employer ensures that the inventory information approval system complies with the requirements for substantiating, paying or reimbursing Code section 213(d) medical expenses and the recordkeeping requirements in section 6001.

(c) Manual Substantiation: Employer’s procedures provide that all charges to the card, other than co-payments, recurring expenses and real-time transactions as described above,
are treated as conditional pending confirmation of the charge. Thus, Employer requires that additional third-party information, such as merchant or service provider receipts, describing (1) the service or product, (2) the date of the service or sale and, (3) the amount, be submitted for review and substantiation.

(d) Correction Procedures for Improper Payments: In case some of the claims that have been paid under the Employer’s card arrangement are subsequently identified as not Medical Care Expenses, the debit card is de-activated until the improper payment is recovered. Additionally, Employer has adopted all of the following correction procedures with respect to the improper payments:

(1) First, upon identifying an improper payment, Employer requires the Participant to pay back to the Plan an amount equal to the improper payment.

(2) Second, where this proves unsuccessful, Employer has the amount of the improper payment withheld from the Participant’s wages or other compensation to the extent consistent with applicable law.

(3) Third, if the improper payment still remains outstanding, Employer utilizes a claims substitution or offset approach to resolve improper claims. For example, if a Participant has received an improper reimbursement of $200 and subsequently submits a substantiated claim incurred during the same coverage period, no reimbursement is made until the improper payment is fully recouped.

(4) If these correction efforts prove unsuccessful, or are otherwise unavailable, the Participant remains indebted to Employer for the amount of the improper payment. In that event and consistent with its business practices, Employer treats the payment as it would any other business indebtedness.

7.12 Pediatric Vaccine Reimbursements. This Plan will not reduce or in any way be amended to limit the reimbursement for pediatric vaccines below the level provided by this Plan as of May 1, 1993. This provision is intended to comply with ERISA Section 609(d) as added by the Omnibus Budget Reconciliation Act of 1993 and shall be interpreted in a manner which is consistent with that provision of federal law.

7.13 Coordination of Benefits with HSA, HRA, etc. Health Care Flexible Spending Account benefits are intended to pay benefits solely for Qualifying Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. The Health Care Flexible Spending Account will not be considered a group health plan for coordination of benefits purposes and such benefits shall not be taken into account when determining benefits payable under any other plan. Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health Care Flexible Spending Account and the HSA, the Participant may choose to seek reimbursement from either the Health Care Flexible Spending Account or the HSA, but not both.

If the Employer also maintains an HRA, then in the event an expense is eligible for reimbursement under both the Health Care Flexible Spending Account and the HRA, the HRA must pay first. Other than this Section, this Plan shall not be coordinated or otherwise connected
to the Employer’s HRA except as permitted by the Code and Treasury Regulations thereunder to maintain this Plan.

7.14 **Health Care Flexible Spending Account Carryovers.** Notwithstanding any other provision of the Plan to the contrary, pursuant to this Section 7.14, unused amounts of up to $550.00 [as adjusted] remaining at the end of a Plan Year (taking into consideration the 90-day run out period) in a Participant's Health Care Flexible Spending Account ("carryover amount") may be used to reimburse the Participant or pay directly for Qualifying Medical Care Expenses incurred during the entire immediately following Plan Year. The maximum carryover amount for the 2020 Plan Year is $550.00. The maximum carryover amount for future plan years will be up to 20% of the maximum salary reduction contribution allowed under Code section 125(i) for that plan year and will be communicated to employees at open enrollment.

With respect to a Participant, the amount that may be carried over to the immediately following Plan Year is equal to the lesser of (1) any unused Health Care Flexible Spending Account amount from the immediately preceding Plan Year; or (2) $550.00 [as adjusted]. Any unused Health Care Flexible Spending Account amount in excess of $550.00 [as adjusted] that remains unused as of the end of the Plan Year (taking into consideration the 90-day run out period) is forfeited. Any unused amount remaining in a Participant's Health Care Flexible Spending Account as of termination of employment also is forfeited (unless, if applicable, the Participant elects COBRA continuation coverage with respect to the Health Care Flexible Spending Account).

In no event shall the carryover amount in the Health Care Flexible Spending Account be cashed out or converted to any other taxable or nontaxable benefit. The carryover amount may be used only to reimburse a Participant for or directly pay for Qualifying Medical Care Expenses.

The carryover amount shall not count against or otherwise affect the maximum amount of Health Care Flexible Spending Account benefits applicable to a Plan Year which a Participant may elect pursuant to Section 7.1.

Qualifying Medical Care Expenses incurred in the current Plan Year will be reimbursed first from a Participant's unused amounts credited for the current Plan Year and only after exhausting these current Plan Year amounts, then from unused amounts carried over from the preceding Plan Year after the end of the 90-day run out period. Any carryover amounts that are used to reimburse a current Plan Year expense cannot exceed $550.00 [as adjusted] and will count against the $550.00 [as adjusted] maximum carryover amount.

**Article 8**

**COBRA Continuation of Coverage**

8.1 **In General.** The following provisions may apply to benefits provided to eligible Participants and their Qualified Beneficiaries under the Plan, but only to the extent that the benefits selected pertain to group health plan coverage pursuant to the provisions of the COBRA. Importantly, this Article only applies to group health plan coverage. It does not apply to non-
health benefits. However, with regard to COBRA’s application to a Health Care Flexible Spending Account, see Section 8.14.

8.2 **Continuation of Coverage.** To the extent required by Section 8.1 above, a covered Employee or Qualified Beneficiary who would lose coverage under this Plan as a result of a Qualifying Event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a covered Employee or Qualified Beneficiary who is a spouse of the covered Employee will be deemed to include an election for continuation coverage under this provision on behalf of any other Qualified Beneficiary who would lose coverage by reason of a Qualifying Event.

If this Plan provides a choice among the types of coverage under this Plan, each Qualified Beneficiary is entitled to make a separate selection among such types of coverage. However, the Qualified Beneficiary may only be able to continue that type of coverage which he or she would have lost as a result of the Qualifying Event.

8.3 **Qualifying Event.** The term “Qualifying Event” means any of the following events which, but for COBRA continuation coverage, would result in the loss of coverage of the covered Employee or Qualified Beneficiary:

(a) death of the covered Employee;

(b) termination (other than by reason of such Employee’s gross misconduct) or reduction of hours of the covered Employee’s employment;

(c) divorce or legal separation of the covered Employee from the Employee’s spouse;

(d) covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare); or

(e) a dependent child ceasing to be a dependent child of a covered Employee under the generally applicable requirements of the Plan.

An event described above is only a Qualifying Event if it causes a loss of coverage for the covered Employee, or Qualified Beneficiary under the group health plan. For this purpose, "loss of coverage" generally means to cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event (including any increase in the premium or contribution that must be paid by a covered Employee (or his/her spouse or dependent child) for coverage under the group health plan). 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.
8.4 Type of Coverage. Continuation coverage under this provision is coverage which is identical to the coverage provided to similarly-situated beneficiaries under the group health plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under the group health plan is modified for any group of similarly-situated beneficiaries, then coverage shall also be modified in the same manner for all Qualified Beneficiaries under the group health plan in connection with such group.

8.5 Duration of Coverage. The coverage under this provision will extend for at least the period beginning on the date coverage is lost as a result of a Qualifying Event (unless otherwise provided) and ending not earlier than the earliest of the following:

(a) In the case of a terminated covered Employee (except for termination for gross misconduct) or a covered Employee whose hours have been reduced, and his or her Qualified Beneficiaries, the date which is 18 months after the date coverage is lost as a result of the Qualifying Event;

(b) In the case of any Qualifying Event except as described in Section 8.5(a), for the Qualified Beneficiaries, the date which is 36 months after the date coverage is lost as a result of the Qualifying Event;

(c) In the case of a covered Employee or Qualified Beneficiary who is disabled at some point before the 61st day after the date coverage is lost as a result of the Qualifying Event as described in Section 8.5(a) and the disability lasts until the end of the 18 month period, the date which is 29 months after the date coverage is lost as a result of the Qualifying Event, provided the Administrator is given notice of the Social Security disability determination within 18 months of the date coverage is lost as a result of the Qualifying Event and within 60 days of the later of (i) the disability determination; (ii) the Qualifying Event; or (iii) the date coverage was lost as a result of the Qualifying Event;

(d) In the case of a second Qualifying Event (must be an event described in Section 8.5(b)) which occurs during the 18 months after the date coverage is lost as a result of the first Qualifying Event described in Section 8.5(a), for the Qualified Beneficiaries, the date which is 36 months after the date coverage is lost as a result of the first Qualifying Event;

(e) In the case of a loss of coverage due to termination (except for gross misconduct) or reduction in hours of a covered Employee which occurs within 18 months after the Employee's entitlement to Medicare, for the Qualified Beneficiaries, the date which is 36 months from the date of entitlement to Medicare;

(f) The date on which the participating Employer ceases to provide any group health plan to any Employee;

(g) The date on which coverage ceases under the Plan by reason of failure to make timely payment of the required contribution pursuant to this provision;

(h) The date on which the covered Employee or Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan (as an employee or otherwise), or becomes entitled to benefits under Title XVIII of the Social Security Act.
However, if the other group health plan has a preexisting condition limitation, coverage under the plan will not cease while such preexisting condition limitation under the other group plan remains in effect, subject to the maximum period of coverage limitations set forth in this Section;

(i) The first day of the month beginning more than 30 days after the date on which the disabled covered Employee or Qualified Beneficiary is determined by the Social Security Administration to be no longer disabled;

(j) In the case of coverage under the Health Care Flexible Spending Account, the last day of the Plan Year within which the Qualifying Event occurred; or

(k) COBRA may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

8.6 Cost of Coverage. COBRA permits the Plan to require payment of an amount that does not exceed 102 percent of the applicable premium (i.e., the full cost to the Plan (including both employer and employee contributions) for coverage for similarly situated beneficiaries with respect to whom a Qualifying Event has not occurred. If coverage is continued due to a disability, COBRA permits the Plan to require the payment of an amount that does not exceed 150 percent of the applicable premium for any period of COBRA coverage if the coverage would not be required to be made available in the absence of a disability extension (e.g. for the last 11 months of the 29-month period during which coverage may continue).

8.7 Payment of Premium.

(a) A covered Employee or Qualified Beneficiary shall only be entitled to continuation coverage provided the Qualified Beneficiary or covered Employee pays the applicable premium required by the Employer in full and in advance, except as provided in (b) below. Such premium shall not exceed the maximum thresholds of applicable federal law. A Qualified Beneficiary or covered Employee may elect to pay such premium in monthly installments. The Plan may also permit payments at other intervals.

(b) Except as provided in (c) below, the payment of any premium shall be considered to be timely if made to the Plan within 30 days after the first day of the applicable period of coverage, or within such longer period of time as permitted under this Plan.

(c) Notwithstanding (a) and (b) above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

8.8 Qualified Beneficiary Must Notify Plan Administrator of Certain Qualifying Events.

(a) It is the responsibility of the covered Employees and Qualified Beneficiaries to provide the following notices to the Plan Administrator:
(1) Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse;

(2) Notice of the occurrence of a Qualifying Event that is a Qualified Beneficiary ceasing to be covered under the Plan as a dependent child;

(3) Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a covered Employee or Qualified Beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(5) Notice that a covered Employee or Qualified Beneficiary: (i) with respect to whom a notice described in paragraph (a)(4) of this Section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled, or (ii) subsequently becomes entitled to Medicare or covered under other group health coverage (but only after any preexisting condition exclusions of the other plan have been exhausted or satisfied).

(b) Notice to the Plan Administrator must be made in writing and must be mailed or hand-delivered to:

Human Resources Department
Ingham County
121 East Maple Street
Mason, Michigan 48854

Oral notice or electronic notice (by e-mail or facsimile) is not acceptable. If mailed, the notice must be postmarked no later than the deadline described below. If hand-delivered, notice must be received by the individual at the address above no later than the deadline described below.

(c) **Required Contents of Notice.** The notice must at a minimum contain the following information:

(1) the name of the Plan;

(2) the name and address of the Employee or former Employee who is or was covered under the Plan;

(3) the nature of the Qualifying Event, and, if applicable, the nature of the initial Qualifying Event that started the COBRA coverage, including any verifying documentation which may be required by the Plan Administrator;
(4) the date of this Qualifying Event, and, if applicable, the initial Qualifying Event;

(5) the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event or initial Qualifying Event, and, if applicable, whether those individuals are receiving COBRA coverage at the time of this notice;

(6) if the notice is for a disability extension, the name and address of the disabled covered Employee or Qualified Beneficiary;

(7) if the notice is for a disability extension, the date that the covered Employee or Qualified Beneficiary became disabled;

(8) if the notice is for a disability extension, the date that the Social Security Administration made its determination of disability. Additionally, a copy of the Social Security Administration's disability determination letter must be attached;

(9) if the notice is regarding (a) the Social Security Administration subsequently determining that the covered Employee or Qualified Beneficiary is no longer disabled or (b) subsequent entitlement of Medicare or coverage under another group health plan, the initial Qualifying Event and the subsequent event terminating coverage and the dates they occurred; and

(10) the signature, name, and contact information of the individual sending the notice.

Furthermore, the Plan requires that the following documents, if relevant to the particular Qualifying Event, be provided with the notice: Death Certificate; Divorce Decree or Legal Separation Agreement; Birth Certificate or Order of Adoption; Marriage Certificate; Social Security Administration's Disability Determination Letter; Spouse’s Notice of Employment Termination or Proof of Loss of Coverage; Qualified Domestic Relations Order.

Any notice that does not contain all of the information required by the Plan must be supplemented in writing within 15 business days with the additional information necessary to meet the Plan's reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this Section.

(d) **Time Periods to Provide Notice.** If written notice is not provided within the time periods provided below, the covered Employee and Qualified Beneficiaries will lose the right to elect COBRA.

(1) Time limits for notices of Qualifying Events. The notice described in Section 8.8(a)(1), (2), or (3) must be furnished within 60 days after the latest of:

(A) the date on which the relevant Qualifying Event occurs; or

(B) 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.
(2) Time limits for notice of disability determination. A notice described in Section 8.8(a)(4) must be furnished before the end of the first 18 months of continuation coverage and within 60 days after the latest of:

(A) the date of the disability determination by the Social Security Administration;

(B) the date on which the Qualifying Event occurs; or

(C) 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.

(3) Time limits for notice of change in disability status, subsequent Medicare entitlement or coverage under another group health plan. The notice described in Section 8.8(a)(5) must be furnished within 30 days after the date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the covered Employee or Qualified Beneficiary is no longer disabled or the date the covered Employee or Qualified Beneficiary becomes entitled to Medicare or covered under other group health coverage.

(e) Person to Provide Notice. With respect to each of the notice requirements of this Section, any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

8.9 Employer Must Notify Plan Administrator of Certain Qualifying Events. Upon the occurrence of a Qualifying Event that is the covered Employee's death, termination of employment (other than by reason of gross misconduct), reduction in hours of employment, or Medicare entitlement, the Employer must notify the Plan Administrator within 30 days after the date coverage is lost as a result of the Qualifying Event.

8.10 Notification to Qualified Beneficiary.

(a) The Plan Administrator (or entity which it has hired) shall provide written notice within 14 days after receipt of the notice of Qualifying Event to each covered Employee and spouse of such covered Employee of his/her right to continuation coverage and the cost, if any, under this provision as required by federal law. However, in the case where the Employer is the Plan Administrator and the Employer is otherwise required to furnish a notice of a Qualifying Event to the Plan Administrator, the Plan Administrator shall provide written notice within 44 days after the date coverage is lost as a result of the Qualifying Event.

(b) The Plan Administrator (or entity which it has hired) shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the Qualifying Event is the divorce or legal separation of the covered Employee from the covered Employee’s spouse or a dependent child ceasing to be a dependent under the terms of this Plan, the Plan Administrator shall only be required to notify a covered Employee or Qualified Beneficiary of his/her right to elect continuation coverage if the covered Employee or
the Qualified Beneficiary notifies the Employer of such Qualifying Event as previously stated. Additionally, the right to extend COBRA coverage may only be provided upon the Plan Administrator receiving proper notice.

(c) Notification of the requirements of this provision to a Qualified Beneficiary who is the spouse of a covered Employee shall be treated as notification to all other Qualified Beneficiaries residing with such spouse at the time notification is made.

8.11 Election of COBRA. A covered Employee and Qualified Beneficiaries each will have an independent right to elect COBRA continuation coverage and shall have 60 days to elect COBRA from the later of (1) the date on which coverage would be lost on account of the Qualifying Event; or (2) the date notice of the right to elect COBRA continuation coverage is provided. 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. Any covered Employee and/or Qualified Beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA coverage.

A covered Employee and/or Qualified Beneficiary then shall have 45 days after the date on which the COBRA election is made to pay for any required premium. Thereafter, payment is timely if made within the time periods of the Plan or 30 days of the due date.

8.12 Special Election Period. Special COBRA rights apply to certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible Employee or former Employee becomes eligible for TAA or ATAA, but only if such election is made within the six months immediately after the date of the TAA/ATAA-related loss of coverage. If the Employee qualifies for TAA or ATAA, he/she must contact the Employer promptly or the Employee will lose the right to elect COBRA during a special second election period.

8.13 Interaction with FMLA. If the Employer is subject to the Family and Medical Leave Act and the Employee does not return to work from the FMLA leave, the Employee and Qualified Beneficiaries may be entitled to continuation coverage under COBRA. A Qualifying Event under COBRA generally will occur if:

(a) the Employee and Qualified Beneficiaries are covered under the Employer’s group health plan on the day before the first day of FMLA leave (or become covered during the FMLA leave);

(b) the Employee does not return to employment with the Employer at the end of the FMLA leave, and
(c) the Employee and Qualified Beneficiaries would, in the absence of COBRA, lose coverage under the group health plan before the end of the maximum coverage period.

Such Qualifying Event occurs on the last day of the FMLA leave. The last day of FMLA leave may be the date the Employee notifies the Employer that the Employee will not be returning to work, if the notification was given before the FMLA was set to expire.

8.14 Application of COBRA to the Health Care Flexible Spending Account. COBRA coverage under the Health Care Flexible Spending Account will be offered only to covered Employees or 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 Care Flexible Spending Account COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health Care Flexible Spending Account coverage in force at the time of the Qualifying Event (i.e., the elected annual limit (including any carryover amount) 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 and covered Employees who were covered under the Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account COBRA coverage. Qualified Beneficiaries and covered Employees may not enroll in the Health Care Flexible Spending Account at open enrollment.

Article 9

Change in Election by the Participant During the Plan Year

9.1 Change in Status. Generally, a Participant’s Benefit Election is irrevocable during a Plan Year; however, a Participant may revoke a benefit election for the balance of a Plan Year and file a new election if both the revocation and the new election are on account of and consistent with a change in status acceptable under the rules and regulations of the Department of the Treasury and Code section 125, as determined by the Administrator. The Participant must make an election change within 30 days of the “change in status” event.

Any new election under this Section shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form explaining the change in status is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations that affect eligibility for coverage:

(a) Legal Marital Status: events that change a Participant’s legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(b) Number of Dependents: events that change a Participant’s number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
(c) **Employment Status:** any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer or of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in the individual’s employment status with the consequence that the individual becomes or ceases to be eligible under the plan, then that change constitutes a change in employment under this subsection;

(d) **Dependent satisfies or ceases to satisfy the eligibility requirements:** An event that causes the Participant’s Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(e) **Residency:** a change in the place of residence of the Participant, Spouse or Dependent.

9.2 **Modifications of the Change in Status Rules.**

(a) For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a “Qualifying Dependent” as defined under Code section 21(b) shall also qualify as a change in status.

(b) In general, a change in election is not consistent with the change in status if the change in status is the Participant’s divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant’s election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, 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 a Participant’s election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan. The Administrator may rely on a Participant’s certification of other coverage unless there is reason to believe the Participant’s certification is incorrect.

(c) As set forth in Article 5, an election to make a contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next pay period following the date that the election change was filed. However, no other election changes can occur as a result of a change in HSA election, except as otherwise described in this Article 9. For example, a Participant generally would not be able to terminate an election under the Health Care Flexible Spending Account Plan in order to be eligible for the HSA, unless one of the exceptions described in this Article for Health Care Flexible Spending Account Plans otherwise applied (such as for change in status). A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described in this Article.

(d) No mid-year election changes are allowed for voluntary benefits offered under this Plan as described in Section 4.1(c), unless otherwise required by law.
(e) For the remainder of the 2020 Plan Year only, a Participant is allowed to make a prospective election change to his or her Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account ("Account(s)") without otherwise meeting the requirements of this Article. Prospective election changes include enrolling in the Account(s), increasing contributions to the Account(s) (total contributions cannot exceed maximum election allowed under this Plan), or decreasing contributions to the Account(s) (not below claims already reimbursed).

9.3 **COBRA Benefits.** Regardless of the consistency requirement, if the Employee or the Employee’s spouse or Dependent becomes eligible for continuation coverage under the Employer’s group health plan as provided in Code section 4980B or any similar state law, then the individual may elect to increase salary reduction contributions under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

9.4 **HIPAA Special Enrollment.** An Employee or Participant may revoke an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f). Unless otherwise provided, such change shall take place on a prospective basis.

(a) As required by HIPAA, a 30-day special enrollment right will arise if:

(1) A current Employee is eligible for, but declined enrollment in, this group health plan coverage (or a Dependent of such Employee is eligible for, but was not enrolled in, this group health plans coverage) because the Employee or Dependent was covered under another group health plan or had other health insurance coverage when this group health plan coverage was previously offered and the other coverage was lost due to either: (i) if the other coverage was COBRA continuation coverage, that coverage has been exhausted; or (ii) if the other coverage was not COBRA continuation coverage, either the coverage was terminated as a result of loss of eligibility for the coverage (including, but not limited to, as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment; in the case of an HMO, the individual no longer resides, lives or works in the service area where the HMO provides benefits and, in cases of the group market, no other package is available to the individual; an individual incurs a claim meeting or exceeding a lifetime limit on all benefits; or the plan no longer offers any benefits to the class of similarly situated individuals that includes the individual), or employer contributions towards such coverage were terminated. Unless otherwise provided in the Employer’s Group Health Plan, the eligible Employee must request enrollment not later than 30 days after the loss of other coverage (or after a claim is denied due to the operation of a lifetime limit on all benefits). Any eligible Dependent may only enroll if that Dependent (or the Employee) meets the above requirements; or

(2) A new Dependent is acquired as a result of marriage, birth, or adoption or placement for adoption, and the group health plan makes coverage available with respect to a Dependent of a Participant or an Employee who has met any waiting period requirements and is eligible to participate under that plan. Unless otherwise provided in the Employer’s Group Health Plan, these election changes to add coverage must be made within 30 days of the date of the marriage, birth or adoption or placement for adoption (or the date dependent
coverage is made available, if later). An election to add the following individuals (if otherwise eligible for coverage under the Plan) as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption is consistent with the special enrollment right: (i) a current Employee who is eligible but not enrolled; (ii) a current Employee who is eligible but not enrolled, and the Spouse of such Employee; (iii) a current Employee who is eligible but not enrolled, and the newly acquired Dependent of such Employee; (iv) the Spouse of a Participant; (v) a current Employee who is eligible but not enrolled, and the Spouse and newly acquired Dependent; and (vi) a newly acquired Dependent of a Participant.

Enrollment applications received after the special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Unless otherwise provided in the Employer’s Group Health Plan, coverage under the special enrollment period for timely submitted requests must be effective no later than the first day of the month after the plan or issuer receives the request for special enrollment. However, with regard to enrollment requests made within 30 days on behalf of a new Dependent acquired due to birth, adoption, or placement for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for adoption (or the date the plan makes dependent coverage available, if later). The prospective increased salary reduction is permitted to reflect the cost of the retroactive coverage under the group health plan from the date of birth, adoption, or placement for adoption.

(b) As required by HIPAA, effective April 1, 2009, a 60-day special enrollment right will arise if the Employee or Dependent is eligible for, but not enrolled in, the Plan and either:

(1) loses coverage under Medicaid, specifically, if the Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for coverage; or

(2) becomes eligible for a Medicaid subsidy, specifically, if the Employee or Dependent becomes eligible for premium assistance, with respect to coverage under the Plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Employee or Dependent with the special enrollment right under subsection (b) must request enrollment within the first 60 days from the date of termination of such coverage under (b)(1) or 60 days from the date the applicant is determined to be eligible for premium assistance under (b)(2). Enrollment applications received after the 60-day special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Coverage under this Plan shall take effect on the same date coverage for this HIPAA special enrollment right takes effect in the underlying Employer’s Group Health Plan.

9.5 Court Order. In the event of a judgment, decree, or order (“order”) resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant’s child:
(a) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant’s plan; or

(b) The Participant shall be permitted 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.

9.6 **Entitlement to Medicare/Medicaid.** A Participant may change elections to cancel health coverage for the Participant or the Participant’s Spouse or Dependent if the Participant or the Participant’s Spouse or Dependent is enrolled in the Employer’s accident or health coverage and becomes 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 Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant’s Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage. See also Section 9.4.

9.7 **Change in Benefit Cost.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the elections of all affected Participants for such Benefit. If the cost of a benefit package option increases or decreases significantly, the Administrator shall permit the affected Participants to make corresponding change in elections under the Plan. A change for a significant decrease in cost includes commencing participation in the Plan. A change for a significant increase in cost allows Participants to revoke their elections and, in lieu thereof, receive coverage under another benefit package option with similar coverage on a prospective basis or drop coverage prospectively if there is no benefit package option with similar coverage. A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from action taken by the Participants or action taken by the Employer. Similar coverage means coverage for the same category of benefits for the same individuals.

9.8 **Significant Curtailment of Benefits.** If the coverage under a Benefit is significantly curtailed during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive, on a prospective basis, coverage under another Benefit package with similar coverage. If the coverage under a Benefit is significantly curtailed and coverage is lost during a Plan Year, affected Participants may revoke their elections of such Benefit, and, in lieu thereof, elect to receive, on a prospective basis, coverage under another benefit package providing similar coverage or to drop coverage prospectively if no similar coverage is offered. Significantly curtailed means an overall reduction in coverage under the Plan that constitutes reduced coverage generally.

9.9 **Change in Coverage Options.** If during the period of coverage a new benefit package option or other coverage option is added or an existing benefit package option is significantly improved, then the affected Participants may elect the newly-added option prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Employees eligible to participate pursuant
to Article 2 who are not participating in the Plan may elect to become Participants and elect the new or newly-improved benefit package option.

9.10 Change in Dependent Care Provider. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the Dependent Care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code section 152(a)(1) through (8).

9.11 Change in Another Employer’s Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer) if (1) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under the final regulations; or (2) the period of coverage under this Plan is different from the period of coverage under the other cafeteria plan or qualified benefits plan. However, no change is permitted under the Health Care Flexible Spending Account. A Participant may make a prospective election change to add Group Health coverage for the Participant, the Participant’s Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children’s health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool or a foreign government group health plan.

9.12 FMLA Leave. A Participant taking leave under FMLA may revoke an existing election of coverage and make a prospective election for the remaining period of coverage as provided under FMLA. Such Participant may also have the right to be reinstated in the same group health plan coverage upon returning from FMLA leave.

9.13 Health Care Flexible Spending Account. A Participant shall not be permitted to change an election to the Health Care Flexible Spending Account as a result of a cost or coverage change.

9.14 Enrollment in a Qualified Health Plan. A Participant may prospectively revoke an election of coverage under the Employer’s Group Health Plan that provides minimum essential coverage (as defined in Code section 5000A(f)(1)) if:

(1) The Participant is eligible for a special enrollment period to enroll in a qualified health plan through a competitive marketplace established under section 1311 of the PPACA (“marketplace”) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a qualified health plan through a marketplace during the marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the Employer's Group Health Plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to revocation in a qualified health plan through a marketplace.
for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

9.15 **Reduction in Hours of Service and Enrollment in Another Plan.** A Participant may prospectively revoke an election of coverage under the Employer's Group Health Plan that provides minimum essential coverage (as defined in Code section 5000A(f)(1)) if:

1. The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Employer's Group Health Plan; and

2. The revocation of the election of coverage under the Employer's Group Health Plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

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

**Article 10**

**Record Keeping and Administration**

10.1 **Designation of the Administrator.** The Administrator shall be designated by the Board of Directors and shall carry out the duties assigned to the Administrator under the Plan. The administration of this Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to ensure that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

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

(a) To make and enforce rules and regulations necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
(b) To construe and interpret the Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (the Administrator’s discretionary interpretation of the Plan in good faith shall be final and conclusive on all persons claiming benefits under the Plan);

(c) To approve reimbursement requests and to authorize the payment of benefits;

(d) To prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;

(e) To furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate and/or as required by law;

(f) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities in writing (such delegation shall expressly identify the delegate(s) and expressly describe the nature and scope of the delegated responsibility);

(g) To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan; and

(h) To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal.

The Plan Administrator, and other fiduciaries of the Plan (including any named fiduciary for claim appeals), have the requisite discretionary authority and control over the Plan to require deferential judicial review of its decisions, as set forth by the U.S. Supreme Court in Firestone Tire & Rubber Co. v. Bruch.

10.3 Examination of Records. In accordance with applicable law, the Administrator will make records available to each Participant for examination at reasonable times during normal business hours.

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

10.5 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.
10.6 **Indemnification of Administrator.** The Employer agrees to indemnify and to defend, to the fullest extent permitted by law, any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys’ fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission in connection with the Plan, if such act or omission is in good faith.

10.7 **Bonding.** The Administrator shall be bonded to the extent required by ERISA.

10.8 **Records.** The Administrator shall keep records containing all relevant data and information pertaining to the administration of the Plan.

10.9 **Assurance of Receipt of Benefits.** The Administrator shall take all necessary action to ensure that Participants receive the benefits to which they are entitled under the Plan.

10.10 **Conflict of Interest.** The Administrator may not decide any matter relating solely to the Administrator’s rights or benefits under the Plan; these decisions shall be made by an individual appointed by the Board of Directors.

10.11 **Exercise of Discretion on a Uniform Basis.** In those instances where the Administrator is granted discretion in making its determinations, and the decision of the Administrator affects the benefits, rights or privileges of Participants, such discretion shall be exercised uniformly so that all Participants similarly situated are similarly treated.

10.12 **Timely Filing of Reports.** The Administrator shall cause to have prepared and filed or furnished, as the case may be, in a timely fashion, such information and reports as are required by applicable law and regulations to be filed or furnished by the Plan.

10.13 **Employment of Agents.** The Administrator has the right to employ agents and advisors to assist the Administrator in the performance of its duties.

10.14 **Provision for Third-Party Plan Service Providers.** Administrator, subject to approval of the Plan Sponsor, may employ the services of such persons as it deems necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the applicable service agreement, obligations under this Plan shall remain the obligation of the Employer.

10.15 **Reliance Upon Information and Advice.** The Administrator may rely upon the written information, opinions or certificates supplied by any agent, counsel, actuary, investment manager, physician or fiduciary.

10.16 **Administration of Claims.** The Administrator shall administer all claims procedures under the Plan, except as otherwise provided.

10.17 **Compensation of Administrator.** The Administrator, if it is not an Employee of Employer, shall be paid a reasonable compensation for its services on behalf of the Plan as may be agreed upon from time to time by Plan Sponsor and the Administrator. Unless otherwise determined by the Plan Sponsor and permitted by law, any Administrator who is also an Employee
of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

10.18 Liability Limitations. The Administrator is not liable or responsible for the acts or omissions of another fiduciary, unless:

(a) the Administrator knowingly participated in, or knowingly attempted to conceal, the act or omission of another fiduciary and the Administrator knew the act or omission was a breach of fiduciary responsibility by the other fiduciary,

(b) the Administrator had knowledge of a breach by the other fiduciary and did not make reasonable efforts under the circumstances to remedy the breach, or

(c) the Administrator’s breach of the Administrator’s fiduciary responsibility permitted the other fiduciary to commit a breach.

10.19 Resignation of Administrator. The Administrator may resign by giving written notice to Plan Sponsor not less than 15 days before the effective date of the resignation.

10.20 Removal of Administrator; Filling Vacancy. The Administrator may be removed at any time, without cause, by the Board of Directors. In such case, the Board of Directors shall fill the vacancy as soon as reasonably possible after the vacancy occurs. Until a new Administrator is appointed, the Board of Directors has full authority to act as the Administrator.

Article 11

HIPAA Privacy and Security for Health Care Flexible Spending Account

11.1 Permitted and Required Uses and Disclosures of Summary Health Information. Except as prohibited by 45 C.F.R. §164.502(a)(5)(i) (related to the prohibition against using or disclosing PHI that is genetic information for underwriting purposes), the Plan may disclose SHI to the Plan Sponsor, if the Plan Sponsor requests the SHI for the following purposes:

(a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(b) Modifying, amending or terminating the Plan.

11.2 Permitted and Required Uses and Disclosure of Protected Health Information. The Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for the purpose of carrying out plan administration functions that the Plan Sponsor performs. Except as permitted in this Article, in all other cases, the Plan will not be disclosing any PHI to the Plan Sponsor in its capacity as Plan Sponsor, and no PHI may be disclosed to the Plan Sponsor unless such disclosure is otherwise permitted by the HIPAA Privacy Rules or Security Rules.
However, enrollment and disenrollment functions performed by the Plan Sponsor are performed on behalf of Plan participants and beneficiaries, and are not plan administration functions. Enrollment and disenrollment information held by the Plan Sponsor is held in its capacity as an employer and is not PHI.

11.3 **Permitted Disclosure of Enrollment/Disenrollment Information.** The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan.

11.4 **Obligations of Plan Sponsor.** The Plan Sponsor agrees that with respect to any PHI and EPHI, as applicable, disclosed to it by the Plan or any other covered entity, the Plan Sponsor shall:

   (a) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law.

   (b) Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

   (c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

   (d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

   (e) Make PHI available in accordance with 45 C.F.R. §164.524 (related to access of individuals to PHI).

   (f) Make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526.

   (g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528.

   (h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 C.F.R. Part 164, Subpart E.

   (i) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

   (j) Ensure that the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is established.
(k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(l) Report to the Plan any security incident, as defined by the HIPAA Security Rules, of which it becomes aware.

(m) Ensure that any agent to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect the EPHI that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the group health plan.

(n) Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

11.5 Adequate Separation. The Plan Sponsor shall only allow employees with specific classifications/designations access to PHI and EPHI. The Plan Sponsor shall designate these employees from time to time. A list of such employees may be obtained from the Plan Sponsor. These specified employees shall only have access to and use PHI and EPHI to the extent necessary to perform plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Article, that employee shall be subject to disciplinary action by the Plan Sponsor for noncompliance pursuant to the discipline and termination procedures of the Plan Sponsor.

The Plan Sponsor shall ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain or transmit EPHI on behalf of the Plan.

11.6 Certification of Plan Sponsor. The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan documents have been amended to incorporate the provisions of Section 164.504(f)(2)(ii) of the Privacy Rule and that the Plan Sponsor agrees to the conditions of the disclosures set forth in this Article.

11.7 Miscellaneous Interpretive Provision. The following provisions apply to limit and further define the operation of HIPAA to the Plan:

(a) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan or the Plan Sponsor be permitted to use or disclose health information in a manner that is inconsistent with HIPAA. Any ambiguity in this Article shall be resolved in favor of a meaning that permits the Plan and Plan Sponsor to comply with HIPAA. Additionally, under no circumstances does this Article extend the rights and obligations of HIPAA to benefits that would otherwise be outside the scope of the Privacy Rules, Security Rules, or Breach Notification Rules. This Article does not create any contractual rights or obligations between the Plan and other parties to Plan benefits that would otherwise be outside the scope of HIPAA. This Article does not extend application of HIPAA to create any obligations for the Plan (or any part or component within the Plan) or the Plan Sponsor that they would not otherwise have under HIPAA.

(b) This Article does not apply and has no legal effect on the Plan (or a component of the Plan) if the Plan (or a component of the Plan) does not meet the definition of
“Health Plan” or “Group Health Plan” as defined by 45 C.F.R. 160.103. Under HIPAA, a “Group Health Plan” is defined as an employee welfare benefit plan (as defined in §3(1) of ERISA, 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in §2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)) including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that: (1) Has 50 or more participants (as defined in §3(7) of ERISA, 29 U.S.C. 1002(7))); or (2) Is administered by an entity other than the employer that established and maintains the plan.

(c) When permitted, it is the intention of the Plan (or any part or component within the Plan) to qualify as an exempted group health plan under 45 C.F.R. 164.520(a)(2) and 164.530(k), or qualify under any exemption of any requirement under HIPAA.

11.8 Effective Date and Applicability of this Article. Generally, the requirements of the Privacy Rules within this Article, including definitions (“Article”), shall be effective as of April 14, 2003, and the requirements of the Security Rules within this Article shall be effective as of April 20, 2005; however, if this Plan should qualify as a “small plan” under HIPAA, the Privacy Rule aspects of this Article will instead become effective on April 14, 2004, and the Security Rule aspects of this Article will instead become effective on April 20, 2006. Generally, the requirements of the Breach Notification Rules shall be effective on September 23, 2009. In no event will this Article become effective prior to the original Effective Date of this Plan. Notwithstanding the above, this Plan will comply with any subsequently issued amendments to the Privacy Rules, Security Rules, and/or Breach Notification Rules only if and as they become applicable to the Plan.

11.9 Hybrid Entity. This provision only applies to the extent to which the Plan provides any non-health benefits such as (but not limited to) disability benefits or group term life insurance benefits. The Plan is a separate legal entity whose business activities include functions covered by the HIPAA Privacy Rules, Security Rules, and Breach Notification Rules, as well as functions not covered by those rules. As a result, the Plan is a “hybrid entity” as that term is defined in 45 C.F.R. §164.103. The Plan’s covered function is the Health Care Flexible Spending Account. All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA Privacy Rules, Security Rules, and Breach Notification Rules with respect to the Health Care Flexible Spending Account.

11.10 HITECH Act. This Plan shall comply with the HITECH Act, and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of the HITECH Act, and any provision of this Plan, applicable law will control.

This Article only applies to health plan coverage within the Health Care Flexible Spending Account.
Article 12

Claims Procedure and Appeal

12.1 Application for Benefits. A Claimant shall make a claim for benefits by making a request pursuant to the procedures specified for each benefit in the various articles of this Plan. Except as otherwise provided in Section 7.14, a claim for reimbursement should be made during the Plan Year, but in no event later than the earlier of: (a) 90 days after the Claimant's termination of participation (unless he or she continues to participate in the relevant Plan, pursuant to its terms or COBRA, as of the last day of the Plan Year); or (b) 90 days following the close of the Plan Year. Any claims submitted after that time will not be considered. Unless otherwise provided for in this Plan, claims for benefits that are insured or are provided by another plan will be reviewed in accordance with the procedures contained in the insurance policies or the other plans. Unless otherwise provided for in this Plan, if a Claimant fails to follow the Plan’s procedures for filing a claim, the Claimant shall be notified of the failure and informed of the proper procedures to be followed in filing a claim for benefits within five days following the failure.

However, with regard to Employer provided debit or credit cards, use of the card is not considered a claim for benefits; a claim does not arise until a paper form has been submitted.

12.2 Timing of Notification of Initial Benefit Determination. A notice of an initial benefit determination will be timely provided to Claimant in accordance with 29 C.F.R. §2560.503-1(f) and as follows:

(a) General Rule for Benefits Other Than Group Health Plan and Disability Plan Benefits. If a claim is wholly or partially denied, the Administrator, with respect to benefits other than group health plan and disability plan benefits, shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after the receipt of a claim by the Plan, unless the Administrator determines that special circumstances require an extension of time of up to an additional 90 days from the end of the initial 90-day period for processing the claim. If an extension of time for processing is necessary, the Administrator will provide the Claimant with written notice of the extension, before the end of the initial 90-day period, explaining the special circumstances requiring an extension of time and the date by which the Plan expects to make a decision.

(b) Group Health Plan Benefits. In the case of a group health plan, the Administrator shall notify a Claimant of the Plan's benefit determination as follows:

(1) Pre-service Claims. In the case of Pre-service Claims, the Administrator shall notify the Claimant of the Plan’s benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. However, this period may be extended one time by the Plan for up to 15 days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan. The Administrator will provide the Claimant with notice of the extension before the end of the initial 15-day period, explaining the reason for the extension of time and the date by which the Plan expects to make a decision. If the extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice
of extension will specifically describe the required information and the Claimant shall have 45 days from receipt of the notice within which to provide the specified information. Failure to respond in a timely and complete manner will result in a benefit denial.

If the Claimant fails to follow the Plan's procedures for filing a Pre-service Claim (and if such failure is a communication (A) by a Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and (B) that communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested), the Administrator will provide oral notice (and in writing if requested by the Claimant) of the failure and the proper procedure to complete the claim, as soon as possible, but not later than five days following the failure.

(2) Post-service Claims. In the case of Post-service Claims, the Administrator shall notify the Claimant of the Plan’s Adverse Benefit Determination within a reasonable time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and the Administrator notifies the Claimant prior to expiration of the initial 30-day period of the reasons for the extension of time and the date by which the Plan expects to render a decision. If the extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant shall have 45 days from receipt of the notice within which to provide the specified information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

(3) Concurrent Care Claims. If the Plan has approved a Concurrent Care Claim:

(A) In the case of a reduction or termination by the Plan of an approved Concurrent Care Claim (other than by Plan amendment or termination) before the end of such approved period of time or number of treatments, the Administrator shall notify the Claimant of this Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(B) In the case of a request of a Claimant to extend the course of treatment beyond the period of time or number of treatments that is an Urgent Care Claim, the Administrator shall make a determination as soon as possible, taking into account the medical exigencies, and shall notify the Claimant of the benefit determination (whether adverse or not) within 24 hours after receipt of the claim by the Plan, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(4) Urgent Care Claims. In the case of Urgent Care Claims, the Administrator shall notify the Claimant of the Plan’s benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Administrator shall notify the Claimant as soon as possible, but not later than
24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but at least 48 hours, to provide the specified information. The Administrator will notify the Claimant of the Plan's benefit determination as soon as possible, but not later than 48 hours after the earlier of (A) the Plan's receipt of the specified information; or (B) the end of the period afforded the Claimant to provide the specified additional information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

If the Claimant fails to follow the Plan's procedures for filing a Pre-service Claim (and if such failure is a communication (A) by a Claimant that is received by a person or organizational unit customarily responsible for handing benefit matters; and (B) that communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested), the Administrator will provide oral notice (and in writing if requested by the Claimant) of the failure and the proper procedure to complete the claim, as soon as possible, but not later than 24 hours following the failure.

12.3 Content of Notification of Initial Benefit Determination. A notice of benefit determination will be sent to the Claimant in written or electronic format in a manner calculated to be understood by the Claimant and in accordance with 29 C.F.R. §2560.503-1(g). In the case of group health plan Urgent Care Claim, the Claimant may be informed orally and will be sent a written or electronic notification no later than three days after the oral notification. The notification to the Claimant of an Adverse Benefit Determination will generally include:

(a) the specific reason or reasons for the adverse determination;
(b) reference to the specific Plan provisions on which the determination is based;
(c) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
(d) a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the Claimant’s right to bring a civil action under ERISA section 502(a) following an Adverse Benefit Determination on review;
(e) If the claim involves a decision by a group health plan:

(1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; and

(2) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
(f) if the claim involves a decision by a group health plan concerning an Urgent Care Claim, a description of the expedited review process for such claims;

12.4 Appeal of Adverse Benefits Determinations. In accordance with 29 C.F.R. §2560.503-1(h), a Claimant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to an appropriate named fiduciary of the Plan and under which there will be a full and fair review of the claim and the Adverse Benefit Determination.

(a) Appealing Adverse Benefit Determination Not Pertaining to Group Health Plan Benefits or Disability Plan Benefits.

(1) A Claimant shall have 60 days following receipt of a notification of an Adverse Benefit Determination within which to appeal the determination to the appropriate named fiduciary of the Plan.

(2) A Claimant may submit written comments, documents, records and other information relating to the claim for benefits.

(3) A Claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant’s claim for benefits.

(4) The review will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) Appealing Adverse Benefit Determination Pertaining to Group Health Plan Benefits.

(1) A Claimant shall have 180 days following receipt of a notification of an Adverse Benefit Determination within which to appeal the determination to the appropriate named fiduciary of the Plan.

(2) The Plan shall comply with Section 12.4(a)(2)-(4).

(3) The review will not give deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the original determination subject to appeal, nor the subordinate of such individual.

(4) If the determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
(5) Medical or vocational experts consulted on behalf of the Plan in connection with the Claimant's Adverse Benefit Determination will be identified, whether or not the advice was relied upon in making the determination.

(6) The health care professional consulted under (4) shall be an individual not consulted in connection with the original determination, nor the subordinate of any such individual.

(7) If the claim involves an Urgent Care Claim, an expedited review process will occur, which may be requested orally or in writing by the Claimant and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

12.5 Timing of Notification of Benefits Determination on Review. A notice of a benefit determination upon review will be timely provided to Claimant in accordance with 29 C.F.R. §2560.503-1(i) and as follows:

(a) Generally. Unless otherwise provided for within this Plan, the Administrator shall notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of Claimant’s request for review by the Plan, unless the Administrator determines that special circumstances require an extension of time of up to 60 days from the end of the initial period for processing the claim. If the Administrator determines an extension of time for processing is required, written notice of the extension will be provided to the Claimant before the end of the initial 60-day period. The extension notice shall indicate the reasons for the extension of time and the date by which the Plan expects to render a decision.

(b) Group Health Plan Benefits.

(1) Pre-service Claims. The Administrator shall notify the Claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than: (i) 30 days after receipt by the Plan of Claimant’s request for review for review of an Adverse Benefit Determination (in the case of a group health plan that provides for one appeal of an Adverse Benefit Determination); or (ii) 15 days after receipt by the Plan of the Claimant's request for review of an Adverse Benefit Determination (in the case of a group health plan that provides for two appeals of an adverse determination and with respect to any one of such two appeals).

(2) Post-service Claims. The Administrator shall notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than: 60 days after receipt by the Plan of Claimant’s request for review of an Adverse Benefit Determination (in the case of a group health plan that provides for one appeal of an Adverse Benefit Determination); or (ii) 30 days after receipt by the Plan of the Claimant's request for review of an Adverse Benefit Determination (in the case of a group health plan that provides for two appeals of an adverse determination and with respect to any one of such two appeals).

(3) Urgent Care Claims. The Administrator shall notify the Claimant of the Plan's benefit determination on review as soon as possible (taking into account the medical circumstances).
exigencies) but not later than 72 hours after receipt of Claimant’s request for review of an Adverse Benefit Determination by the Plan.

12.6 Content of Notification of Benefit Determination on Review. A notice of the Plan's benefit determination on review will be sent to the Claimant in written or electronic format in a manner calculated to be understood by the Claimant and in accordance with 29 C.F.R. §2560.503-1(j). The notification to the Claimant of an Adverse Benefit Determination will generally include:

(a) the specific reason or reasons for the adverse determination;

(b) reference to the specific Plan provisions on which the benefit determination is based;

(c) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant’s claim for benefits;

(d) if any voluntary appeal rights exist, a statement describing any voluntary appeal procedures offered by the Plan and the Claimant’s right to obtain the information about such procedures and a statement of the Claimant’s right to bring an action under ERISA section 502(a);

(e) if the claim involves a decision by a group health plan:

(1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(2) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant’s medical circumstances, or a statement of such explanation will be provided free of charge upon request;

(3) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

NOTE: Subject to Section 12.7, if Claimant should initiate a lawsuit, it shall be brought within three years after exhaustion of the claims procedures.

12.7 Voluntary Levels of Appeal. To the extent that the Plan offers voluntary levels of appeal (except to the extent that the Plan is required to do so by state law), including voluntary arbitration or any other form of dispute resolution, in addition to those appeals rights provided in Sections 12.2 through 12.6:
(a) The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the Plan;

(b) Any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(c) A Claimant may elect to submit a benefit dispute to such voluntary level of appeals only after exhaustion of the appeals otherwise permitted by Section 12.2 through 12.6;

(d) The Plan will provide to any Claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the Claimant's rights to any other benefits under the Plan and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(e) No fees or costs will be imposed on the Claimant as part of the voluntary level of appeal.

12.8 Arbitration. The Plan shall not require arbitration of an Adverse Benefit Determination, except to the extent that: (a) the arbitration is conducted as one of the two appeals otherwise permitted by Sections 12.2 through 12.6 and in accordance with the requirements applicable to such appeals; and (b) the Claimant is not precluded from challenging the decision under ERISA section 502(a) or other applicable law.

Article 13

Amendment and Termination of the Plan

13.1 Amendment and Termination. Although the Plan Sponsor intends to maintain this Plan indefinitely, it reserves the right to amend or terminate the Plan at any time. The amendment or termination shall be made by a written instrument and shall be communicated to all Participants in writing. Any decision to amend or terminate the Plan and any and all benefits provided under the Plan shall be made either by the Board of Directors or by any person or persons authorized by the Board of Directors to take such action.

Coverage upon termination will be governed by the terms of the Plan; provided, however, that the rights of Participants and their Dependents upon termination of the Plan are limited to expenses incurred before termination.
Article 14

Miscellaneous Provisions

14.1 **Gender and Number.** Except where otherwise indicated by the context, as used in this agreement the masculine gender includes the feminine and neuter, and words used in the singular include the plural.

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

14.3 **Controlling Law.** The construction, validity and administration of the Plan shall be governed by the laws of the State of Michigan, to the extent such laws are not preempted by federal law. With respect to group health plans, those plans will provide benefits in accordance with COBRA, ERISA, NMHPA, USERRA, PPACA, the Mental Health Parity Act, as amended (“MHPA”); the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”); the Genetic Information Nondiscrimination Act of 2008 (“GINA”); the Family and Medical Leave Act of 1993, as amended (“FMLA”); HIPAA; and the Women’s Health and Cancer Rights Act of 1998, as amended (“WHCRA”) and other group health plan laws to the extent required by such laws.

14.4 **Participation in Plan Not Contract of Employment.** The establishment of the Plan, the creation of any account or the payment of any benefit does not create in any Employee, Participant, or other party a right to continuing employment with Employer. This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be consideration or an inducement for the employment of any Participant.

14.5 **Participants’ Rights.** Except as may be required by law, the existence of the Plan shall not give any Participant or beneficiary any equity or other interest in the assets, business or affairs of the Employer; the right to challenge any action taken by the Employer's officers, directors or stockholders, or any policy adopted or followed by the Employer; or the right to examine any of the books and records of the Employer. The rights of all Participants and their beneficiaries shall be limited to their right to receive payment of their benefits from the Plan when due and payable in accordance with the terms of the Plan.

14.6 **Information to be Furnished by Participants.** Participants shall provide the Employer and Administrator with information and evidence, and shall sign documents, as may be reasonably requested from time to time for the purpose of administration of the Plan.

14.7 **Assignment or Alienation of Benefits.** No benefits under this Plan may be voluntarily or involuntarily assigned or alienated, except pursuant to the terms of this Plan.

14.8 **NMSN.** With respect to benefits that are group health plans, the Plan shall provide benefits in accordance with the applicable requirements of any national medical support notice, or “NMSN,” Specifically, the Administrator shall adhere to the terms of any applicable NMSN that satisfies the requirements as set forth by law.
14.9 **State Recovery of Medicaid Payments.** Notwithstanding any other provision of this Plan to the contrary, if this Plan provides benefit payments on behalf of a covered person who is also covered by a state’s Medicaid program, the Plan shall be subject to the state’s right to reimbursement for benefits the state has paid on behalf of the covered person, provided that the state has an assignment of rights made by or on behalf of the covered person, or the covered person’s beneficiary, as may be required by the state medical assistance plan. Specifically, payment for benefits with respect to a Participant will be made in accordance with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of enactment of the Omnibus Reconciliation Act of 1993).

14.10 **Coordination with Medicaid.** Notwithstanding any other provisions of this Plan to the contrary, with respect to any benefit deemed a group health plan, this Plan shall comply with ERISA section 609(b). This Plan shall not take into account, with respect to Plan enrollment or the payment of benefits Participant or Participant's beneficiary, that such individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under title XIX of the Social Security Act.

14.11 **Honor of State Subrogation Rights.** Notwithstanding any other provision of this Plan to the contrary, the Plan will honor any subrogation rights that a state may have gained from a Medicare-eligible beneficiary covered by the Plan by virtue of the state’s having paid Medicare benefits, provided that the Plan has a legal liability for coverage. To the extent that payment has been made under a state plan for medical assistance approved under title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items of services.

14.12 **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 a Participant or to someone else (e.g., a health care provider) on a Participant's or a 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 the Participant or the provider. If the refund is not received from either the Participant or the provider, the overpayment will be deducted from future Plan benefits available to a Participant or a Dependent, but the amounts withheld may not reduce a Participant's pay below the applicable state minimum wage law to the extent permitted by law. Any overpayment a Participant owes due to his or a Dependents ineligibility for Plan benefits will be reduced by the amount of any contributions the Participant paid for coverage for the person while ineligible.

14.13 **Errors.** An error cannot give a benefit to an individual if an individual is not actually entitled to the benefit.
14.14 **Exclusive Benefit.** This Plan shall be maintained for the exclusive benefit of the Participants who participate in the Plan.

14.15 **Action by the Employer.** Whenever the Employer, under the terms of the Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

14.16 **No Guarantee of Tax Consequences.** Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant’s gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant’s gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

14.17 **Indemnification of Employer by Participants.** If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security or other tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax, plus any penalties, that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant’s share of any Social Security or other tax that would have been paid on such compensation, less any such additional income and taxes actually paid by the Participant.

14.18 **Funding.** Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

14.19 **COBRA Continuation of Coverage.** Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the continuation coverage requirement of Code section 4980B (the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X, as amended, (COBRA)), the Plan will be operated in accordance with Code section 4980B and any regulations and guidance thereunder.

14.20 **Family and Medical Leave Act (FMLA).** Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and any regulations and guidance thereunder, this Plan shall be operated in accordance with Treasury Regulation section 1.125-3 as well as FMLA and any regulations and guidance thereunder.
14.21 **Health Insurance Portability and Accountability Act (HIPAA).** Notwithstanding anything in this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of HIPAA, this Plan shall be operated in accordance with HIPAA and any regulations and guidance thereunder.

14.22 **Uniform Services Employment and Reemployment Rights Act (USERRA).** Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and any regulations and guidance thereunder.

14.23 **Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).** Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of MHPA and/or the MHPAEA, this Plan shall be operated in accordance with MHPA and/or the MHPAEA and any regulations and guidance thereunder.

14.24 **Genetic Information Nondiscrimination Act of 2008 (GINA).** Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of GINA, this Plan shall be operated in accordance with GINA and any regulations and guidance thereunder.

14.25 **Patient Protection and Affordable Care Act of 2010 (PPACA).** Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of PPACA, this Plan shall be operated in accordance with PPACA and any regulations and guidance thereunder.

14.26 **Severability.** If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

Executed this _____ day of ______________, 2020.

**Ingham County**

By: ________________________________

Jared Cypher, Interim Controller

Ingham County
Section 125 Second Amended and Restated
Flexible Benefit Plan
Ingham County

Section 125 Second Amended and Restated Flexible Benefit Plan

SUMMARY PLAN DESCRIPTION
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Ingham County
Section 125 Second Amended and Restated Flexible Benefit Plan

Summary Plan Description

A. Introduction

Effective January 1, 2005, Ingham County (“Employer”) adopted a flexible benefit plan for its Employees. The purpose of this Plan is to give Employees the flexibility to reduce their taxable cash compensation in order to obtain nontaxable dependent care benefits, medical benefits, and/or other health or welfare benefits.

Some of the benefits provided on a pre-tax basis are provided under separate plans or programs (e.g., your Employer’s group health plan or other group arrangements). This summary generally does not provide the full detail of these other benefit plans. For information on such plans, please consult the separate Summary Plan Descriptions for such plans. This Summary Plan Description does, however, describe the benefits available under your Employer’s Dependent Care Flexible Spending Account and Health Care Flexible Spending Account in full detail and shall constitute the Summary Plan Description for those benefit arrangements to the extent such a summary is required by law.

This Summary Plan Description has been prepared to generally explain the provisions of the Plan. It does not give the full details of the Plan, nor any separate plans or programs of the Employer. This Summary Plan Description is not meant to interpret, extend, or change the Plan in any way. In case of a conflict between this Summary and the actual provisions of the formal Plan document, the provisions of the Plan document will control.

B. Basic Information

B-1. Name of Plan: Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan.

B-2. Name, Address and Telephone Number of Plan Sponsor and Plan Administrator: Ingham County, 121 East Maple Street, Mason, Michigan 48854, (517) 676-7332.

B-3. Name and Address of the Contract Administrator of the Plan: Total Administrative Services Corporation (TASC), 2302 International Lane, Madison, Wisconsin 53704-3140.

B-4. Employer Identification Number: 38-6005629.

B-5. Type of Plan: Cafeteria plan.
B-6. **Effective Date of Plan:** January 1, 2005. The Plan has been amended several times since then. The effective date of this amendment and restatement is August 1, 2020.

B-7. **Agent for Service of Legal Process:** Ingham County Clerk, 341 S. Jefferson, Mason, Michigan 48854.

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

B-8. **Type of Administration of the Plan:** Employer Administered.

B-9. **Plan Year:** The Plan Year starts on each January 1 and ends on each December 31.

B-10. **Employer:** Employer means Ingham County and any successor which shall maintain this Plan.

### C. Rules for Eligibility and Participation in the Plan

C-1. **When am I Eligible to Participate in the Plan?** Unless otherwise provided in a collective bargaining agreement, you will be eligible to participate in the Plan if you meet each of the following requirements:

   (a) You are an "Employee," which means any person that the Employer classifies as a common law employee and who is on the Employer’s W-2 payroll, but does not include (i) leased employees (including individuals defined as leased employees in Code section 414(n)), contract workers, independent contractors, temporary employees or casual employees for the period such individual is so classified by the Employer, whether or not any such individual is on the Employer’s W-2 payroll or is determined by a court, regulatory agency or others to be a common law employee of the Employer; (ii) individuals who perform services for Employer 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 the Employer; (iii) self-employed individuals; (iv) partners in a partnership; (v) non-employee directors; and (vi) any more-than-2% shareholder in an S corporation.

   (b) You are eligible for the Employer's group health plan.

   (c) You are 18 years of age.

   (d) You are a permanent Employee and are regularly scheduled to work at least 20 hours per week (unless otherwise specified for permanent employment in your collective bargaining agreement, if applicable). However, newly transferred Employees who were employed on a full-time basis by the Ingham County Road Commission as of May 30, 2012, who were eligible for the Ingham County Road Commission’s Cafeteria Plan, and who were transferred to Ingham County effective June 1, 2012, are ineligible for this Plan until January 1, 2013.
(e) You are not a temporary employee.

(f) Eligibility for HSA Benefits also requires that you be an "HSA-Eligible Individual." This means that you are eligible to contribute to an HSA under the requirements of Internal Revenue Code (the "Code") section 223 and that you: (i) have elected qualifying High Deductible Health Plan coverage offered by the Employer ("High Deductible Health Plan" or "HDHP" means the high deductible health plan offered by your Employer that is intended to qualify as a high deductible health plan under Code section 223(c)(2), as described in materials that will be provided separately to you by the Employer); (ii) are not enrolled in any disqualifying non-High Deductible Health Plan coverage, whether or not through the Employer (including the General-Purpose Health Care Flexible Spending Account option solely as the result of a carryover of unused amounts in a Health Care Flexible Spending Account from the prior Plan Year); (iii) are not enrolled in Medicare; and (iv) may not be claimed as a dependent on another person's tax return. If you elect HSA benefits, you will be required to certify that you meet all of the requirements under Code section 223 to be eligible to contribute to an HSA.

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

C-2. When Will My Participation Begin? With regard to the benefits described in Sections D-1(a), D-1(b), D-1(d), and D-1(e), you will become a Participant in the Plan the later of the date you satisfy the eligibility requirements or the Effective Date of this Plan. However, if you are a new Employee and became eligible under Section C-1 as of the date of hire, your participation in this Plan is retroactive to your date of hire if you make your election within thirty (30) days after your hire date. This provision does not apply if you terminate employment and arerehired within 30 days or if you return from an unpaid leave of absence of less than 30 days. Moreover, the salary reduction amounts for retroactive coverage can only be made from compensation not yet available on the date of the election.

With regard to the other benefits under this Plan described in Section D-1(e), your participation will begin the first day of the Plan Year following the date you become eligible, or the Effective Date of this Plan if later.

C-3. When Will My Participation End and Under What Circumstance Will It Be Reinstated? Your participation in the Plan will end when you:

(a) cease employment with the Employer;

(b) you lose eligibility under the plan;
(c) the Plan terminates; or

(d) you revoke your election as provided in the Plan.

While coverage ceases for the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account on the date of the event, underlying group health care coverage will cease at the end of the month in which the event occurs. Termination of participation will automatically revoke your elections and benefits as of the dates specified in the insurance or other benefit plans. You may also be entitled to continue certain benefits pursuant to state and federal law after your participation ends.

Except as indicated below, if your participation ended and you again become eligible, you may begin participation at the time provided in Section C-2. If you terminate employment for any reason, including, but not limited to, disability, retirement, layoff or voluntary resignation, and then are rehired within 30 days or less of the date of a termination of employment, you will be reinstated in this Plan accordingly to your previous elections and will not be allowed to make a new election. If you terminate employment and are not rehired within 30 days or cease to be eligible for any other reason, including, but not limited to, a reduction in hours, you must complete the eligibility requirements described in Section C-1 before again becoming eligible to participate in the Plan. A new election may then be made. An HSA benefit election will only be reinstated if you are an HSA-Eligible Individual.

C-4. How will Participating in the Plan Affect My Social Security and Other Benefits? 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.

C-5. Do I Have the Option of Continuing Some of My Benefits After My Participation Ends? You may have the right to continue your group health plan benefits pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time (“COBRA”). COBRA continuation coverage is a temporary extension of group health plan coverage under the Plan under certain circumstances when coverage would otherwise end. COBRA coverage may become available to you when you would otherwise lose your group health plan coverage under the Plan. Generally, this means you may be able to continue the same group health plan coverage that you had immediately before the Qualifying Event. It can also become available to your spouse and dependent children (as set forth in 26 U.S.C. §4980B(g)(1)), if they are covered under the Plan, when they would otherwise lose their group health plan coverage under the Plan.

If you are or were provided coverage under your Employer’s group health plan, you are considered a “covered employee.” The terms “covered employee” and “you” are used interchangeably for purposes of this Section. Your spouse and dependent children (as set forth in 26 U.S.C. §4980B(g)(1)) who are covered under the same plan before the date of the Qualifying Event are considered to be “Qualified Beneficiaries.” A Qualified Beneficiary also includes a
child who is born to or placed for adoption with the covered employee during the COBRA coverage and any individual defined as such in 26 U.S.C. §4980B(g)(1). These terms will be used throughout the remainder of this Section. The continuation coverage will not be conditioned on a physical examination or other evidence of insurability and will be identical to the coverage provided to similarly-situated employees or family members.

However, special rules exist with regard to COBRA’s application to a Health Care Flexible Spending Account. See Section C-5(l).

(a) Qualifying Event. The term "Qualifying Event" means any of the following events which, but for COBRA continuation coverage, would result in the loss of coverage of you or a Qualified Beneficiary:

(1) For Covered Employees. You are entitled to elect COBRA if you lose your group health plan coverage under the Plan because of the termination of your employment (for reasons other than your gross misconduct) or reduction in your hours of employment.

(2) For Qualified Beneficiaries. Your Qualified Beneficiaries shall have the right to continuation coverage for themselves if they lose group health plan coverage under the Plan for any of the following reasons:

(A) your death;

(B) the termination of your employment (for reasons other than your gross misconduct) or reduction in your hours of your employment;

(C) your divorce or legal separation from your spouse;

(D) you become entitled to benefits under Title XVIII of the Social Security Act (Medicare); or

(E) your dependent child ceases to be a dependent child under the generally applicable requirements of the Plan.

(3) Loss of Coverage Defined. An event described above is only a “Qualifying Event” if it causes a loss of coverage for you or a Qualified Beneficiary under the group health plan. For this purpose, "loss of coverage" generally means to cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event (including any increase in the premium or contribution that must be paid by you (or your spouse or dependent child) for coverage under the group health plan). 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.
(b) **Type of Coverage.** Continuation coverage under this provision is coverage which is identical to the coverage provided to similarly-situated beneficiaries under the group health plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under the group health plan is modified for any group of similarly-situated beneficiaries, then coverage shall also be modified in the same manner for all qualified beneficiaries under the group health plan in connection with such group.

(c) **Duration of Coverage.** The coverage under this provision will extend for at least the period beginning on the date coverage is lost as a result of a Qualifying Event (unless otherwise provided) and ending not earlier than the earliest of the following:

1. In the case of a terminated covered employee (except for termination for gross misconduct) or a covered employee whose hours have been reduced, and his or her Qualified Beneficiaries, the date which is 18 months after the date coverage is lost as a result of the Qualifying Event;

2. In the case of any Qualifying Event except as described in (c)(1) above, for the Qualified Beneficiaries, the date which is 36 months after the date coverage is lost as a result of the Qualifying Event;

3. In the case of a covered employee or Qualified Beneficiary who is disabled at some point before the 61st day after the date coverage is lost as a result of the Qualifying Event as described in (c)(1) and the disability lasts until the end of the 18 month period, the date which is 29 months after the date coverage is lost as a result of the Qualifying Event, provided the Plan Administrator is given notice of the Social Security disability determination within 18 months of the date coverage is lost as a result of the Qualifying Event and within 60 days of the later of (i) the disability determination; (ii) the Qualifying Event; or (iii) the date coverage was lost as a result of the Qualifying Event;

4. In the case of a second Qualifying Event (must be an event described in (c)(2)) which occurs during the 18 months after the date coverage is lost as a result of the first Qualifying Event described in (c)(1), for the Qualified Beneficiaries, the date which is 36 months after the date coverage is lost as a result of the first Qualifying Event;

5. In the case of a loss of coverage due to termination (except for gross misconduct) or reduction in hours of a covered employee which occurs within 18 months after the employee's entitlement to Medicare, for the Qualified Beneficiaries, the date which is 36 months from the date of entitlement to Medicare;

6. The date on which the participating Employer ceases to provide any group health plan to any employee;

7. The date on which coverage ceases under the Plan by reason of failure to make timely payment of the required contribution pursuant to this provision;
The date on which the covered employee or Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan, (as an employee or otherwise) or becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the plan will not cease while such preexisting condition limitation under the other group plan remains in effect, subject to the maximum period of coverage limitations set forth in this Section;

The first day of the month beginning more than 30 days after the date on which the disabled covered employee or Qualified Beneficiary is determined by the Social Security Administration to be no longer disabled;

In the case of coverage under the Health Care Flexible Spending Account, the last day of the Plan Year within which the Qualifying Event occurred; or

COBRA may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

(d) **Cost of Coverage.** COBRA permits the Plan to require payment of an amount that does not exceed 102 percent of the applicable premium (i.e., the full cost to the Plan, including both employer and employee contributions) for coverage for similarly situated beneficiaries with respect to whom a Qualifying Event has not occurred). If coverage is continued due to a disability, COBRA permits the Plan to require the payment of an amount that does not exceed 150 percent of the applicable premium for any period of COBRA coverage if the coverage would not be required to be made available in the absence of a disability extension (e.g., for the last 11 months of the 29-month period during which coverage may continue).

(e) **Payment of Premium.**

A covered employee or Qualified Beneficiary shall only be entitled to continuation coverage provided that he or she pays the applicable premium required by the Employer in full and in advance, except as provided in (2) below. Such premium shall not exceed the maximum thresholds of applicable federal law. A Qualified Beneficiary or covered employee may elect to pay such premium in monthly installments.

Except as provided in (3) below, the payment of any premium shall be considered to be timely if made to the Plan within 30 days after the first day of the applicable period of coverage, or within such longer period of time as permitted under the Plan.

Notwithstanding (1) and (2) above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.
(f) **You Must Notify Plan Administrator of Certain Qualifying Events.**

(1) The Plan will offer COBRA continuation coverage to you and/or your Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. It is the responsibility of the covered employees and Qualified Beneficiaries to provide the following notices to the Plan Administrator:

(A) Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered employee from his or her spouse;

(B) Notice of the occurrence of a Qualifying Event that is a Qualified Beneficiary ceasing to be covered under the Plan as a dependent child;

(C) Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(D) Notice that a covered employee or Qualified Beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(E) Notice that a covered employee or Qualified Beneficiary: (i) with respect to whom a notice described in paragraph (1)(D) of this Section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled, or (ii) subsequently becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of the other plan have been exhausted or satisfied).

(2) Notice to the Plan Administrator must be made in writing and must be mailed or hand-delivered to:

Human Resources Department
Ingham County
121 East Maple Street
Mason, Michigan 48854

Oral notice or electronic notice (by e-mail or facsimile) is not acceptable. If mailed, the notice must be postmarked no later than the deadline described below. If hand-delivered, notice must be received by the individual at the address above no later than the deadline described below.

(3) **Required Contents of Notice.** The notice must at a minimum contain the following information:

(A) the name of the Plan;
(B) the name and address of the employee or former employee who is or was covered under the Plan;

(C) the nature of this Qualifying Event, and, if applicable, the nature of the initial Qualifying Event that started your COBRA coverage, including any verifying documentation which may be required by the Plan Administrator;

(D) the date of this Qualifying Event, and, if applicable, the initial Qualifying Event;

(E) the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event or initial Qualifying Event, and, if applicable, whether those individuals are receiving COBRA coverage at the time of this notice;

(F) if the notice is for a disability extension, the name and address of the disabled covered employee or Qualified Beneficiary;

(G) if the notice is for a disability extension, the date that the covered employee or Qualified Beneficiary became disabled;

(H) if the notice is regarding a disability extension, the date that the Social Security Administration made its determination of disability. Additionally, a copy of the Social Security Administration's disability determination letter must be attached;

(I) if the notice is regarding (a) the Social Security Administration subsequently determining that the covered employee or Qualified Beneficiary is no longer disabled or (b) subsequent entitlement of Medicare or coverage under another group health plan, the initial Qualifying Event and the subsequent event terminating coverage and the dates they occurred; and

(J) the signature, name, and contact information of the individual sending the notice.

Furthermore, the Plan requires that the following documents, if relevant to the particular Qualifying Event, be provided with the notice: Death Certificate; Divorce Decree or Legal Separation Agreement; Birth Certificate or Order of Adoption; Marriage Certificate; Social Security Administration's Disability Determination Letter; Spouse’s Notice of Employment Termination or Proof of Loss of Coverage; Qualified Domestic Relations Order.

Any notice that does not contain all of the information required by the Plan must be supplemented in writing within 15 business days with the additional information necessary to meet the Plan's reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this Section. Otherwise, you and your Qualified Beneficiaries will lose the right to elect COBRA.
(4) Time Periods to Provide Notice. If written notice is not provided within the time periods provided below, the covered employee and Qualified Beneficiaries will lose the right to elect COBRA:

(A) Time limits for notices of Qualifying Events. The notice described in paragraph (f)(1)(A), (B), or (C) of this Section must be furnished 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.

(B) Time limits for notice of disability determination. A notice described in paragraph (f)(1)(D) of this Section must be furnished before the end of the first 18 months of continuation coverage and within 60 days after the latest of: (i) the date of the disability determination by the Social Security Administration; (ii) the date on which the Qualifying Event occurs; or (iii) 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.

(C) Time limits for notice of change in disability status, subsequent Medicare entitlement or coverage under another group health plan. The notice described in paragraph (f)(1)(E) of this Section must be furnished within 30 days after the date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the covered employee or Qualified Beneficiary is no longer disabled or the date the covered employee or Qualified Beneficiary becomes entitled to Medicare or covered under other group health plan coverage.

(5) Person to Provide Notice. With respect to each of the notice requirements of this Section, any individual who is either the covered employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered employee or Qualified Beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

(g) Employer Must Notify Plan Administrator of Certain Qualifying Events. Upon the occurrence of a Qualifying Event that is the covered employee's death, termination of employment (other than by reason of gross misconduct), reduction in hours of employment, Medicare entitlement or commencement of a bankruptcy proceeding of the employer, the Employer must notify the Plan Administrator within 30 days of the date coverage is lost as a result of the Qualifying Event.

(h) Notification to Qualified Beneficiary.

(1) The Plan Administrator (or entity which it has hired) shall provide written notice within 14 days after receipt of the notice of Qualifying Event to each covered employee and spouse of such covered employee of his/her right to continuation coverage and the cost, if any, under this provision as required by federal law. However, in the case where the Employer is the Plan Administrator and the Employer is otherwise required to furnish a notice of
a Qualifying Event to the Plan Administrator, the Plan Administrator shall provide written notice within 44 days after the date coverage is lost as a result of the Qualifying Event.

(2) The Plan Administrator (or entity which it has hired) shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the Qualifying Event is the divorce or legal separation of the covered employee from the covered employee's spouse or a dependent child ceasing to be a dependent under the terms of this Plan, the Plan Administrator shall only be required to notify a covered employee or Qualified Beneficiary of his/her right to elect continuation coverage if the covered employee or the Qualified Beneficiary notifies the Employer of such Qualifying Event as previously stated. Additionally, the right to extend COBRA coverage may only be provided upon the Plan Administrator receiving proper notice.

(3) Notification of the requirements of this provision to a Qualified Beneficiary who is the spouse of a covered employee shall be treated as notification to all other Qualified Beneficiaries residing with such spouse at the time notification is made.

(i) Election of COBRA. You and your Qualified Beneficiaries each will have an independent right to elect COBRA continuation coverage and shall have 60 days to elect COBRA from the later of (1) the date on which coverage would be lost on account of the Qualifying Event; or (2) the date notice of the right to elect COBRA continuation coverage is provided. 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. Any covered employee and/or Qualified Beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA coverage.

You and/or your Qualified Beneficiaries then shall have 45 days after the date on which the COBRA election is made to pay for any required premium. Thereafter, payment is timely if made within the time periods of the Plan or 30 days of the due date.

(j) Special Election Period. Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if such election is made within the six months immediately after the date of the TAA/ATAA-related loss of coverage. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Employer promptly or you will lose the right to elect COBRA during a special second election period.

(k) Interaction with FMLA. If your Employer is subject to the Family and Medical Leave Act and you do not return to work from your FMLA leave, you and your Qualified Beneficiaries may be entitled to continuation coverage under COBRA. A Qualifying Event under
COBRA generally will occur if: (1) you and your Qualified Beneficiaries are covered under your Employer’s group health plan on the day before the first day of FMLA leave (or become covered during the FMLA leave); (2) you do not return to employment with the Employer at the end of the FMLA leave, and (3) you and your Qualified Beneficiaries would, in the absence of COBRA, lose coverage under the group health plan before the end of the maximum coverage period. Such Qualifying Event occurs on the last day of the FMLA leave. The last day of FMLA leave may be the date you notify the Employer that you will not be returning to work, if the notification was given before the FMLA was set to expire.

(l) Application of COBRA to Health Care Flexible Spending Account. COBRA coverage under the Health Care Flexible Spending Account will be offered only to covered employees or 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 Care Flexible Spending Account COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health Care Flexible Spending Account coverage in force at the time of the Qualifying Event (i.e., the elected annual limit (including any carryover amount) 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 and covered employees who were covered under the Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account COBRA coverage. Qualified beneficiaries or covered employees may not enroll in the Health Care Flexible Spending Account at open enrollment.

C-6. What Happens to My Coverage if I Take Leave Under the 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 medical, dental, vision and prescription coverage and Health Care 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 medical, dental, vision and prescription coverage and Health Care 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 medical, dental, vision and prescription coverage and Health Care 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 medical, dental, vision and prescription coverage and Health Care Flexible Spending Account coverage, 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 medical, dental, vision or prescription coverage or Health Care 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 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.

C-7. What Happens to My Coverage if I Enter or Return From Military Service? Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may have special rights to health care coverage under your Health Care Flexible Spending Account. These rights can include extended health care coverage. If you may be affected by this law, ask your Plan Administrator for further details.

D. Benefits Available Under the Plan

D-1. What Benefit Options are Available Under the Plan? Your Employer adopted this Plan to provide you with the flexibility to elect among permitted taxable benefits and qualified nontaxable benefits offered through this Plan for the Plan Year. Specifically, and unless otherwise provided in a collective bargaining agreement (if applicable), you may elect to receive your normal compensation in cash or to reduce that compensation to receive Employer-provided coverage on a pre-tax basis for:

(a) Premium Payment options, including medical, prescription, vision or dental coverage under your Employer’s Group Health, Group Vision and Group Dental Plans or other benefit plans (which are incorporated by reference);

(b) Health Savings Account ("HSA") benefits, for an HSA established and maintained outside of the Plan with the Employee’s HSA trustee/custodian. However, these benefits cannot be elected with Health Care Flexible Spending Account benefits unless the Limited-Purpose Health Care Flexible Spending Account and/or the Post-Deductible Health Care Flexible Spending Account options are selected. In no event shall Benefits under the Plan be provided in the form of deferred compensation. For the Plan Year 2020, the Employer will contribute to the HSA in the amount of $600.00 for HAS-Eligible Individuals who elected single HDHP coverage and $1,200.00 for HSA-Eligible Individuals who elected family HDHP coverage, which will be directly deposited into the Account; these amounts are subject to change for future years and will be communicated to Plan Participants.

If you are covered by the General-Purpose Health Care Flexible Spending Account option solely as the result of a carryover of unused amounts in a Health Care Flexible Spending Account from the prior Plan Year, then you may not contribute to an HSA even for months in the Plan Year after the Health Care Flexible Spending Account no longer has any amounts available to pay or reimburse medical expenses.

However, if you participate in the General-Purpose Health Care Flexible Spending Account option in a Plan Year and elect, for the following Plan Year, to participate in the Limited-Purpose Health Care Flexible Spending Account and/or Post-Deductible Health Care Flexible Spending Account options, then you may elect to have any amounts from the General-Purpose Health Care Flexible Spending Account option carried over to the Limited-Purpose Health Care Flexible Spending Account and/or Post-Deductible Health Care Flexible Spending Account options in accordance with Section D-23. In such case, you are eligible to contribute to an HSA.
for the following Plan Year if you are otherwise eligible under Code section 223(c)(1)(A). During the 90-day run-out period for the General Purpose Health Care Flexible Spending Account option, the unused Health Care Spending Account amounts may be used to reimburse any allowed section 213(d) medical expenses incurred prior to the end of the General-Purpose Health Care Flexible Spending Account option Plan Year. Any claims covered by the Limited-Purpose Health Care Flexible Spending Account and/or Post Deductible Health Care Flexible Spending Account options must be timely reimbursed up to the amount elected for the Limited-Purpose Health Care Flexible Spending Account and/or Post Deductible Health Care Flexible Spending Account options Plan Year; any claims in excess of the elected amount may be reimbursed after the 90-day run-out period when the amount of any carryover is determined.

(c) Dependent Care Flexible Spending Account benefits;

(d) Health Care Flexible Spending Account, including election of one of the following options:

(1) General-Purpose Health Care Flexible Spending Account benefits, which allows reimbursement of Qualifying Medical Care Expenses as described in Section D-12 (this option cannot be elected with the HSA);

(2) Limited-Purpose Health Care Flexible Spending Account benefits, which allows reimbursement of coverage expenses for vision care, dental care, or preventive care benefits as described in Section D-12; or

(3) Post-Deductible Health Care Flexible Spending Account benefits, which allows reimbursement of Qualifying Medical Care Expenses, as described in Section D-12, after the requisite deductible has been met. Specifically, Qualifying Medical Care Expenses incurred prior to satisfaction of the applicable deductible required under the HDHP will not be reimbursed.

The Limited-Purpose and the Post-Deductible Health Care Flexible Spending Account options may be selected together.

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

Although the Employer also maintains an HRA, the salary reduction has no interaction with the HRA and does not provide any funding toward the HRA. Thus, the mere fact that an individual participates in any of the above benefits funded pursuant to a salary reduction election does not result in attributing the salary reduction to the HRA. An "HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

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, it shall mean the portion of the Plan Year coinciding with and following the date participation commences, as
D-2. **Can I Elect to Receive Cash in Lieu of Coverage Available Under the Group Health Plan?** Yes, but only if you meet the requirements of Sections D-2, D-3 and E-2. Unless otherwise provided in a collective bargaining agreement, the Plan permits Participants who are eligible to receive medical coverage under the Employer’s Group Health Plan to elect a monthly cash payment in lieu of provided medical coverage under the Group Health Plan, provided that the Participant meets the requirements of Sections D-2, D-3 and E-2. The amount of the monthly cash payment in lieu of medical coverage is $131.22 for single coverage, $222.22 for two-person coverage or $249.66 for family coverage. These amounts are subject to change on an annual basis and will be communicated to you during the open enrollment period. If you experience a change in election event described in Article H, you will be permitted as the Group Health Plans allow, to revoke this election and make a new election. Upon revocation, the cash payment shall cease.

D-3. **What are the Restrictions on Electing to Receive Cash in Lieu of Coverage Available Under the Group Health Plan?** In order to receive a monthly cash payment when waiving Group Health Plan coverage, you must provide reasonable evidence at least one time each Plan Year that:

(a) You are (or will be) enrolled in alternative "minimum essential coverage" from another employer-sponsored group health plan (other than Ingham County, unless as otherwise specified in a collective bargaining agreement) for the Plan Year (or that portion of the Plan Year) to which the cash waiver applies; and

(b) Each member of your "expected tax family" is (or will be) enrolled in alternative minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) for the Plan Year (or that portion of the Plan Year) to which the cash waiver applies.

"Minimum essential coverage" is any insurance plan that meets the Affordable Care Act requirement for having health coverage and is described in Code section 5000A(f) (other than coverage in the individual market, whether or not obtained through the Marketplace).

Your "expected tax family" includes all individuals for whom you reasonably expect to claim a personal exemption deduction under Code section 151 for the taxable year or years that begin or end in or with the Plan Year to which to cash waiver applies.

Additionally, Employer will not make the cash waiver payment if it knows or has reason to know that you, or any member of your expected tax family, do not (or will not) have alternative minimum essential coverage during the eligible Plan Year. If after the start of the Plan Year, the alternative coverage subsequently terminates for you and/or any member of your expected tax family, you must immediately notify Employer, at which time the cash waiver payment will cease.
D-4. Can I Pay the Employee Cost of Coverage Under the Group Health Plan with Pre-tax Dollars Under the Plan? Yes. The Plan will allow you to reduce your pay in pre-tax dollars to make the required Employee contribution to purchase coverage under the Employer’s Group Health 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 Health Plan benefits will be provided by separate plans governed by separate plan documents.

D-5. Can I Purchase Dependent Care Flexible Spending Account Benefits with Pre-tax Dollars Under the Plan? Yes. 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 Qualifying Dependent Care Expenses, as defined in Section D-10 below, incurred by you during the Plan Year. 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 must, by federal law, be forfeited. Any reimbursements you receive for Qualifying 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.

D-6. What is My Limitation on Dependent Care Flexible Spending Account Benefits? The reimbursement (when combined with all other reimbursements received by you under the Plan during the same calendar year) may not exceed your Account Balance, nor the least of the following limits:

(a) Your earned income for the calendar year (i.e., wages, salary, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year).

(b) If you are married, your spouse’s actual or deemed earned income.

(c) $5,000 (reduced to $2,500 in the case of a separate return filed by a married person as defined in Code section 21(e)).

For purposes of (b) above, your spouse will be deemed to have earned income of $250 ($500 if you have two or more dependents), for each month in which your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student at an educational institution.

D-7. Can I Purchase Health Care Flexible Spending Account Benefits with Pretax Dollars Under the Plan? Yes. The Plan allows you to reduce your compensation by an amount not to exceed $2,700.00 (may be adjusted by the Employer for future years and will be communicated to Plan Participants on an annual basis) per Plan Year (even if more than one Health Care Flexible Spending Account is selected) and have the amount of the reduction credited to a Health Care Flexible Spending Account for your benefit. You can then draw on your account during the Plan Year for reimbursement of Qualifying Medical Care Expenses, as defined in
Section D-12, incurred by you during your period of 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 any unused amounts in excess of $550.00 [as adjusted pursuant to Section D-23] remaining in your Health Care Flexible Spending Account at the end of the Plan Year must, by federal law, be forfeited. See Section I-1 for further information. Any reimbursements you receive for Qualifying Medical 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.

D-8. **Who is Entitled to the Allocations in My Account(s)?** The Dependent Care Flexible Spending Account and the Health Care Flexible Spending Account are not separate funds from the Employer’s assets. These Accounts are created by the Employer for recordkeeping purposes only to keep track of contributions and to determine forfeitures.

D-9. **How Much Will My Salary be Reduced?** This is entirely up to you. 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. In making this decision you should realize that any amounts remaining in both your Dependent Care Flexible Spending Account after you have been reimbursed for all Qualifying Dependent Care Expenses incurred during the Plan Year will, as required by federal law, be forfeited. In making this decision you should realize that any amounts remaining in both your Health Care Flexible Spending Account after you have been reimbursed for all Qualifying Medical Care Expenses incurred during the Plan Year will, as required by federal law, be forfeited. See Section I-1 for further information. 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 Qualifying Medical Care Expenses.

D-10. **What are Qualifying Dependent Care Expenses?** Under the Plan you will be reimbursed only for dependent care expenses meeting **all** of the following conditions:

(a) The expenses are incurred for services rendered: (i) on or after the date that your election to receive Dependent Care Flexible Spending Account benefits becomes effective; and (ii) during the Plan Year to which it applies.

(b) Each individual for whom you incur the expenses is:

1. your dependent (who is a qualifying child within the meaning of Internal Revenue Code section 152) who has not attained age 13, or

2. your spouse or dependent (as defined in Section 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 who has the same principal place of abode as you for more than half of such taxable year.
However, in circumstances of legally separated or divorced parents or parents who live apart at all times during the last six months of the calendar year, a child as described in this subsection (b) and in Code sections 21(e)(5) and 152(e) will be the "dependent" of the parent having custody for the greater portion of the calendar year.

(c) The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you (and your spouse) to be gainfully employed, with the exception for short, temporary absences. If your spouse is not working or actively looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self care. The expenses must be incurred when at least one member of your household meets (b)(1) or (b)(2) above.

(d) The expenses are not paid or payable to a child of yours (within the meaning of Section 152(f)(1)) who is under age 19 at the end of the year in which the expenses are incurred, to an individual for whom you or your spouse are entitled to a personal tax exemption as a dependent, to your spouse, or to the parent of your child as described in (b)(1) above.

(e) If the expenses are incurred for services outside your household, they will be reimbursed if the dependent who is described in (b)(1) above, or the spouse or dependent who is described in (b)(2) above, regularly spends at least eight hours per day in your household. The expenses may not be paid for services outside your household at a camp where the dependent stays overnight.

(f) If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

D-11. Would I be Better Off Taking the Child Care Tax Credit Rather Than Reducing My Salary and Electing Dependent Care Flexible Spending Account? 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.
D-12. **What Are Qualifying Medical Care Expenses?** The term “Qualifying Medical Care Expenses” has different meanings for each of the three Health Care Flexible Spending Account options, for:

(a) General-Purpose Health Care Flexible Spending Account benefits, it means expenses incurred during the Coverage Period by the individuals described below for medical care as defined in Code section 213(d), as limited by section 213(b), and only as allowed to be reimbursed under Code section 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 Care 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 section 7702B(c) or any premium payments for health care coverage. With the exception of advance payments for orthodontia, qualifying Medical 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 Medical Care Expenses include expenses incurred on or after January 1, 2020 for a medicine or a drug (regardless of prescription) and menstrual care products;

(b) Limited-Purpose Health Care Flexible Spending Account benefits, it means the expenses described in Section D-12(a), but are limited to unreimbursed section 213(d) expenses for:

1. Services or treatments for dental care (excluding premiums);
2. Services or treatments for vision care (excluding premiums); or
3. Services or treatments for preventive care as defined in Code section 223(c)(2)(C). Preventive care for purposes of section 223(c)(2)(C) includes, but is not limited to, the following: periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals; routine prenatal and well-child care; child and adult immunizations; tobacco cessation programs; obesity weight-loss programs; and screening services. (This may also include any drugs or medications to the extent that such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking cessation or weight-loss program). However, preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition;

(c) Post-Deductible Health Care Flexible Spending Account benefits, means the expenses described in Section D-12(a), but are limited to expenses for services incurred after the High Deductible Health Plan deductible has been met.

Qualifying Medical Care Expenses for purposes of the General-Purpose and Post-Deductible options include, for example, expenses you have incurred for:
(a) Medicine and drugs (regardless of prescription) and menstrual care products.

(b) Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).

(c) Medical examination, x-ray and laboratory service, and insulin treatment the doctor ordered.

(d) Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.

(e) Hospital care (including meals and lodging), clinic costs, lab fees.

(f) Inpatient medical treatment at a center for drug addicts or alcoholics (including meals and lodging).

(g) Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.

(h) Weight-loss program participation expenses only if the purpose of participation is to treat a specific disease or diseases as diagnosed by a physician. Diet food items are not a Qualifying Medical Care Expense.

(i) Ambulance service and other travel costs to get medical care. If you used your own car, you can claim what you spent for gas and oil to go to and from the place you received the care; or you can claim mileage at the rate listed in IRS Publication 502, located at www.irs.gov. Add parking and tolls to the amount you claim under either method.

You cannot obtain reimbursement for:

(a) The basic cost of Medicare insurance (Medicare A).

(b) Life insurance or income protection policies.

(c) The hospital insurance benefits tax withheld from your pay as part of the social security tax or paid as part of social security self-employment tax.

(d) Nursing care for a healthy baby.

(e) Illegal operations, treatments or drugs.

(f) Travel your doctor told you to take for rest or change.

(g) Funeral expenses.
(h) Insurance premiums.

(i) Long-term care expenses.

**Qualifying medical expenses include only those expenses incurred for:**

(a) Yourself.

(b) Your spouse.

(c) Your dependents (as defined in Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B)). The definition of “Dependent,” for purposes of this Section, also includes your child (as defined in Code section 152(f)(1)) until the end of the calendar month in which the child turns 26 years of age. The definition of “child” for this purpose shall not include a child of your child.

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

**D-13. Are Medical Expenses for Which I Receive Reimbursement Eligible for a Tax Deduction?** Generally, individuals can only deduct medical expenses to the extent they exceed 10 percent (this amount may further change pursuant to law) of their adjusted gross income. Expenses reimbursed by your Employer are not counted towards meeting this threshold and would not otherwise be deductible.

**D-14. Can I Pay for Medical Care and Dependent Care Expenses with an Employer Provided Debit or Credit Card?** Yes. Your Employer has provided you with the opportunity to access funds in your Health Care Flexible Spending and/or Dependent Care Flexible Spending Accounts through the use of debit cards. When you are issued a card, you must certify upon enrollment in the Health Care Flexible Spending and/or Dependent Care Flexible Spending programs, and each Plan Year thereafter, that the card will only be used for Dependent Care and/or Qualifying Medical Care Expenses for yourself, your spouse or dependents, and that the expense has been incurred as the service has been provided. You must further certify that any expense paid with the card has not been otherwise reimbursed and that the Participant will not seek reimbursement under any other plan covering these benefits. With regard to the Dependent Care Flexible Spending program, you must also certify that you and your spouse, if any, are “gainfully employed” and that the expenses paid with the debit card are for the “care” of the Dependent who is a “Qualifying Individual.” These certifications are reaffirmed each time the card is used. You must agree to retain sufficient documentation for any expense paid with the card, including invoices and receipts, where appropriate. The card is automatically canceled at termination of participation in the program.
Use of the card is limited to the maximum dollar amount of coverage available in your Health Care Flexible Spending and/or Dependent Care Flexible Spending Accounts. With regard to the Health Care Flexible Spending program, the card is only effective at merchants and service providers authorized by Employer relating to health care. When you use the card at the point of sale, the medical provider or merchant and/or the dependent day care provider is paid the full amount of the charge (assuming there is sufficient coverage within the Health Care Flexible Spending and/or Dependent Care Flexible Spending Accounts) and your maximum available coverage remaining is reduced by that amount.

D-15. **What is an HSA?** The HSA is not an employer-sponsored employee benefit plan. It is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of “qualified medical expenses” as set forth in Code section 223. Consequently, an HSA trustee/custodian, not the Employer, will establish and maintain your HSA. The HSA trustee/custodian will be chosen by you, as the Participant, and not by the Employer. Your Employer may, however, limit the number of HSA providers to whom it will forward pre-tax salary reductions, a list of whom will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian. Your HSA is administered by your HSA trustee/custodian. Your Employer’s role is limited to allowing you to contribute to your HSA on a pre-tax salary-reduction basis. Your Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified above is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

D-16. **What are the Maximum HSA Benefits that I May Elect?** Your annual contribution for HSA benefits is equal to the annual benefit amount that you elect (for example, if the maximum $7,100.00 annual benefit amount is elected, then the annual contribution amount is also $7,100.00).

In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made ($3,550.00 for single and $7,100.00 for family are the statutory maximum amounts for 2020).

An additional catch-up contribution ($1,000 for 2009 and thereafter) may be made for Participants who are HSA-Eligible Individuals who are age 55 or older and are not yet entitled to Medicare.

The maximum annual contribution (including the catch-up contribution) shall be:

(a) reduced by any matching (or other) Employer contribution made on your behalf; and

(b) prorated for the number of months in which you are an HSA-Eligible Individual, except as indicated in the following sentence. If you are an HSA-Eligible Individual
during the month of December (even if you were not an HSA-Eligible Individual the entire taxable year), you may still contribute the maximum annual contribution as described above; however, you must then remain an HSA-Eligible Individual until the last day of the twelfth month following the last month of the taxable year in order to avoid taxation and penalties.

D-17. **How are My HSA Benefits Paid?** When you complete the election form / salary reduction agreement, you specify the amount of HSA benefits that you wish to pay for with your salary reduction. From then on, you make a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). For example, suppose that you have elected to contribute up to $1,000 per year for HSA benefits and that you have chosen no other benefits under this Plan. If you pay all of your contributions, then our records would reflect that you have contributed a total of $1,000 during the Plan Year. If you are paid biweekly, then our records would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the HSA benefits that you have elected. Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld. Your Employer has no authority or control over the funds deposited in your HSA.

D-18. **Will I be Taxed on the HSA Benefits that I Receive?** You may save both federal income taxes and FICA (Social Security) taxes by participating in this Plan. However, very different rules apply with respect to taxability of HSA benefits than for other benefits offered under this Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA, see the communications materials provided by your HSA trustee/custodian and see IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”). The Employer cannot guarantee that specific tax consequences will flow from your participation in this Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA benefits. Remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

D-19. **Who Can Contribute to an HSA Under this Plan?** Only Employees who are HSA-Eligible Individuals can participate in the HSA benefits. An HSA-Eligible Individual means an individual who meets the eligibility requirements of Code section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage (including the General-Purpose Health Care Flexible Spending Account option solely as the result of a carryover of unused amounts in a Health Care Flexible Spending Account from the prior Plan Year). The terms of the High Deductible Health Plan that has been selected by your Employer will be further described in materials that will be provided separately to you by the Employer.

D-20. **Can I Change My HSA Contribution Under this Plan?** You may increase, decrease or revoke your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the pay period following the date in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirements.
D-21. **Which Plan Pays First if More Than One Plan Applies?** Health Care Flexible Spending Account benefits are intended to pay benefits solely for Qualifying Medical Care Expenses for which you have not been previously reimbursed and will not seek reimbursement elsewhere. The Health Care Flexible Spending Account will not be considered a group health plan for coordination of benefits purpose and such benefits shall not be taken into account when determining benefits payable under any other plan. Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health Care Flexible Spending Account and the HSA, you may choose to seek reimbursement from either the Health Care Flexible Spending Account or the HSA, but not both. If the Employer also maintains an HRA, then in the event an expense is eligible for reimbursement under both the Health Care Flexible Spending Account and the HRA, the HRA must pay first.

D-22. **Where Can I Get More Information on My HSA and its Related Tax Consequences?** For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by your HSA trustee/custodian. You may also want to review IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”).

D-23. **Health Care Flexible Spending Account Carryovers.** Notwithstanding any other provision of the Plan to the contrary, pursuant to this Section D-23, unused amounts of up to $550.00 [as adjusted] remaining at the end of a Plan Year (taking into consideration the 90-day run out period) in your Health Care Flexible Spending Account ("carryover amount") may be used to reimburse you or pay directly for Qualifying Medical Care Expenses incurred during the entire immediately following Plan Year. The maximum carryover amount for the 2020 Plan Year is $550.00. The maximum carryover amount for future plan years will be up to 20% of the maximum salary reduction contribution allowed under Code section 125(i) for that plan year and will be communicated to employees at open enrollment.

With respect to you, the amount that may be carried over to the immediately following Plan Year is equal to the lesser of (1) any unused Health Care Flexible Spending Account amount from the immediately preceding Plan Year; or (2) $550.00 [as adjusted]. Any unused Health Care Flexible Spending Account amount in excess of $550.00 [as adjusted] that remains unused as of the end of the Plan Year (taking into consideration the 90-day run out period) is forfeited. Any unused amount remaining in your Health Care Flexible Spending Account as of termination of employment also is forfeited (unless, if applicable, you elect COBRA continuation coverage with respect to the Health Care Flexible Spending Account).

In no event shall the carryover amount in the Health Care Flexible Spending Account be cashed out or converted to any other taxable or nontaxable benefit. The carryover amount may be used only to reimburse you for or directly pay for Qualifying Medical Care Expenses.
The carryover amount shall not count against or otherwise affect the maximum amount of Health Care Flexible Spending Account benefits applicable to a Plan Year which you may elect pursuant to Section D-7.

Qualifying Medical Care Expenses incurred in the current Plan Year will be reimbursed first from your unused amounts credited for the current Plan Year, and only after exhausting these current Plan Year amounts, then from unused amounts carried over from the preceding Plan Year after the end of the 90-day run out period. Any carryover amounts that are used to reimburse a current Plan Year expense cannot exceed $550.00 [as adjusted] and will count against the $550.00 [as adjusted] maximum carryover amount.

E. Cash Payment Election Procedure

E-1. How do I Elect to Receive a Cash Payment in Lieu of Coverage Under the Employer’s Group Health Plan? When you commence employment with the Employer, or prior to the beginning of a Plan Year, you may obtain an election form from the Employer to elect to waive coverage under the Group Health Plan and to receive a cash payment instead. The election form must be completed and returned to the Employer prior to the beginning of the Plan Year to which it is to apply. Any change or revocation of the election will not take effect until the next Plan Year after the change or revocation is made, except as provided in Article H and Section D-3.

E-2. Are There Any Restrictions on My Election to Receive Cash? Yes. In order to elect to receive cash in lieu of coverage under the Group Health Plan, you must meet the requirements of Section D-3 and will be required to provide a written waiver of the Employer's Group Health Plan on a form provided by the Administrator.

E-3. What Happens if I Fail to Make an Election? If you do not make an election to receive a cash payment in lieu of coverage under the Employer’s Group Health Plan, you will not receive a cash payment.

F. Purchasing Alternative Benefits Through Salary Reduction

F-1. How do I Reduce My Salary in Order to Purchase Alternative Benefits with Pretax Dollars? When you first become eligible and prior to the beginning of each Plan Year thereafter, your Employer will provide you with an election form and salary reduction agreement for you to complete to receive the optional benefits under this Plan. This form must be completed and returned to your Employer prior to the beginning of the Plan Year when your election becomes effective, or, for new participants, prior to the first day of the first pay period that your election will become effective as stated in the election form. Unless otherwise agreed, you will pay for your share of the cost of coverage by having a portion of the cost deducted from each paycheck on a pre-tax basis (generally an equal portion from 24 out of 26 pay periods).

F-2. What Happens if I Fail to Return the Election Form to the Administrator? If you are a new Employee and fail to return a completed election form to the Administrator by the due date, you will be enrolled in the minimal medical coverage offered under the Plan specifically
the employee-only PHP Standard Plan. If you fail to renew your election, you will automatically be enrolled according to your election the previous year for the Premium Payment option benefits under Section D-1(a) only and deemed to have agreed to a salary reduction in the amount of the cost, as may vary from year to year, for the same benefits elected in the previous year. You will have to affirmatively elect all other benefits, including the HSAs; accident, dental and cancer benefits; and the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Programs each year; you will be deemed not to participate in these benefits unless you elect them each year. These deemed elections will remain in effect unless one of the events described in Article H occurs to justify a mid-year election change.

F-3. **How will the Employer Pay the Dependent Care or Medical Care Expenses?**
The Employer will, at its option, pay the expenses by either reimbursing you or directly paying your Dependent Care or Medical Care Service Provider.

F-4. **What Happens if I Terminate Participation in the Middle of the Year?** If you cease participation in the Plan for any reason, you will also cease participation in the Health Care Flexible Spending Account and Dependent Care Flexible Spending Accounts. You may not make additional contributions to the Health Care Flexible Spending Account, and you may only be reimbursed for claims incurred during your participation in the Plan. The total amount credited to your Health Care Flexible Spending Account (minus previous reimbursements) shall be available to you for claims that occur during the period of your participation. You must apply for reimbursement on or before the 90th day after your termination of participation. Only claims incurred during the Coverage Period prior to your termination may be reimbursed. However, you may be able to continue to receive medical benefits pursuant to COBRA.

Additionally, you may not make additional contributions to the Dependent Care Flexible Spending Account after your participation ceases. However, the total amount credited to your Dependent Care Flexible Spending Account (minus previous reimbursements) shall be available to you for claims that occur during the remainder of the Plan Year. Only claims incurred during your participation in the Plan and for the remainder of that Plan Year may be reimbursed. You must apply for reimbursement on or before the 90th day after the close of the Plan Year in which your termination occurred. In essence, the Plan will allow you to spend down the remaining balance in your Account for claims that occur until the end of the Plan Year.

G. **Claims Procedure**

G-1. **How do I Make a Claim for Reimbursement of a Dependent Care Expense or a Medical Care Expense?** Claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA trustee/custodian (for example, issues involving the investment or distribution of your HSA funds) shall be administered by your HSA trustee/custodian in accordance with the HSA trustee or custodial document between you and such trustee/custodian. However, if you have elected to receive Dependent Care Flexible Spending Account or Health Care Flexible Spending Account coverage for a Plan Year, you may apply to the Administrator for reimbursement of expenses incurred during the year by submitting an application, in writing, stating the following:
(a) the amount, date and nature of the expense with respect to which a benefit is requested;

(b) the name of the person, organization or entity to which the expense was or is to be paid and the taxpayer identification number (Social Security Number, if an individual);

(c) the name of the person on whose behalf the Expense was incurred and if the person is not the Participant, the person’s relationship to the Participant;

(d) the amount recovered, or expected to be recovered, under any insurance arrangement or other plan; and

(e) any other information as the Employer may require, including bills, invoices, receipts, canceled checks or other statements of the Expense.

However, with regard to Employer provided debit or credit cards, use of the card is not considered a claim for benefits; a claim does not arise until a paper form has been submitted.

Also, in the case of Employer provided debit or credit cards, your Employer has established the following procedures for substantiating claimed medical and dependent care expenses after the use of the card:

(a) Automatic Substantiation for Health Care Flexible Spending Account: For expenses incurred at medical care providers (as identified by the Merchant Category Code) and at stores with the Drug Stores and Pharmacies Merchant Category Code (if 90% of the store's gross receipts for the prior taxable year consisted of items which qualify as medical care expenses under Code section 213(d)), payments with the card that are made in the following manner are automatically substantiated, without the need to turn in receipts or other documentation.

(1) Co-Payment Transactions: If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the major medical plan of the Participant or is an exact multiple of not more than five times the dollar amount of the co-payment, the charge is fully substantiated without the need for submission of a receipt or further review. The same holds true for combinations of up to five co-payments in the case of tiered co-payments as long as they are exact matches of multiples or combinations. The co-payment schedule under the major medical plan must be independently verified by the Employer.

(2) Recurring Transactions: Employer permits automatic reimbursement, without further review, of recurring expenses that match expenses previously approved as to amount, provider, and time period (e.g., for a Participant who refills a prescription drug on a regular basis at the same provider for the same amount).

(3) Real-Time Transactions: If the merchant, service provider or other independent third-party (e.g., Pharmacy Benefit Manager), at the time and point of sale, provides
information to verify to Employer (including electronically by e-mail, the internet, intranet or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review (i.e., “real-time substantiation”).

(b) Inventory Information Approval System for Health Care Flexible Spending Account: An inventory information approval system may be used to substantiate payments made using a debit card, including payments at merchants and service providers that are not described in paragraph (a) of this Section. Debit card transactions using this system are fully substantiated without the need for submission of a receipt by the employee or further review.

(1) When an employee uses the card, the payment card processor's or participating merchant's system collects information about the items purchased using the inventory control information (for example, stock keeping units (SKUs)). The system compares the inventory control information for the items purchased against a list of items, the purchase of which qualifies as expenses for medical care under Code section 213(d) (including nonprescription medications);

(2) These medical expenses are totaled and the merchant's or payment card processor's system approves the use of the card only for the amount of medical expenses eligible for coverage under the Health Care Flexible Spending Account;

(3) If the transaction is only partially approved, the Participant is required to tender additional amounts, resulting in a split-tender transaction;

(4) If, after matching inventory information, it is determined that only some of the items purchased are Code section 213(d) medical expenses, the transaction is approved only as to those medical expenses. In this case, the merchant or service-provider must request additional payment from the Participant for the items that do not satisfy the definition of medical care under Code section 213(d);

(5) The merchant or service-provider must also request additional payment from the Participant if he or she does not have sufficient Health Care Flexible Spending Account coverage to purchase the medical items;

(6) Any attempt to use the card at non-participating merchants or service-providers will fail.

(7) Employer ensures that the inventory information approval system complies with the requirements for substantiating, paying or reimbursing Code section 213(d) medical expenses and the recordkeeping requirements in section 6001.

(c) Manual Substantiation for Health Care Flexible Spending Account: Employer’s procedures provide that all charges to the card, other than co-payments, recurring expenses and real-time transactions as described above, are treated as conditional pending confirmation of the charge. Thus, Employer requires that additional third-party information, such
as merchant or service provider receipts, describing (1) the service or product, (2) the date of the service or sale and, (3) the amount, be submitted for review and substantiation.

(d) Automatic Substantiation for Dependent Care Flexible Spending Account: Payments with the card that are made in the following manner are automatically substantiated, without the need to turn in receipts or other documentation.

(1) Recurring Transactions: Employer permits automatic reimbursement, without further review, of recurring expenses that match expenses previously substantiated and approved as to provider and time period if the amount is equal to or less than previously substantiated expenses (e.g., for a Participant who uses the same day care provided and incurs the same expense, or less, each month). Similarly, Dependent Care Expenses previously substantiated and approved through nonelectronic methods may also be treated as substantiated without further review.

(e) Manual Substantiation for Dependent Care Flexible Spending Account: Employer’s procedures provide that all charges to the card, other than recurring expenses as described above (i.e., new provider or increase in amount), are treated as conditional pending confirmation of the charge. Thus, Employer requires that additional third-party information, such as dependent day care provider receipts, describing (1) the service, (2) the date of the service and (3) the amount, be submitted for review and substantiation.

(f) Correction Procedures for Improper Payments for Health Care Flexible Spending and/or Dependent Care Flexible Spending Accounts: In case some of the claims that have been paid under the Employer’s card arrangement are subsequently identified as not Medical Care Expenses and/or Dependent Care Expenses, the debit card will be de-activated until the improper payment is recovered. Additionally, Employer has adopted all of the following correction procedures with respect to the improper payments:

(1) First, upon identifying an improper payment, Employer requires the Participant to pay back to the Plan an amount equal to the improper payment.

(2) Second, where this proves unsuccessful, Employer has the amount of the improper payment withheld from the Participant’s wages or other compensation to the extent consistent with applicable law.

(3) Third, if the improper payment still remains outstanding, Employer utilizes a claims substitution or offset approach to resolve improper claims. For example, if a Participant has received an improper reimbursement of $200 and subsequently submits a substantiated claim incurred during the same coverage period, no reimbursement is made until the improper payment is fully recouped.

(4) If these correction efforts prove unsuccessful, or are otherwise unavailable, the Participant remains indebted to Employer for the amount of the improper payment. In that event and consistent with its business practices, Employer treats the payment as it would any other business indebtedness.
If you think an error has been made in determining your benefits, then you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Administrator. If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

G-2. What if My Benefits are Denied? The term "Adverse Benefit Determination" means (a) any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(a) Timing of Notification of Initial Benefit Determination. A notice of an initial benefit determination will be timely provided to you in accordance with 29 C.F.R. §2560.503-1(f) and as follows:

(1) General Rule for Benefits Other Than Group Health Plan and Disability Plan Benefits. If your claim is wholly or partially denied, the Administrator, with respect to benefits other than group health plan and disability plan benefits, will provide you with a notification of the Plan’s Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Plan, unless the Administrator determines that special circumstances require an extension of time of up to an additional 90 days from the end of the initial 90-day period for processing your claim. If an extension of time for processing is necessary, the Administrator will provide you with written notice of the extension, before the end of the initial 90-day period, explaining the special circumstances requiring an extension of time and the date by which the Plan expects to make a decision.

(2) Group Health Plan Benefits. In the case of a group health plan, the Administrator shall notify you of the Plan's benefit determination as follows:

(A) Pre-service Claims. A "Pre-service Claim" is any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. If your claim involves a Pre-service Claim, the Administrator shall notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of your claim by the Plan. However, this period may be extended one time by the Plan for up to 15 days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan. The Administrator will provide you with notice of the extension before the end of the initial 15-day period, explaining the reason for the extension of time and the date by which the Plan expects to make a decision. If the extension is necessary due to your failure to submit the information
necessary to decide the claim, the notice of extension will specifically describe the required
information and you shall have 45 days from receipt of the notice within which to provide the
specified information. Failure to respond in a timely and complete manner will result in a benefit
denial.

If you fail to follow the Plan's procedures for filing a Pre-service Claim (and if such failure
is a communication (A) by you that is received by a person or organizational unit customarily
responsible for handing benefit matters; and (B) that communicates at least your name, a specific
medical condition or symptom, and a specific treatment, service or product for which prior
approval is requested), the Administrator will provide oral notice (and in writing if requested by
you) of the failure and the proper procedure to complete the claim, as soon as possible, but not
later than five days following the failure.

(B) Post-service Claims. A "Post-service Claim" is any claim
for a benefit under a group health plan that is not a Pre-Service Claim. If your claim involves a
Post-service Claim, the Administrator shall notify you of the Plan's Adverse Benefit Determination
within a reasonable time, but no later than 30 days after receipt of your claim. This period may be
extended one time by the Plan for up to 15 days if the Administrator determines that such an
extension is necessary due to matters beyond the control of the Plan and the Administrator notifies
you prior to expiration of the initial 30-day period of the reasons for the extension of time and the
date by which the Plan expects to render a decision. If the extension is necessary due to your
failure to submit the information necessary to decide the claim, the notice of extension will
specifically describe the required information and you shall have 45 days from receipt of the notice
within which to provide the specified information. Failure to respond in a timely and complete
manner will result in the denial of benefit payment.

(C) Concurrent Care Claims. A "Concurrent Care Claim is a
claim for an ongoing course of treatment to be provided over a period of time or number of
treatments. If the Plan has approved a Concurrent Care Claim:

(i) In the case of a reduction or termination by the
Plan of such approved Concurrent Care Claim (other than by Plan amendment or termination)
before the end of such approved period of time or number of treatments, the Administrator shall
notify you of this Adverse Benefit Determination at a time sufficiently in advance of the reduction
or termination to allow you to appeal and obtain a determination on review of that Adverse Benefit
Determination before the benefit is reduced or terminated.

(ii) In the case of a request of a Claimant to extend
the course of treatment beyond the period of time or number of treatments that is an Urgent Care
Claim, the Administrator shall make a determination as soon as possible, taking into account the
medical exigencies, and shall notify you of the benefit determination (whether adverse or not)
within 24 hours after receipt of the claim by the Plan, provided the claim is made to the Plan at
least 24 hours before the expiration of the prescribed period of time or number of treatments.

(D) Urgent Care Claims. An "Urgent Care Claim" is, as further
defined in 29 C.F.R. 2560.503-1(m)(1), any claim for medical care or treatment with respect to
which the application of the time periods for making non-urgent care determinations: (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or (ii) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If your claim involves an Urgent Care Claim, the Administrator shall notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, the Administrator shall notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You shall be afforded a reasonable amount of time, taking into account the circumstances, but at least 48 hours to provide the specified information. The Administrator will notify you of the Plan's benefit determination as soon as possible, but not later than 48 hours after the earlier of (i) the Plan's receipt of the specified information; or (ii) the end of the period afforded you to provide the specified additional information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

If the Claimant fails to follow the Plan's procedures for filing a Pre-service Claim (and if such failure is a communication (A) by a Claimant that is received by a person or organizational unit customarily responsible for handing benefit matters; and (B) that communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested), the Administrator will provide oral notice (and in writing if requested by the Claimant) of the failure and the proper procedure to complete the claim, as soon as possible, but not later than 24 hours following the failure.

(b) Content of Notification of Initial Benefit Determination. A notice of benefit determination will be sent to you in written or electronic format in a manner calculated to be understood by you Claimant and in accordance with 29 C.F.R. §2560.503-1(g). The notification to you of an Adverse Benefit Determination will generally contain the following information:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the determination is based;
3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA section 502(a) following an Adverse Benefit Determination on review.
5. In the case of a decision by a group health plan:
(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

(B) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(6) In the case of a decision by a group health plan concerning an Urgent Care Claim, you may be informed orally and will be sent a written or electronic notification no later than three days after the oral notification. You will also receive a description of the expedited review process for such claims.

NOTE: If your claim has been denied and you want to submit your claim for review, you must follow the Claims Review Procedure.

G-3. What is the Claims Review Procedure?

(a) Filing an Appeal of Adverse Benefits Determinations. In accordance with 29 C.F.R. §2560.503-1(h), you shall have a reasonable opportunity to appeal an Adverse Benefit Determination to an appropriate named fiduciary of the Plan and under which there will be a full and fair review of the claim and the Adverse Benefit Determination.

(1) Appealing Adverse Benefit Determination Not Pertaining to Group Health Plan Benefits or Disability Plan Benefits.

(A) You must file the claim for review to the appropriate named fiduciary of the Plan no later than 60 days after you have received notification of an Adverse Benefit Determination.

(B) You may submit written comments, documents, records and other information relating to the claim for benefits.

(C) You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

(D) This review will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
(2) Appealing Adverse Benefit Determination Pertaining to Group Health Plan Benefits.

(A) You must file the claim for review to the appropriate named fiduciary of the Plan no later than 180 days following receipt of notification of an Adverse Benefit Determination.

(B) The Plan must comply with Section G-3(a)(1)(B)-(D).

(C) Your claim will be reviewed without deference to the initial Adverse Benefit Determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

(D) In deciding an appeal of any Adverse Benefit Determination that is based in whole or part on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item was experimental, investigational, or not medically necessary or appropriate), the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(E) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination will be identified, without regard to whether the advice was relied upon in making the determination.

(F) The health care professional engaged for purposes of a consultation under (D) above will be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

(G) If your claim involves an Urgent Care Claim, an expedited review process will occur, which you may request orally or in writing. All necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile or other available similarly expeditious method.

(b) Timing of Notification of Benefits Determination on Review. A notice of a benefit determination upon review will be timely provided to Claimant in accordance with 29 C.F.R. §2560.503-1(i) and as follows:

(1) Generally. Unless otherwise provided for within this Plan, the Administrator must provide you with notification of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after the Plan’s receipt of your request for review by the Plan, unless the Administrator determines that special circumstances require an extension of time of up to 60 days from the end of the initial period for processing your claim. If the Administrator determines an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. The
extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

(2) **Group Health Plan Benefits.**

(A) **Pre-service Claims.** The Administrator shall notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than: (i) 30 days after receipt by the Plan of your request of review of an Adverse Benefit Determination (in the case of a group health plan that provides for one appeal of an Adverse Benefit Determination); or (ii) 15 days after receipt by the Plan of your request for review of an Adverse Benefit Determination(in the case of a group health plan that provides for two appeals of an adverse determination and with respect to any one of such two appeals).

(B) **Post-service Claims.** The Administrator shall notify you of the Plan's benefit determination on review within a reasonable period of time, but not later than: 60 days after receipt by the Plan of your request for review of an Adverse Benefit Determination (in the case of a group health plan that provides for one appeal of an Adverse Benefit Determination); or (ii) 30 days after receipt by the Plan of the Claimant's request for review of an Adverse Benefit Determination (in the case of a group health plan that provides for two appeals of an adverse determination and with respect to any one of such two appeals).

(C) **Urgent Care Claims.** The Administrator shall notify you of the Plan's benefit determination on review as soon as possible (taking into account the medical exigencies) but not later than 72 hours after receipt of your request for review of an Adverse Benefit Determination by the Plan.

(c) **Content of Notification of Benefit Determination on Review.** A notice of the Plan's benefit determination on review will be sent to you in written or electronic format in a manner calculated to be understood by you and in accordance with 29 C.F.R. §2560.503-1(j). In the case of an Adverse Benefit Determination, the notification will set forth:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
4. If any voluntary appeal right exists, a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures and a statement of your right to bring an action;
5. In the case of a claim for group health plan:
(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion, will be provided to you free of charge upon request;

(B) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement of such explanation will be provided free of charge upon request;

(C) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

**NOTE:** Subject to the provisions of Section G-4, if you have a claim for benefits which is denied upon review, in whole or in part, you may file suit in a state or federal court; however, such suit must be brought within three years of the denial upon review.

G-4. **Voluntary Levels of Appeal.** If and to the extent that the Plan offers voluntary levels of appeal (except to the extent that the Plan is required to do so by state law), including voluntary arbitration or any other form of dispute resolution, in addition to those appeals rights provided in Sections G-2 and G-3:

(a) The Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the Plan;

(b) Any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(c) You may elect to submit a benefit dispute to such voluntary level of appeals only after exhaustion of the appeals otherwise permitted by Sections G-2 and G-3;

(d) The Plan will provide to you, upon request, sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of you as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Plan and information about the applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and
(e) No fees or costs will be imposed on you as part of the voluntary level of appeal.

G-5. Arbitration. The Plan shall not require arbitration of an Adverse Benefit Determination, except to the extent that: (a) the arbitration is conducted as one of the two appeals otherwise permitted by Sections G-2 and G-3 and in accordance with the requirements applicable to such appeals; and (b) you are not precluded from challenging the decision under ERISA section 502(a) or other applicable law.

H. Changes in Election

H-1. Can I Change or Revoke 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. You are permitted to change elections if you have a “change in status” event, as determined by the Plan Administrator, and you make an election change that is on account of and consistent with the event within 30 days of the event. New elections will take effect as determined by the Administrator, but no earlier than the first pay period after you return the change in election form. Federal law considers the following events to be “changes in status" if they affect eligibility for coverage:

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

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

(c) Any of the following changes in employment status 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;

(d) 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

(e) A change in the place of residence of you, your spouse or dependent.

H-2. Are there any Exceptions to the Changes in Status Rules?

(a) If you are participating in the Dependent Care Flexible Spending Account, there is a change in status if your dependent no longer meets the eligibility qualifications for dependent care.

(b) With regard to Health Savings Accounts ("HSAs"), you may increase, decrease, or revoke your HSA benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan’s administrative procedures for processing election changes. The change will become effective on the first day of the pay period following the date you properly
submit your election change. No other benefits package option election changes can be made as a result of a change in your HSA benefits election unless permitted as a result of events otherwise described in this Article. For example, generally you would not be able to terminate an election under the Health Care Flexible Spending Account in order to be eligible for the HSA, unless one of the exceptions described above for Health Care Flexible Spending Account benefits otherwise applied (such as a change in status).

(c) No mid-year election changes are allowed for voluntary benefits offered under this Plan as described in Section D-1(c), unless otherwise required by law.

(d) For the remainder of the 2020 Plan Year only, you are allowed to make a prospective election change to your Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account ("Account(s)") without otherwise meeting the requirements of this Article. Prospective election changes include enrolling in the Account(s), increasing contributions to the Account(s) (total contributions cannot exceed maximum election allowed under this Plan), or decreasing contributions to the Account(s) (not below claims already reimbursed).

H-3. When is a Change in Election Consistent with a Change in Status? There are detailed rules on when a change in election is deemed to be consistent with a “change in status.” In addition, there are laws that give you rights to change accident and 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.

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.

If you, your Spouse or your Dependent becomes eligible for COBRA coverage under Employer’s group health plan, then you may elect to increase payments under this Plan to pay for the coverage. This does not apply for COBRA eligibility due to divorce, annulment or legal separation.

H-4. Can I Change or Revoke My Elections Due to a Change in Cost or Coverage? If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then your Employer will automatically increase or decrease, as the case may be, your cafeteria plan election. If the cost increases or decreases significantly, you will be permitted to make corresponding changes in your elections, 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 elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage. If your coverage is curtailed and you lose coverage, you may revoke your election and elect to receive, on a prospective basis, coverage under another Plan with similar coverage or to drop coverage if no similar coverage is offered. In addition, if your Employer adds a new coverage option or eliminates an existing option, 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 another employer plan. Specifically, you may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer) if (1) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under the final regulations; or (2) the period of coverage under this Plan is different from the period of coverage under the other cafeteria plan or qualified benefits plan. However, no change is permitted under the Health Care Flexible Spending Account. Also, you may make a prospective election change to add Group Health coverage for yourself, your spouse or dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children’s health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool or a foreign government group health plan.

You may not change your election under the Health Care Flexible Spending Account if you experience a change in cost or coverage. You also 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.

H-5. What are HIPAA Special Enrollment Rights? An Employee or Participant may revoke an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f). Unless otherwise provided, such change shall take place on a prospective basis.

(a) As required by HIPAA, a 30-day special enrollment right will arise if:

1. A current Employee is eligible for, but declined enrollment in, this group health plan coverage (or a Dependent of such Employee is eligible for, but was not enrolled in, this group health plans coverage) because the Employee or Dependent was covered under another group health plan or had other health insurance coverage when this group health plan coverage was previously offered and the other coverage was lost due to either: (i) if the other coverage was COBRA continuation coverage, that coverage has been exhausted; or (ii) if the other coverage was
not COBRA continuation coverage, either the coverage was terminated as a result of loss of
eligibility for the coverage (including, but not limited to, as a result of legal separation, divorce,
cessation of dependent status, death, termination of employment, or reduction in the number of
hours of employment; in the case of an HMO, the individual no longer resides, lives or works in
the service area where the HMO provides benefits and, in cases of the group market, no other
package is available to the individual; an individual incurs a claim meeting or exceeding a lifetime
limit on all benefits; or the plan no longer offers any benefits to the class of similarly situated
individuals that includes the individual), or employer contributions towards such coverage were
terminated. Unless otherwise provided in the Employer’s Group Health Plan, the eligible
Employee must request enrollment not later than 30 days after the loss of other coverage (or after
a claim is denied due to the operation of a lifetime limit on all benefits). Any eligible Dependent
may only enroll if that Dependent (or the Employee) meets the above requirements; or

(2) A new Dependent is acquired as a result of marriage, birth, or adoption
or placement for adoption, and the group health plan makes coverage available with respect to a
Dependent of a Participant or an Employee who has met any waiting period requirements and is
eligible to participate under that plan. Unless otherwise provided in the Employer’s Group Health
Plan, these election changes to add coverage must be made within 30 days of the date of the
marriage, birth or adoption or placement for adoption (or the date dependent coverage is made
available, if later). An election to add the following individuals (if otherwise eligible for coverage
under the Plan) as a result of the acquisition of a new Dependent through marriage, birth, adoption
or placement for adoption is consistent with the special enrollment right: (i) a current Employee
who is eligible but not enrolled; (ii) a current Employee who is eligible but not enrolled, and the
Spouse of such Employee; (iii) a current Employee who is eligible but not enrolled, and the newly
acquired Dependent of such Employee; (iv) the Spouse of a Participant; (v) a current Employee
who is eligible but not enrolled, and the Spouse and newly acquired Dependent; and (vi) a newly
acquired Dependent of a Participant.

Enrollment applications received after the special enrollment period will not
be considered and the next opportunity to enroll will be at open enrollment. Unless otherwise
provided in the Employer’s Group Health Plan, coverage under the special enrollment period for
timely submitted requests must be effective no later than the first day of the month after the plan
or issuer receives the request for special enrollment. However, with regard to enrollment requests
made within 30 days on behalf of a new Dependent acquired due to birth, adoption, or placement
for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for
adoption (or the date the plan makes dependent coverage available, if later). The prospective
increased salary reduction is permitted to reflect the cost of the retroactive coverage under the
group health plan from the date of birth, adoption, or placement for adoption.

(b) As required by HIPAA, effective April 1, 2009, a 60-day special enrollment
right will arise if the Employee or Dependent is eligible for, but not enrolled in, the Plan and either:

(1) loses coverage under Medicaid, specifically, if the Employee or
Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under
a State child health plan under Title XXI of the Social Security Act and coverage of the Employee
or Dependent under such a plan is terminated as a result of loss of eligibility for coverage; or
(2) becomes eligible for a Medicaid subsidy, specifically, if the Employee or Dependent becomes eligible for premium assistance, with respect to coverage under the Plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Employee or Dependent with the special enrollment right under subsection (b) must request enrollment within the first 60 days from the date of termination of such coverage under (b)(1) or 60 days from the date the applicant is determined to be eligible for premium assistance under (b)(2). Enrollment applications received after the 60-day special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Coverage under this Plan shall take effect on the same date coverage for this HIPAA special enrollment right takes effect in the underlying Employer’s Group Health Plan.

This Section only applies to group health plan coverage covering two or more Employees. This Section does not apply to HIPAA excepted benefits such as retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as “excepted benefits,” as defined in Treasury Regulation section 54.9831-1(c).

H-6. **Can I Change or Revoke My Election Due to a Court Order?** A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order defined in ERISA section 609) which requires accident or health coverage for your child allows:

   (a) the Plan to change an election to provide coverage for the child if the order requires coverage under your plan; or

   (b) 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.

H-7. **Can I Change or Revoke My Election Due to FMLA Leave?** If you take leave under FMLA, as described in Section C-6, 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.

H-8. **Can I Change or Revoke My Election Due to Eligibility for Medicare or Medicaid?** You may change elections to cancel your 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 Section 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. See also Section H-5.

H-9. Can the Administrator Change Participant Elections? 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.

H-10. Can I Revoke My Election to Enroll in a Qualified Health Plan? Yes. You may prospectively revoke an election of coverage under the Employer's Group Health Plan that provides minimum essential coverage (as defined in Code section 5000A(f)(1)) if:

(1) You are eligible for a special enrollment period to enroll in a qualified health plan through a competitive marketplace established under section 1311 of the PPACA ("marketplace") pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a qualified health plan through a marketplace during the marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the Employer's Group Health Plan corresponds to the intended enrollment of you and any related individuals who cease coverage due to revocation in a qualified health plan through a marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

H-11. Can I Revoke My Election Due to Reduction in Hours of Service and Enrollment in Another Plan? Yes. You may prospectively revoke an election of coverage under the Employer's Group Health Plan that provides minimum essential coverage (as defined in Code section 5000A(f)(1)) if:

(1) You have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you ceasing to be eligible under the Employer's Group Health Plan; and

(2) The revocation of the election of coverage under the Employer's Group Health Plan corresponds to the intended enrollment of you, and any related individuals who cease coverage due to revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

H-12. Voluntary Benefits. No mid-year election changes are allowed for voluntary benefits offered under this Plan as described in Section D-1(c), unless otherwise required by law.
I. Forfeiture of Account Balances

I-1. Under What Circumstances Will My Health Care Flexible Spending Account Balances be Forfeited? Except as otherwise provided in this Section, the amount credited to your Health Care Flexible Spending Account for any Plan Year can only be used to reimburse you or pay for Qualifying Medical Care Expenses incurred while you were a participant during the Plan Year and only if you apply for reimbursement on or before the earlier of: (a) the 90th day following the termination of your participation (unless you continue to participate pursuant to COBRA as of the last day of the Plan Year); or (b) the 90th day following the close of the Plan Year. If any balance remains in your Health Care Flexible Spending Account for any Plan Year after all reimbursements and payments, up to $550 [as adjusted] of such remaining balance may be carried over to reimburse you or pay for Qualifying Medical Care Expenses incurred during the immediately following Plan Year. Any remaining balance in excess of $550 [as adjusted] will not be carried over to reimburse you for Medical Care Expenses incurred during subsequent Plan Year. You will forfeit all rights with respect to the excess balance of the Health Care Flexible Spending Account. The excess balance shall remain the property of the Employer to defray reasonable administrative costs. Any remaining excess balance must be allocated among Participants on a reasonable and uniform basis.

IMPORTANT EXCEPTION REGARDING QUALIFIED RESERVIST DISTRIBUTIONS: If, however, you are a member of a reserve component (as defined in section 101 of title 37, United States Code) and are ordered or called to active duty for a period in excess of 179 days or for an indefinite period, then you may take a Qualified Reservist Distribution in cash. A “Qualified Reservist Distribution” is a taxable distribution of the unused amounts remaining in the Health Care Flexible Spending Account (excluding any carryover amount otherwise permitted under Section D-23), which equals the amount you have contributed to the Account through payroll deductions as of the date of your Qualified Reservist Distribution request minus the reimbursements you have received from the Account as of the date of your request. Your request must be made during the period beginning on the date of such order or call to active duty and ending on the last day of the Plan Year and must be accompanied by a copy of the order or call to active duty. The Employer must then pay the Qualified Reservist Distribution within a reasonable time, but not more than sixty (60) days after the request was made.

A Participant who takes a Qualified Reservist Distribution will automatically terminate participation in the Health Care Flexible Spending Account and may only regain participation status by meeting the eligibility and participation requirements set forth in Sections C-1 and C-2 and meeting the requirements of Article H.

I-2. Under What Circumstances Will My Dependent Care Flexible Spending Account Balances be Forfeited? The amount credited to your Dependent Care Flexible Spending Account for any Plan Year can only be used to reimburse you or pay for Dependent Care Expenses incurred while you were a participant during the Plan Year (and for the remainder of that Plan Year) and only if you apply for reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in your Dependent Care Flexible Spending Account for any Plan Year after all reimbursements and payments under the Dependent Care Flexible Spending Account, it will not be carried over to reimburse you for Dependent Care Expenses incurred during...
a subsequent Plan Year. You will forfeit all rights with respect to the balance of the Dependent Care Flexible Spending Account. The balance shall remain the property of the Employer and may be used to defray reasonable administrative costs.

**J. Plan Administration**

J-1. **How is the Plan Administered?** The Plan is administered by your Employer, which is designated as the Administrator. The Administrator is responsible for maintaining records of the Plan and Participants and for interpreting the Plan in the course of administration.

J-2. **Who Pays the Costs of the Plan?** The costs of the Plan are paid by the Administrator from the general assets of the Employer and forfeitures of Participant Accounts. However, a separate HSA trustee/custodial fee may be assessed by your HSA trustee/custodian for your HSA established and maintained by you outside of the Plan.

J-3. **Can Benefits or Payments Under the Plan be Assigned?** No. Generally, benefits and payments under this Plan cannot be assigned or alienated. However, there is a limited exception that applies if the Plan receives a “Qualified Medical Child Support Order.” The Health Care Flexible Spending Account benefits under the Plan can be assigned to a child of a Participant pursuant to a court-approved property settlement agreement or court order if the requirements set forth in the Plan are met. A medical child support order must satisfy certain specific conditions to be "qualified." The terms of the Plan outline the required criteria. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Administrator. Additionally, your rights to reimbursement may be subject to assignment to the State in the event you have received Medicaid and/or Medicare benefits for your medical expenses.

**K. Amendment or Termination of the Plan**

K-1. **Can the Employer Amend or Terminate the Plan?** 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 Board of Directors or other governing body of your Employer or by any person or persons authorized by the Board of Directors 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.

K-2. **If the Plan Terminates, How Will Reimbursements or Payments for Medical Care or Dependent Care Expenses be Made?** If the Plan terminates, you will be entitled to payment or reimbursement for Dependent Care or Medical Care Expenses incurred during the Plan Year if you apply for reimbursement or payment on or before the 90th day after the termination of the Plan. Your reimbursement will not exceed the remaining balance, if any, in your Dependent
Care Flexible Spending Account or your Health Care Flexible Spending Account for the Plan Year in which the expenses were incurred.

K-3. **Are Benefits Under the Plan Insured?** The benefits provided under this Plan are simply the tax savings benefits which result from a Participant making elections to pay for the benefits with pre-tax dollars. Thus, the pre-tax benefits under the Plan are not insured by an insurance company or under Title IV of the Employee Retirement Income Security Act of 1974 because that law does not apply. Instead, the Plan is funded by the Employer’s assets.

**L. Statement of Your Rights**

L-1. **What are My Rights Under the Newborns’ and Mothers’ Health Protection Act?** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant (as allowed by the plan)), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

L-2. **What are My Rights Under ERISA?** This Plan is exempt as a "governmental plan" from the provisions of ERISA.
July 9, 2020

Ms. Sue Graham
Director
Ingham County Human Resources
5303 S. Cedar Street, Ste. 2012
Lansing, MI 48911

Re: Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan

Dear Ms. Graham:

Attached please find the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan ("Plan"), the Plan’s associated Summary Plan Description ("SPD"), Plan Administration Manual ("PAM"), HIPAA Plan Sponsor Certification, and Resolutions.

As discussed, the Plan and SPD have been amended and restated to incorporate all previous Amendments and Summaries of Material Modifications. The previous Plan was drafted for an effective date of January 1, 2005 and had 11 Amendments as well as 12 Summaries of Material Modification. These restated documents also incorporated the following changes to conform to 2020 practices:

- Updated the cash in lieu of medical coverage amounts;
- Updated employer contributions for 2020 to HSAs to $600 single/$1200 family;
- Updated 2020 Health FSA maximum salary reduction as $2700;
- Updated provision that requests for mid-year change in elections must be provided within 30 days of the event;
- Added two new mid-year election changes allowed under the Affordable Care Act:
  - Revocation of coverage due to enrollment in a qualified health plan through the marketplace, or
Revocation of coverage due to a reduction of hours even if eligibility under the County’s plan is not affected; and

- Updated signor of Plan documents to Jared Cypher, Interim Controller.

Additionally, due to recent legislation spurred by COVID-19, we have amended the Plan to incorporate the following changes:

- The health FSA may reimburse over-the-counter medicine and menstrual care products, effective January 1, 2020. The Amendment itself does not reference these specific products, although the SMM does, but instead refers to the applicable Internal Revenue Code sections;
- The carryover provision is increased to 20% of the maximum health FSA amount allowed under Code section 125(i) (i.e., $550 for the 2020 plan year); and
- Mid-year change in elections may now be made on a prospective basis for the health FSA and dependent care FSA accounts without the need to meet the traditional change in election rules. However, this is only for the remainder of the 2020 calendar year, and a participant may not reduce his/her election below claims already reimbursed.

Please review the documents carefully to ensure they adequately reflect your intent. Once reviewed, please have Mr. Jared Cypher sign and date the Plan on behalf of Ingham County. **Please be certain the Plan is executed prior to August 1, 2020.**

To formally adopt the Plan, the Board of Commissioners for Ingham County must adopt the attached Resolutions and incorporate them into the Board minutes. While the Board had previously passed Resolutions in 2011 allowing the Controller/Administrator to execute future amendments to or restatement of the Plan without further involvement of the Board of Commissions, Mr. Cypher has the title of Interim Controller. Therefore, he must be separately authorized to take action.

Please also ensure the Plan Sponsor Certification is also executed for purposes of HIPAA. Additionally, if TASC has not already provided one, please note that the Health Care Flexible Spending Account is subject to HIPAA privacy rules and you must also distribute a Notice of Privacy Practices for that Account. Please let us know if you’d like assistance in this regard.

**Please retain the executed Plan documents for your files, and return a copy of the executed signature page of the Plan, Resolutions and Plan Sponsor Certification to our offices.** It is essential that you maintain files of executed documents as mandated by the Internal Revenue Code. Documents are required to be executed in a timely manner and available on the premises of the Plan Administrator for audit and review by the IRS upon request.

Please be aware that numerous laws apply to the benefits offered under the Plan, such as COBRA, HIPAA, and PPACA. Each of these laws requires distribution of notices to eligible employees and/or participants, as well as requiring other documentation (such as HIPAA privacy and
security policies and procedures). The requirements are extensive. Please contact us if you would like further information or assistance with regard to these obligations.

Timely distribution of the SPD to your employees, retirees (if applicable) and COBRA participants is required. If you have questions about the timeframe to distribute these documents, please ask. As new participants enter the Plan in the future, they also must be furnished with a copy of the SPD. These documents explain the provisions of the Plan in laymen's terms and answer typical questions which participants may raise relating to the Plan. If you have questions about the timeframe or method to distribute these documents, please review the PAM or feel free to contact us.

The PAM explains certain federal law requirements applicable to the Plan with which you must comply when sponsoring and administering the Plan. For example, the PAM outlines the time period for distributing the SPD and includes information related to conducting nondiscrimination testing.

Thank you for the opportunity to draft these documents for Ingham County. If you have any questions or comments concerning the attached documents, please give me a call.

Very truly yours,

Fraser Trebilcock Davis & Dunlap, P.C.

[Signature]

Elizabeth H. Latchana

EHL jsn
Attachments
INGHAM COUNTY

RESOLUTIONS TO BE ADOPTED BY THE BOARD OF COMMISSIONERS

A Meeting of the Board of Commissioners of Ingham County (the “Company”) was held on
______________________, 2020. Sufficient members were present to constitute a quorum of the
Board of Commissioners of the Company. Following a reading of the Plan and an extensive discussion
concerning the provisions, the following resolutions were, upon motion duly made, unanimously adopted:

RESOLVED, that Ingham County’s adoption of the Ingham County
Section 125 Second Amended and Restated Flexible Benefit Plan (“Plan”),
effective as of the dates contained therein, is affirmed and ratified.

RESOLVED FURTHER, that the actions of the Interim Controller, Jared
Cypher, necessary to adopt the Plan on behalf of Ingham County are hereby
affirmed and ratified.

RESOLVED FURTHER, that the Interim Controller or Controller is
authorized to take further actions on behalf of Ingham County that are
necessary to execute any future amendment to or restatement of the Plan
and that such amendment or restatement will be adopted by Ingham County,
effective as of the dates contained therein, without need for a further
Resolution or Board of Commissioners involvement.

I certify that the above is a true and complete record of action taken by the Board of
Commissioners of Ingham County on the ___ day of ____________________, 2020.

By:

Its: ____________________________
HIPAA Privacy Plan Sponsor Certification to Health Care Flexible Spending Account

Ingham County (the “Plan Sponsor”), the sponsor of the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan (the “Plan”), of which the health care flexible spending account within may be a “group health plan” as defined 45 CFR § 160.103, hereby certifies that the Plan documents that govern the Plan have been amended to incorporate the following provisions and the Plan Sponsor agrees that with respect to any PHI and EPHI, as applicable, disclosed to it by the health care flexible spending account or any other covered entity, the Plan Sponsor shall:

(a) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law.

(b) Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make PHI available in accordance with 45 C.F.R. §164.524 (related to access of individuals to PHI).

(f) Make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526.

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528.

(h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 C.F.R. Part 164, Subpart E.

(i) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) Ensure that the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is established.

(k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(l) Report to the Plan any security incident, as defined by the HIPAA Security Rules, of which it becomes aware.

(m) Ensure that any agent to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect the EPHI that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the group health plan.

(n) Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

Authorized Signature ____________________________________________
Printed Name & Title _______________________________________________
Plan Sponsor ____________________________________________ Date ________
INTRODUCED BY THE COUNTY SERVICES AND FINANCE COMMITTEES OF THE:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION ADOPTING THE INGHAM COUNTY SECTION 125 SECOND AMENDED AND RESTATED FLEXIBLE BENEFIT PLAN

WHEREAS, the Ingham County Section 125 Flexible Benefit Plan and SPD have been amended and restated to incorporate all previous Amendments and Summaries of Material Modifications; and

WHEREAS, these restated documents also incorporate changes to conform to 2020 practices; and

WHEREAS, the Plan has been amended to incorporate changes to the benefit of employees due to recent legislation spurred by the COVID-19 pandemic; and

WHEREAS, adoption by the Ingham County Board of Commissioners of the amendments and restatements are recommended by legal counsel to meet the requirements of applicable Internal Revenue Code sections.

THEREFORE BE IT RESOLVED, that Ingham County's adoption of the Ingham County Section 125 Second Amended and Restated Flexible Benefit Plan (“Plan”), effective as of the dates contained therein, is affirmed and ratified.

BE IT FURTHER RESOLVED, that the actions of the Controller/Administrator necessary to adopt the Plan on behalf of Ingham County are hereby affirmed and ratified.

BE IT FURTHER RESOLVED, that the Controller/Administrator is authorized to take further actions on behalf of Ingham County that are necessary to execute any future amendment to or restatement of the Plan and that such amendment or restatement will be adopted by Ingham County, effective as of the dates contained therein, without need for a further Resolution or Board of Commissioners involvement.

BE IT FURTHER RESOLVED, that the Controller/Administrator is authorized to sign any necessary documents and contract agreement(s) upon approval as to form by the County Attorney.
TO: Board of Commissioners County Services and Finance Committees
FROM: Sue Graham, Human Resources Director
DATE: July 7, 2020
SUBJECT: Resolution Amending the Health Advisory Leave Policy
For the meeting agendas of July 21 (County Services) and July 22 (Finance)

BACKGROUND
Ingham County has declared a health advisory beginning March 10, 2020 due to the coronavirus pandemic. In response to the coronavirus pandemic, on March 24, 2020, the Board of Commissioners adopted Resolution #20-112 approving a Health Advisory Leave (HAL) Policy. Since that time, circumstances have developed such that amendment to this policy is warranted to further the purpose and intent of the policy to provide relief to employees experiencing hardship during the coronavirus pandemic. The proposed amendments reflected in the attached document would:

1. Permit the HAL Policy to apply where an employee subject to a mandatory work schedule reduction under the Work Share Program and the reduction in hours by Ingham County does not qualify the employee for Work Share benefits under applicable State law.
2. Clarify that “caring for a family member” includes temporary care of an individual which becomes necessary due to visitation restrictions at a nursing home or assisted living facility.
3. Expand the nature of supporting documentation to correspond with the proposed amendments.

ALTERNATIVES
The Board of Commissioners could decline to authorize the proposed amendments.

FINANCIAL IMPACT
The financial impact to the County will depend upon the extent the amendments increase utilization of HAL. An increase in utilization is not expected to be significant at this time.

STRATEGIC PLAN CONSIDERATIONS
The adoption of a Health Advisory Leave Policy is in furtherance of the following strategic goal(s) and task(s) included in the Strategic Plan:

Goal F. Human Resources and Staffing: Attract and retain exceptional employees who reflect the community they serve and who prioritize public service. Strategy 1: Attract and retain employees who value public service.

OTHER CONSIDERATIONS
The proposed amended language has been approved by corporate counsel.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution to amend the Health Advisory Leave Policy.
Introduction:

Agenda Item 9c

INTRODUCED BY THE COUNTY SERVICES AND FINANCE COMMITTEES OF THE:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION AMENDING THE HEALTH ADVISORY LEAVE POLICY

WHEREAS, Ingham County has declared a health advisory beginning March 10, 2020 due to the coronavirus pandemic; and

WHEREAS, in response to the coronavirus pandemic, on March 24, 2020, the Board of Commissioners adopted Resolution #20-112 approving a Health Advisory Leave (HAL) Policy; and

WHEREAS, since that time, circumstances have developed such that amendment to this policy is warranted to further the purpose and intent of the policy to provide relief to employees experiencing hardship during the coronavirus pandemic; and

WHEREAS, the proposed amendments reflected in the attached document would:

1. Permit the HAL Policy to apply where an employee subject to a mandatory work schedule reduction under the Work Share Program and the reduction in hours by Ingham County does not qualify the employee for Work Share benefits under applicable State law.
2. Clarify that “caring for a family member” includes temporary care of an individual which becomes necessary due to visitation restrictions at a nursing home or assisted living facility.
3. Expand the nature of acceptable supporting documentation to correspond with the proposed amendments; and

WHEREAS, the proposed amended language has been approved as to form by corporate counsel.

THEREFORE BE IT RESOLVED, that the Board of Commissioners hereby approves the proposed amendments to the Health Advisory Leave Policy retroactive to March 10, 2020 and going forward.
ALL OTHER EMPLOYEES:

Depending on the nature and severity of the situation, an Elected Official/Department Head (or designee) may authorize a request for Health Advisory Leave for employees who are not required to report to work and who are not required to be available to work. These employees:

1. May not be required to report to work or may be directed to stay away from their worksites.
2. May be instructed not to report until contacted by their Elected Official/Department Head (or designee) with further directions.
3. May be instructed not to report to work if they are reasonably believed to have been exposed to, or infected with, the severe communicable disease.
4. May be instructed not to report to work if the employee is showing symptoms of the severe communicable disease (for example, coughing, sneezing, fever, diarrhea, nausea, etc.) until they are free of fever (100.4 degrees or greater) and/or free of any other symptoms (coughing, sneezing, etc.) for at least 24 hours prior to the start of their shift, without the use of fever reducing or other symptom altering medicines (cough suppressants). “Symptoms of the severe communicable disease” are defined as those identified by qualified medical professionals and/or health officials. Supporting documentation from a health care provider is not required.
5. May be subject to a mandatory work schedule reduction under the Work Share Program and the reduction in hours by Ingham County does not qualify the employee for Work Share benefits under applicable State law.

HEALTH ADVISORY LEAVE: If the Elected Official/Department Head (or designee) authorizes the employee to take Health Advisory Leave, the employee:

1. May use up to 120 hours of paid Health Advisory Leave per year to care for themselves or their family member during a Health Advisory period. This paid leave is separate and distinct from any other category of paid leave, including but not limited to paid sick leave. “Care for a family member” includes care required due to closure of schools, day care facilities, nursing homes or assisted living facilities or temporary care of an individual which becomes necessary due to visitation restrictions at a nursing home or assisted living facility.
2. If approved for Health Advisory Leave under Section 5 above, the employee may only use Health Advisory Leave to cover any reduction in hours by Ingham County under the Work Share Program, which does not qualify the employee for Work Share benefits under applicable State law.
3. May not use Health Advisory Leave for previously scheduled unrelated medical appointments/procedures, vacation or other leaves of absence unrelated to the Health Advisory.
4. Paid Health Advisory Leave hours are available for use to provide paid leave for hours an employee is regularly scheduled to work.
5. Must follow established call-in/reporting procedures to notify supervision of their absence in the event Health Advisory leave is taken.
Extension: An employee may request an extension of Health Advisory Leave for one of the following reasons:

1) If an employee has been infected with a severe communicable disease, is reasonably likely to spread a severe communicable disease to coworkers or customers through the performance of the employee's regular job duties, and/or is unable to perform the essential functions of their job without possible harm to themselves or others.

2) If an employee is subject to a mandatory work schedule reduction under the Work Share Program and the reduction hours by Ingham County does not qualify the employee for Work Share Program benefits under applicable State law. A request under this provision only qualifies the employee for Health Advisory Leave to cover the reduction in hours that they are not otherwise qualified for benefits under the Work Share Program.

After consulting the Controller/Administrator, and appropriate Elected Official or Department Head, the Human Resources Director will determine whether additional hours of Health Advisory Leave will be granted, taking into consideration all relevant information, which may include but is not limited to the recommendation of the employee’s or employee’s family member’s health care provider.
TO:    Board of Commissioners County Services and Finance Committees
FROM: Sue Graham, Human Resources Director
DATE: July 6, 2020
SUBJECT: Resolution to Approve Generic Service Credit Purchase for County Employee: Cindy S. Farley
For the meeting agendas of 7/21 and 7/22

BACKGROUND
Pursuant to standing County Resolution #02-101, dated April 9, 2002, it is permissible for employees to purchase generic service credit under the Municipal Employees’ Retirement System (MERS). Cindy S. Farley has completed the MERS application and received the cost estimate to purchase zero (0) years, five (5) months under the County’s plan.

ALTERNATIVES
The Board of Commissioners may choose not to approve the request.

FINANCIAL IMPACT
Resolution #02-101 provides that the cost for generic service “must be totally borne by the employee.”

STRATEGIC PLAN CONSIDERATIONS
N/A

OTHER CONSIDERATIONS
N/A

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution to approve generic service credit purchase for County employee Cindy S. Farley.
WHEREAS, pursuant to standing County Resolution #02-101, dated April 9, 2002, it is permissible for employees to purchase generic service credit under the Municipal Employees’ Retirement System (MERS); and

WHEREAS, the Resolution further provides that the cost for generic service “must be totally borne by the employee”; and

WHEREAS, Cindy S. Farley has completed the MERS application and received the cost estimate to purchase zero (0) years, five (5) months under the County’s plan; and

WHEREAS, by Board of Commissioners approval under the standing Resolution, and by the employee’s payment to MERS, Ms. Farley will purchase zero (0) years, five (5) months generic service.

THEREFORE BE IT RESOLVED, that upon the request of County employee Cindy S. Farley, the Board of Commissioners hereby approves the purchase of zero (0) years, five (5) months generic service under County Resolution #02-101.

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners is authorized on behalf of the County to sign and execute all MERS documents to effectuate and finalize this transaction, subject to approval as to form, by the County Attorney.
TO: Board of Commissioners County Services and Finance Committees  
FROM: Sue Graham, Human Resources Director  
DATE: July 7, 2020  
SUBJECT: Resolution Authorizing Extension of the Contract for Sparrow Occupational Health Services  
For the meeting agendas of July 21 (County Services) and July 22 (Finance)

BACKGROUND
Ingham County and Sparrow Occupational Health Services have an existing contract for the provision of occupational health services to employees (physicals, drug screens and occupational injury care) with an expiration date of September 30, 2020. This contract was authorized by Resolution #15-305 which extended the contract through this date. It has been typical practice that we would re-bid a contract after 5 years and not policy. Given the current state of affairs and with the support of the Purchasing Department, we propose to extend this contract for a 1-year period with plans to issue an RPF for Occupational Health Services during 2021.

Sparrow Occupational Health Services is in agreement with a 1-year extension of the contract and is willing to extend the prices for physicals/drug screens that they are currently charging with the existing contract. Injury care will continue to be billed according to the State of Michigan Workers Compensation Fee Schedule (see attached letter from Sparrow Occupational Health Services).

ALTERNATIVES
The Board of Commissioners could decline to authorize the extension. In that event, an RFP would be issued for Occupational Health Services. Given the current state of affairs, there is a potential for a lapse in such services during the RFP process.

FINANCIAL IMPACT
Sparrow Occupational Health Services is willing to extend the prices for physicals/drug screens that they are currently charging with the existing contract. Injury care will continue to be billed according to the State of Michigan Workers Compensation Fee Schedule.

STRATEGIC PLAN CONSIDERATIONS
The adoption of a Health Advisory Leave Policy is in furtherance of the following strategic goal(s) and task(s) included in the Strategic Plan:

Goal F. Human Resources and Staffing: Attract and retain exceptional employees who reflect the community they serve and who prioritize public service. Strategy 1: Attract and retain employees who value public service.

OTHER CONSIDERATIONS
Ingham County is obligated to provide for care for occupational injuries and illnesses incurred by employees pursuant to the Michigan Workers Disability Compensation Act, PA 317 of 1969 as amended, MCL 418.101 et seq.
RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution to support a 1-year extension of the contract for occupational health services with Sparrow Occupational Health Services to expire September 30, 2021.
To:        Sue Graham

From:    Jared Wirth, Sue Stock

CC:    

Date:    7/14/2020

Re:    Sparrow Occupational Health Contract

Sue,

As we near completion of the contract between Ingham County and Sparrow’s Occupational Health Services we would like to formally express our interest in extending the agreement for an additional year. We feel that this has been a mutually beneficial agreement, as we have worked collaboratively with Ingham County to provide quality medical services to Ingham County employees. The existing contract expires September 30, 2020.

We are willing to extend the prices for physicals/drug screens that we are charging with the existing contract.

Injury care will continue to be billed according to the present State of Michigan Workers Compensation Fee Schedule

We look forward to the opportunity to continue to work with you to keep the employees of Ingham County healthy and on the job. Please let us know if you have any questions or if you need additional information. This extension would expire on September 30, 2021.
Introduc ed by the County Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION AUTHORIZING EXTENSION OF THE CONTRACT FOR SPARROW OCCUPATIONAL HEALTH SERVICES

WHEREAS, Ingham County and Sparrow Occupational Health Services have an existing contract for the provision of occupational health services to employees (physicals, drug screens and occupational injury care) with an expiration date of September 30, 2020; and

WHEREAS, this contract was authorized by Resolution #15-305 which extended the contract through this date; and

WHEREAS, while it has been typical practice that a contract is re-bid after 5 years, it is not required by policy; and

WHEREAS, with the current state of affairs due to the coronavirus pandemic, and with the support of the Purchasing Department, it is desirable to extend this contract for a 1-year period with plans to issue an RPF for Occupational Health Services during 2021; and

WHEREAS, Sparrow Occupational Health Services is in agreement with a 1-year extension of the contract and is willing to extend the prices for physicals/drug screens that they are currently charging with the existing contract.

THEREFORE BE IT RESOLVED, that the Board of Commissioners hereby approves a 1-year extension of the current contract for occupational health services with Sparrow Occupational Health Services through September 30, 2021.

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners is authorized on behalf of the County to sign and execute all contracts or documents necessary to effectuate and finalize this transaction, subject to approval as to form, by the County Attorney.
WHEREAS, the U.S. Environmental Protection Agency continues to document increasing levels of greenhouse gas emissions, largely from transportation, residential and commercial buildings, industrial sources, agricultural practices and the handling of waste, all of which heavily contribute to warming our climate; and

WHEREAS, the consensus conclusion of scientific and policy assessments from the Intergovernmental Panel on Climate Change calls for urgent and decisive actions by governments around the world to make “rapid, far-reaching and unprecedented changes in all aspects of society” in order to limit global warming to 1.5 degrees Celsius to avoid the most disastrous impacts; and

WHEREAS, the federal U.S. Fourth National Climate Assessment detailed the massive threat that climate change poses to the American economy and underscored the need for emergency climate action at all levels of government; and

WHEREAS, the temperature in Verkhoyansk, Siberia hit 101 degrees Fahrenheit on June 20, 2020, the hottest temperature ever recorded in the Arctic Circle; and

WHEREAS, the Environmental Law & Policy Center’s 2019 Assessment of the Impacts of Climate Change on the Great Lakes highlighted the significant impacts in our own backyard, including the flooding of streets, homes and agricultural areas, power outages, record low and high temperatures, delayed planting, and weather-related school and business closures; and

WHEREAS, the Ingham County Board of Commissioners on June 9, 2020, formally declared racism a public health crisis; and

WHEREAS, the economic and environmental hardships related to climate warming disproportionately affect underserved populations, particularly Black and Latino residents; and

WHEREAS, the National Centers for Disease Control has unequivocally stated that climate change affects health, resulting in further untold costs to citizens, especially people of color and low-income residents; and

WHEREAS, people of color in the U.S. are 38% more likely to be exposed to the asthma-causing pollutant nitrogen oxide from climate-warming cars, construction equipment, and industrial sources like coal plants, according to a 2014 study from the University of Minnesota; and

WHEREAS, more than 1,000 local governments in 18 countries have already signed emergency declarations, including, Ann Arbor, Kalamazoo and Washtenaw County; and

WHEREAS, the most recent meeting of the U.S. Conference of Mayors issued a resolution declaring a climate emergency and calling for decarbonization in time to keep the global rise in temperatures to a 1.5-degree Celsius level and emphasizing that such efforts must involve local governments and their jurisdictions; and
WHEREAS, Ingham County’s five-year strategic action plan, which outlines the County’s vision, values and resource allocations, distinguishes services to residents first, in addition to monitoring environmental hazards and environmental protection; and

WHEREAS, a formal declaration of a climate emergency by Ingham County can help provide the catalyst to mobilize residents, businesses, institutions, faith, civil rights and community organizations to work together to prioritize the immediate reduction of CO2 emissions and support the County’s efforts to plan for community resilience and adaptation under environmental threat.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners hereby declares a climate emergency for Ingham County.

BE IT FURTHER RESOLVED, that the intent of this declaration is to build awareness and urgency to develop sustainable practices in County government, including identifying and implementing environmental programming into its existing commitments.

BE IT FURTHER RESOLVED, that Ingham County accepts a role of regional leadership, and as such will seek partnerships with other regional governments, businesses, community groups, educational and other anchor institutions to best utilize regional expertise and resources to meet shared goals.

BE IT FURTHER RESOLVED, that Ingham County will, expeditiously and with serious determination, seek any available state, federal, and private funding for this effort and form alliances with other Michigan cities that have declared a climate emergency or have a written climate action plan to lobby for such funding.

BE IT FURTHER RESOLVED, that Ingham County will underscore the need for full community participation, inclusion, and support for the climate mobilization effort.

BE IT FURTHER RESOLVED, that Ingham County commits to keeping the concerns of vulnerable communities central to these efforts and will proactively invite and encourage underserved and vulnerable communities to actively participate in order to advocate directly for their needs.