
Agenda

Call to Order
Approval of the June 17, 2020 Minutes
Additions to the Agenda
Limited Public Comment

1. **Treasurer’s Office** – 1st Quarter Investment Report

2. **Sheriff’s Office** – Resolution to Authorize a Contract with Mid-Michigan Police K9 to Purchase and Train a Replacement Canine Dog for the Sheriff’s Office

3. **Law & Court Committee** – Resolution to Adopt the 2021 Juvenile Justice Community Agency Process Calendar

4. **Fair Office** – Resolution to Host a Halloween Event at Ingham County Fairgrounds

5. **Parks Department**
   a. Resolution to Authorize the Revenue Collection of Parks Vehicle Entrance Fees at the Lake Lansing Boat Launch
   b. Resolution to Authorize Fees for Camping at Burchfield Park
   c. Resolution to Authorize a Contract with Laux Construction LLC for Burchfield Park Improvements

6. **Health Department**
   a. Resolution to Authorize an Agreement with Drug and Laboratory Disposal, Inc.
   b. Resolution to Authorize an Agreement with Ingham Health Plan Corporation
   c. Resolution to Authorize a 2020 -2021 Agreement with the Michigan Department of Health and Human Services for the Delivery of Public Health Services Under the Comprehensive Agreement
   d. Resolution to Accept Ryan White Part D Covid-19 Funding Award from HRSA
   e. Resolution to Accept U.S. Department of Health and Human Services Health Resources and Services Administration Provider Relief Funds
   f. Resolution to Accept U.S. Department of Health and Human Services Health Resources and Services Administration Provider Relief Funds
   g. Resolution to Extend Ob/Gyn Physician Services Agreement with Edward W. Sparrow Hospital Association
   h. Resolution to Authorize an Agreement with Michigan State University College of Nursing for Pediatric Nurse Practitioner Services
7. **Human Service Committee** – Resolution Authorizing the Ingham County Racial Equity Taskforce to Accept **Donations**

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

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

10. **Road Department**
    a. Resolution to Approve **Local Road Agreements** with Alaiedon, Aurelius, Bunker Hill, Leroy, Locke, Stockbridge, Vevay and Wheatfield Townships
    b. Resolution Authorizing the Extension of Resolution #17-235 for **Dust Control Solution**
    c. Resolution Authorizing the Extension of RFP #17-349, Purchase of Seasonal Corrosion Inhibited Liquid **De-Icer Solution**

11. **Human Resources Department**
    a. Resolution Authorizing Extension of the Contract for Sparrow **Occupational Health Services**
    b. Resolution Adopting the Ingham County Section 125 Second Amended and Restated Flexible **Benefit Plan**
    c. Resolution to Approve Generic Service Credit Purchase for County Employee: **Cindy S. Farley**

12. **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. **911 Tower Update**

13. **Controller/Administrator’s Office** – Resolution to Authorize **Budget Adjustments** for 2020 Based on the Annual Evaluation of the County’s Financial Reserve Policy

**Announcements**

**Public Comment**

**Adjournment**

**PLEASE TURN OFF CELL PHONES OR OTHER ELECTRONIC DEVICES OR SET TO MUTE OR VIBRATE TO AVOID DISRUPTION DURING THE MEETING**

The County of Ingham will provide necessary reasonable auxiliary aids and services, such as interpreters for the hearing impaired and audio tapes of printed materials being considered at the meeting for the visually impaired, for individuals with disabilities at the meeting upon five (5) working days notice to the County of Ingham. Individuals with disabilities requiring auxiliary aids or services should contact the County of Ingham in writing or by calling the following: Ingham County Board of Commissioners, P.O. Box 319, Mason, MI 48854 Phone: (517) 676-7200. A quorum of the Board of Commissioners may be in attendance at this meeting. Meeting information is also available on line at www.ingham.org.
FINANCE COMMITTEE
June 17, 2020
Draft Minutes

Members Present: Morgan, Grebner, Crenshaw, Polsdofer, Schafer, Tennis, and Maiville.

Members Absent: None.

Others Present: Michael Townsend, Lindsey McKeever, Andrew Bouck, Bill Conklin, Elizabeth Noel, Michael Tanis, and others.

The meeting was called to order by Chairperson Morgan at 6:30 p.m. virtually via Zoom in accordance with the Governor’s Executive Order 2020-75 regarding the Open Meetings Act.

Approval of June 3, 2020 Minutes

MOVED BY COMM. MAIVILLE, SUPPORTED BY COMM. CRENSHAW, TO APPROVE THE MINUTES OF THE JUNE 3, 2020 FINANCE COMMITTEE MEETING.

THE MOTION CARRIED UNANIMOUSLY.

Additions to the Agenda

Agenda Change –
8. Road Department – Claim Made by Melissa Serafini Against Ingham County

Late –
9. Animal Control – Resolution to Accept a Two Seven Oh! Grant for Reimbursement of Medical Costs

10. Circuit Court Family Division
   a. Resolution to Authorize Amendments to the 2020 Contract with Ingham Intermediate School District for Educational Instruction at the Ingham Academy
   b. Resolution to Authorize Amendments to the 2020 Contract with Highfields for Educational Instruction at the Ingham Academy

Limited Public Comment

None.

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

1. Sheriff’s Office – Resolution to Continue Support Service Agreement with Carousel Industries for the Jail & Training Rooms Audio & Video Systems with the Ingham County Sheriff’s Office
2. Community Corrections – Resolution to Authorize Submission of a Grant Application and a Contract with the Michigan Department of Corrections for Ingham County/City of Lansing Community Corrections and Program Subcontracts for FY 2020-2021

3. Fair Office – Resolution Adjusting Horse Show Fees for 2020

4. Health Department – Resolution to Amend Resolutions #19-552 and #19-507 and to Authorize an Agreement with Community Mental Health for the Region 7 Perinatal Collaborative

5. 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


7. Community Agencies – Resolution Approving Criteria for Evaluating 2021 Community Agency Funding Applications

8. Animal Control – Resolution to Accept a Two Seven Oh! Grant for Reimbursement of Medical Costs

9. Circuit Court Family Division
   a. Resolution to Authorize Amendments to the 2020 Contract with Ingham Intermediate School District for Educational Instruction at the Ingham Academy
   b. Resolution to Authorize Amendments to the 2020 Contract with Highfields for Educational Instruction at the Ingham Academy

THE MOTION CARRIED UNANIMOUSLY.

THE MOTION TO APPROVE THE ITEMS ON THE CONSENT AGENDA CARRIED UNANIMOUSLY.

8. Road Department – Claim Made by Melissa Serafini Against Ingham County

MOVED BY COMM. CRENSHAW, SUPPORTED BY COMM. TENNIS, TO ACCEPT THE ATTORNEY-CLIENT PRIVILEGE RECOMMENDATION REGARDING THE CLAIM MADE BY MELISSA SERAFINI AGAINST INGHAM COUNTY AND TO AUTHORIZE THE ATTORNEY FOR MMRMA TO PROCEED IN THIS MATTER CONSISTENT WITH THE RECOMMENDATIONS.

THE MOTION CARRIED. **Yeas:** Morgan, Tennis, Grebner, Crenshaw, Polsdof, Maiville

**Nays:** Schafer

**Absent:** None
Announcements

Discussion.

Commissioner Crenshaw stated that, as a reminder for Commissioners who were on the Controller Search Committee, there would be a meeting on June 18, 2020 to conduct interviews. He further stated that the Committee would be meeting at the Fairgrounds Office at 12:30 p.m., and would proceed with interviews starting at 1:00 p.m.

Public Comment

None.

Adjournment

The meeting was adjourned at 6:35 p.m.
RESOLUTION ACTION ITEMS:

The Controller’s Office recommends approval of the following resolutions:

2. **Sheriff’s Office** – Resolution to Authorize a Contract with Mid-Michigan Police K9 to Purchase and Train a Replacement Canine Dog for the Sheriff’s Office

This resolution will approve the entry into a contract on behalf of the Ingham County Sheriff’s Office with Mid-Michigan Police K9, in an amount not to exceed $13,500 to purchase a new Canine dog and to train its handler. This will be a replacement for Canine Smoke, who retired due to age on June 18, 2020. Funds are available within the Sheriff’s Office budget for this purchase.

See memo for details.

3. **Law & Courts Committee** – Resolution to Adopt the 2021 Juvenile Justice Community Agency Process Calendar

This resolution will authorize the adoption of the 2021 Juvenile Justice Community Agency Process calendar to establish time lines and a budget amount. A total of $125,000 was allocated in 2020 out of Juvenile Justice Millage funds for this program. Grants were awarded in the amount of $143,071.

See memo for details.

4. **Fair Office** – Resolution to Host a Halloween Event at Ingham County Fairgrounds

This resolution authorizes a contract with Debbie Katz Productions for a Halloween Event at the Ingham County Fairgrounds. Total cost of the event including the main contract and marketing and other expenses will not exceed $150,000. Funds currently budgeted for expenses associated with the 2020 Fair will be utilized to cover the costs associated with this event. This Halloween event will take the place of the Fair as the large main event to be held at the Fairgrounds this year.

5a. **Parks Department** - Resolution to Authorize the Revenue Collection of Parks Vehicle Entrance Fees at the Lake Lansing Boat Launch

This resolution approve the revenue collection of the parks vehicle entrance fees at the Lake Lansing Boat Launch for vehicles not launching watercraft on days that allow at the Lake Lansing Boat Launch at the current rates listed below:

- Resident Vehicle Daily - $3
- Resident Vehicle Annual - $32
- Non-Resident Vehicle Daily - $5
- Non-Resident Vehicle Annual - $42
5b. **Parks Department** - Resolution to Authorize Fees for Camping at Burchfield Park

This resolution authorizes fees for camping options at Burchfield Park:

- Rustic Camping in designated areas $15/night (for the 2021 season)
- Yurt/Cabin Camping $85/night (for future season, when yurt/cabins are built)
- $200 damage fee for cleanup of campsites

5c. **Parks Department** - Resolution to Authorize a Contract with Laux Construction LLC for Burfield Park Improvements

This resolution authorizes a contract with Laux Construction LLC as quoted in the base bid in the amount of $409,902.73 plus a 10% contingency of $40,990.27 for a total construction cost not to exceed $450,893 to enter into a contract for the purpose of making improvements to Burchfield Park. The scope of work includes, but is not limited to, the construction of sidewalk, kayak launch, ADA parking spaces, drainage improvements, resurfacing of gravel drives and parking lots as well as upgrading restroom buildings.

6a. **Health Department** - Resolution to Authorize an Agreement with Drug and Laboratory Disposal, Inc.

This resolution authorizes an agreement with Drug and Laboratory Disposal (DLD) for providing hazardous waste hauling services effective August 1, 2020 through July 31, 2022 with a two year period renewal option at the rates outlined in DLD’s proposal.

6b. **Health Department** - Resolution to Authorize an Agreement with Ingham Health Plan Corporation

This resolution authorizes a provider agreement with IHPC for the period of October 1, 2020 through September 30, 2021. This provider agreement will allow IHPC to pay on a fee-for-services basis for primary care services provided to IHPC members assigned to ICHD’s Community Health Centers (CHCs). ICHD will receive the same fee-for-service payment as other IHPC medical providers. The reimbursement amount will be no less than Medicaid reimbursement rates, minus co-payments, deductibles and other similar amounts.

6c. **Health Department** - Resolution to Authorize a 2020-2021 Agreement with the Michigan Department of Health and Human Services for the Delivery of Public Health Services Under the Comprehensive Agreement

This resolution authorizes the annual comprehensive agreement with Michigan Department of Health & Human Services (MDHSS) in an amount just over $6.4 million effective October 1, 2020 through September 30, 2021. Additional details are included in the memorandum that accompanies the resolution.

6d. **Health Department** - Resolution to Accept Ryan White Part D Covid-19 Funding Award from HRSA

This resolution funding award totaling $35,514.00 is from the U.S. Department of Health Resources and Services Administration (HRSA). These funds are a one-time HRSA award effective April 1, 2020 through March 31, 2021. This one time funding will support ICHD’s CHCs immediate response to COVID-19 among people with HIV and the nation’s most vulnerable populations.
6e. **Health Department - Resolution to Accept U.S. Department of Health and Human Services Health Resources and Services Administration Provider Relief Funds**

This resolution authorizes a funding award of $281,039.03 from the U.S. Department of Health Resources and Services Administration (HRSA), Provider Relief Fund. This funding support is for the period of June 19, 2020 through March 31, 2021. This funding will reimburse ICHC only for health care related expenses or lost revenues that are attributable to coronavirus.

6f. **Health Department - Resolution to Accept U.S. Department of Health and Human Services Health Resources and Services Administration Provider Relief Funds**

This resolution accepts a funding award of $52,169.59 from the U.S. Department of Health and Human Services Administration (HRSA), Provider Relief Fund. This funding will provide needed support to ICHD’s CHCs due to revenues lost as a result of the coronavirus and will be effective April 17, 2020 through December 31, 2020.

6g. **Health Department - Resolution to Extend Ob/Gyn Physician Services Agreement with Edward W. Sparrow Hospital Association**

This resolution authorizes an extension to the agreement with Sparrow for providing 1.0 FTE physician services, including oversight of mid-level providers and medical administration support to ICHD Women’s Health Services for an amount not to exceed $100,000 annually, effective July 1, 2020 through June 30, 2023.

6h. **Health Department - Resolution to Authorize an Agreement with Michigan State University College of Nursing for Pediatric Nurse Practitioner Services**

This resolution is an agreement with Michigan State University’s College of Nursing (MSU CON), to provide a pediatric nurse practitioner (NP) at the Willow Community Health Center, to be paid no more than $31,467.32 a year, effective September 1, 2020 through August 31, 2021.

7. **Human Service Committee – Resolution Authorizing the Ingham County Racial Equity Taskforce to Accept Donations**

This resolution authorizes the Ingham County Racial Equity Taskforce to raise funds and accept donations for the purpose of promoting and assisting the Taskforce with accomplishing its goals to achieve equitable outcomes in wealth accumulation and income, education, safety, health and other measures of well-being among all Black Ingham County residents.

8. **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.
9. **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.

10a. **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.

![Table](image-url)
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.

10b. **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.

See memo for details.

10c. **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.

11a. **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.

11b. **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.

11c. **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.

12a. **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) 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 the 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.
13. **Controller/Administrator’s Office** – Resolution to Authorize Budget Adjustments for 2020 Based on the Annual Evaluation of the County’s Financial Reserve Policy

This resolution will amend the 2020 budget to authorize a transfers totaling $745,236 from the General Fund unassigned balance to the Public Improvements Fund in the amount of $520,236 and to the Budget Stabilization Fund in the amount of $225,000 in order to provide adequate funds for infrastructure maintenance and improvements and meet minimum targets

**PRESENTATION/DISCUSSION/OTHER ITEM:**

1. **Treasurer’s Office** – 1st Quarter Investment Report
# INGHAM COUNTY
## POOLED CASH AND INVESTMENTS
### MARCH 31, 2020

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**TOTAL CERTIFICATES OF DEPOSIT**: 14,014,867.19

### RESERVE AND SAVINGS

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**TOTAL RESERVE AND SAVINGS**: 42,616,228.46

### FEDERAL AGENCY COUPON SECURITIES

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| Federal Farm Credit Bank | 12/19/2019 | 12/30/2026 | 2.30 | 1,000,000.00 |
| Federal Farm Credit Bank | 12/3/2019  | 12/18/2028 | 2.53 | 1,987,500.00 |
| Federal Farm Credit Bank | 3/25/2020  | 3/25/2025  | 1.20 | 2,000,000.00 |
| Federal Home Loan Bank  | 11/7/2016  | 11/1/2021  | 1.50 | 2,000,000.00 |
| Federal Home Loan Bank  | 5/28/2019  | 8/28/2028  | 3.17 | 1,000,088.06 |
| Federal Home Loan Bank  | 7/18/2019  | 7/17/2025  | 2.46 | 2,000,000.00 |
| Federal Farm Credit Bank | 3/30/2020 | 3/30/2027 | 1.55 | 2,000,000.00 |
| Federal Home Loan Bank  | 3/26/2020  | 3/25/2025  | 1.20 | 2,000,000.00 |
| Federal Farm Credit Bank | 4/23/2019 | 4/24/2023 | 2.70 | 2,000,000.00 |

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**TOTAL COMMERCIAL PAPER**

$17,890,210.27

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</tr>
<tr>
<td>South Lyon Community Schools</td>
<td>5/15/2013</td>
<td>5/1/2020</td>
<td>2.24</td>
</tr>
<tr>
<td>Wayland Union School District</td>
<td>12/1/2016</td>
<td>5/1/2020</td>
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<tr>
<td>Lansing Board of Water and Light</td>
<td>6/15/2011</td>
<td>7/1/2020</td>
<td>3.5</td>
</tr>
<tr>
<td>Haslett Schools</td>
<td>5/24/2017</td>
<td>5/1/2021</td>
<td>2.01</td>
</tr>
<tr>
<td>South Lyon Community Schools</td>
<td>5/15/2013</td>
<td>5/1/2022</td>
<td>2.69</td>
</tr>
<tr>
<td>State of Michigan A REG</td>
<td>6/19/2017</td>
<td>11/1/2022</td>
<td>1.97</td>
</tr>
<tr>
<td>Houghton-Portage Township</td>
<td>6/21/2016</td>
<td>5/1/2025</td>
<td>2.7</td>
</tr>
<tr>
<td>Ionia School District</td>
<td>3/22/2017</td>
<td>5/1/2025</td>
<td>2.2</td>
</tr>
</tbody>
</table>

**TOTAL MUNICIPAL BONDS**

$5,141,912.99

**TOTAL POOLED INVESTMENTS**

$96,660,806.97

**TOTAL POOLED CASH AND INVESTMENTS**

$109,138,076.16

---

Eric A. Schertzing, Ingham County Treasurer
TO: Board of Commissioners / Law and Courts Committee  
FROM: Lieutenant Andy Daenzer  
DATE: Thursday, June 25th 2020  
SUBJECT: Request to Purchase a New Canine for ICSO

BACKGROUND  
The Ingham County Sheriff’s Office would like the approval to enter into a contract to purchase and train a Narcotics/Patrol Canine with Mid-Michigan Police K9 to replace a retired Canine.

ALTERNATIVES  
The alternative is to not replace the retired Canine. The ICSO currently has 4 Canine Teams assigned to the road patrol. The teams are a regional asset utilized by every police agency in the County. If we do not replace the retired Canine, we would have less availability to respond to the average 200 plus calls for service the Canine team handles annually.

FINANCIAL IMPACT  
The cost for the Canine and training is $13,500. The training includes a 5-week handler course.

STRATEGIC PLANNING IMPACT  
The strategic plan may be impacted if this is not approved by reducing the Sheriff’s Office’s ability to maintain its current ability to locate missing and/or wanted persons, as well its continued efforts to combat the opiate epidemic.

OTHER CONSIDERATIONS  
Our narcotics trained Canines are a frontline tool in fighting the opiate epidemic in the public and in our jail facility. The Sheriff’s Office has a responsibility to use every tool at its disposal to maintain safety and security in the confines of our jail by conducting random Canine searches. A narcotics trained Canine is a forward locating tool in eliminating the potential pit falls of narcotics in our jail.

RECOMMENDATION  
Based on the information presented, I respectfully recommend approval of the attached resolution to enter into a contract with Mid-Michigan Police K9 to purchase and train a new Canine for the ICSO Canine team.
Introduced by the Law & Courts and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE A CONTRACT WITH MID-MICHIGAN POLICE K9 TO PURCHASE AND TRAIN A REPLACEMENT CANINE DOG FOR THE SHERIFF’S OFFICE

WHEREAS, the Ingham County Sheriff’s Office has had, during Sheriff Scott Wriggelsworth’s tenure as the Sheriff, a Canine Team; and

WHEREAS, the Canine Team has consisted of 4 canines assigned to road patrol that serve as a regional and Ingham County Jail asset; and

WHEREAS, Deputy Narlock retired Canine Smoke on June 18, 2020 in good standing due to age; and

WHEREAS, the new Canine team would be trained to detect narcotics including opiates for detection in our jail, schools and the public; and

WHEREAS, the new Canine team would also be trained in obedience, article search, area search and tracking for suspects and missing persons including children and adults; and

WHEREAS, the Ingham County Sheriff’s Office has a long history of purchasing trained Canine dogs; and

WHEREAS, the Ingham County Sheriff’s Office requests to enter into a contract with Mid-Michigan Police K9 to purchase a new Canine and to train its new handler at a cost not to exceed $13,500; and

WHEREAS, the Ingham County Sheriff’s Office would use account number 10130110 Special Units to pay this cost; and

WHEREAS, upon the future retirement of this new Canine with a handler in good standing the ownership and any liabilities and responsibilities for the Canine will be transferred from Ingham County to the handler for $1.00.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners approves the entry into a contract on behalf of the Ingham County Sheriff’s Office with Mid-Michigan Police K9, in an amount not to exceed $13,500 to purchase a new Canine dog and to train its handler.

BE IT FURTHER RESOLVED, that the Ingham County Board of Commissioners authorizes the Board Chair to sign any necessary contract documents that are consistent with this resolution and approved as to form by the County Attorney.

BE IT FURTHER RESOLVED, that the Ingham County Board of Commissioners directs the Controller/Administrator to make the necessary budget adjustments in the Ingham County Sheriff’s Office budget.
TO: Law & Courts and Finance Committees
FROM: Teri Morton, Deputy Controller
DATE: July 7, 2020

SUBJECT: Resolution to Adopt the 2021 Juvenile Justice Community Agency Process Calendar

For the meeting agendas of Law & Courts July 16 and Finance July 22

BACKGROUND
This resolution would authorize the adoption of the attached 2021 Juvenile Justice Community Agency Process calendar to establish timelines and a budgeted amount for the process. The Board of Commissioners has reserved a portion of the Juvenile Justice Millage annually to enable this grant process. This process partners with local agencies to provide some preventive services to eligible at-risk county youth outside the formal judicial process to help reduce the Court’s formal dockets.

ALTERNATIVES
This is a discretionary program and is not required.

FINANCIAL IMPACT
In 2020, the Board of Commissioners allocated $125,000 in funding for this program from the Juvenile Justice Millage proceeds. The 2019 year end audited fund balance is $2,400,900 for the Juvenile Justice Millage Fund.

OTHER CONSIDERATION
Grant awards for 2020 were in the amount of $143,071:

- Child and Family Charities – Nexus Program $ 40,024
- Child and Family Charities - Teen Court $ 26,547
- Resolution Services Center of Central Michigan – Restorative Justice $ 37,500
- Resolution Services Center of Central Michigan – Youth Diversion $ 20,000
- Small Talk Children’s Assessment Center $ 19,000

RECOMMENDATION
I recommend approval of the attached resolution after the Board of Commissioners establishes an amount for the 2021 Juvenile Justice Millage Community Agency Process along with the attached calendar.
Introduced by the Law & Courts and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO ADOPT THE 2021 JUVENILE JUSTICE COMMUNITY AGENCY PROCESS CALENDAR

WHEREAS, a Juvenile Justice Millage was approved by the voters of Ingham County in November of 2002 and subsequently renewed, for the purpose of funding an increase to Ingham County’s capacity to detain and house juveniles who are delinquent or disturbed, and to operate new and existing programs for the treatment of such juveniles; and

WHEREAS, the Ingham County Board of Commissioners wishes to adopt a resolution to establish the 2021 Juvenile Justice Community Agency Process and to reserve Juvenile Justice Millage funds in the amount of $________ for this purpose.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners hereby adopts the attached 2021 Juvenile Justice Community Agency Process Calendar to establish time lines for the process.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 28, 2020</td>
<td>The Board of Commissioners adopts the 2021 Juvenile Justice Community Agency Process Calendar Resolution.</td>
</tr>
<tr>
<td>July 29, 2020</td>
<td>A press release is prepared announcing the availability of Juvenile Justice Community Agency funds and invites community organizations to submit an application. The application deadline is August 19, 2020 at 5:00pm.</td>
</tr>
<tr>
<td>August 21, 2020</td>
<td>The Controller’s Office prepares a summary of the Juvenile Justice Community Agency applicants and forwards the summary to the County Attorney’s Office to ensure that the agency’s proposed purposes are legal under Michigan Law and comply with the intent of the Juvenile Justice Millage.</td>
</tr>
<tr>
<td>September 22, 2020</td>
<td>A Juvenile Justice Community Agency notebook is prepared by the Controller/Administrator’s Office. The notebook includes all agencies who submitted applications for review by the Law &amp; Courts Committee. (Notebook is distributed at the September 22, 2020 Board of Commissioners’ Meeting)</td>
</tr>
<tr>
<td>October 1, 2020</td>
<td>The Law &amp; Courts Committee reviews the Juvenile Justice Community Agency applications and makes recommendations for funding. Juvenile Justice Community Agency applicants are invited to attend the Law &amp; Courts Committee meeting. The Law &amp; Courts Committee makes their recommendations by resolution to the Finance Committee.</td>
</tr>
<tr>
<td>October 7, 2020</td>
<td>The Finance Committee approves the resolution for Juvenile Justice Community Agency funding to the Board of Commissioners.</td>
</tr>
<tr>
<td>October 13, 2020</td>
<td>The Board of Commissioners authorizes a resolution for the 2021 Juvenile Justice Community Agency grant awards.</td>
</tr>
<tr>
<td>October 16, 2020</td>
<td>The Juvenile Justice Community Agency applications are sent to the County Attorney’s Office for contract preparation.</td>
</tr>
<tr>
<td>October 16, 2020</td>
<td>Juvenile Justice Community Agencies are notified of the County grant award and informs the agency that a County contract will be forthcoming in December.</td>
</tr>
<tr>
<td>December 2020</td>
<td>Contracts are received from the County Attorney’s Office and mailed to the Juvenile Justice Community Agencies for appropriate signatures. When the contracts are mailed, a request is made to agencies to mail their Certificate of Insurances and a Revised Scope of Services if the grant award is different than the original requested amount.</td>
</tr>
<tr>
<td>January 2021</td>
<td>Fifty percent of the grant award is sent to the Juvenile Justice Community Agency upon receipt of the agency’s signed contract and the appropriate documentation as listed above.</td>
</tr>
<tr>
<td>July 9, 2021</td>
<td>The Juvenile Justice Community Agencies send in their first six month report to the Controller’s Office and upon review by staff, a check for the remaining portion of the grant is sent to the agency.</td>
</tr>
</tbody>
</table>
TO: Board of Commissioners Human Services and Finance Committees  
FROM: Lindsey McKeever, Fairgrounds Events Director  
DATE: July 7, 2020  
SUBJECT: Halloween at the Fairgrounds

BACKGROUND  
The Ingham County Fair Board’s mission statement is to maintain a high quality facility through optimal use of resources, and meet the customer’s needs for staging agricultural, cultural, educational and entertainment events, paying special attention to ensure each experience is unique with the goal of becoming a premier entertainment facility in Michigan. Having been forced to pivot after the 2020 Fair was essentially cancelled, the Fairgrounds is looking to host events to generate revenue and provide recreational opportunities for our residents. The Ingham County Fairgrounds Pumpkin Palooza with a total budget of $150,000.00 will provide a one of a kind Halloween experience for all ages at an affordable yet profitable price point. The Pumpkin Palooza is a family friendly alternative to traditional haunted attractions where guests stroll through twenty-two different hand carved pumpkin scenes over the course of a half mile walk through the fairgrounds at night. The Fair plans to enter into contract with Debbie Katz Productions for an amount not to exceed $125,000.00 to rent the 22 pumpkin scenes and various ancillary items.

ALTERNATIVES  
The Ingham County Fairgrounds could choose not pursue a Halloween attraction of this size and expense and instead create smaller, less expensive events.

FINANCIAL IMPACT  
Funds currently budgeted for expenses associated with the 2020 Fair will be utilized to cover the costs associated with this event. This Halloween event will take the place of the Fair as the large main event to be held at the Fairgrounds this year.

If the event sells out, the financial impact of an event of this size would be significant in reducing the expected revenue shortfall for the 2020 budget year.

STRATEGIC PLANNING IMPACT  
This resolution supports the long-term objective of providing recreational opportunities.

RECOMMENDATION  
Based on the information presented, I respectfully recommend approval of the attached resolution to allow the Fair to impose fees for special events.
### Rental from Debbie Katz Productions:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery of materials</td>
<td>2 person team to supervise setup</td>
<td></td>
</tr>
<tr>
<td>Layouts of all 22 scenes</td>
<td>Layout of how scenes fit on the trail</td>
<td></td>
</tr>
<tr>
<td>Marketing materials</td>
<td>Soundtracks for the scenes</td>
<td></td>
</tr>
<tr>
<td>Speakers</td>
<td>Lanterns to light the trails</td>
<td></td>
</tr>
</tbody>
</table>

22 Scenes include:

<table>
<thead>
<tr>
<th>Scene 1</th>
<th>Scene 2</th>
<th>Scene 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice in Wonderland</td>
<td>Field of Jacks</td>
<td>Monsters</td>
</tr>
<tr>
<td>Birds and butterflies</td>
<td>Frogs</td>
<td>Skeleton Motorcycles</td>
</tr>
<tr>
<td>Carnival</td>
<td>Graveyard</td>
<td>Solar System</td>
</tr>
<tr>
<td>Cartoon Characters</td>
<td>Pumpkin Scarecrows</td>
<td>Super Heroes</td>
</tr>
<tr>
<td>Disney Castle w/princesses</td>
<td>Pumpkin tree</td>
<td>Under the Sea</td>
</tr>
<tr>
<td>Dinosaurs</td>
<td>Jungle</td>
<td>Winter Wonderland</td>
</tr>
<tr>
<td>Fashion</td>
<td>LOVE</td>
<td>2 scenes created specifically for us</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Sunset Time</th>
<th>Opening</th>
<th># of tickets available per night</th>
<th>Kids Ages 5-12</th>
<th>Kids Age 13-17</th>
<th>Adults 18+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday, October 9</td>
<td>7:05pm</td>
<td>8pm</td>
<td>3,000</td>
<td>$8.00</td>
<td>$10.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>Saturday, October 10</td>
<td>7:03pm</td>
<td>8pm</td>
<td>3,000</td>
<td>$10.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>Sunday, October 11</td>
<td>7:01pm</td>
<td>8pm</td>
<td>3,000</td>
<td>$8.00</td>
<td>$10.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>Friday, October 16</td>
<td>6:53pm</td>
<td>8pm</td>
<td>3,000</td>
<td>$8.00</td>
<td>$10.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>Saturday, October 17</td>
<td>6:51pm</td>
<td>8pm</td>
<td>3,000</td>
<td>$10.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>Sunday, October 18</td>
<td>6:50pm</td>
<td>8pm</td>
<td>3,000</td>
<td>$8.00</td>
<td>$10.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>Friday, October 23</td>
<td>6:42pm</td>
<td>7:30pm</td>
<td>3,500</td>
<td>$8.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>Saturday, October 24</td>
<td>6:41pm</td>
<td>7:30pm</td>
<td>3,500</td>
<td>$10.00</td>
<td>$14.00</td>
<td>$18.00</td>
</tr>
<tr>
<td>Sunday, October 25</td>
<td>6:39pm</td>
<td>7:30pm</td>
<td>3,500</td>
<td>$8.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>Thursday, October 29</td>
<td>6:34pm</td>
<td>7:15pm</td>
<td>4,000</td>
<td>$10.00</td>
<td>$16.00</td>
<td>$20.00</td>
</tr>
<tr>
<td>Friday, October 30</td>
<td>6:33pm</td>
<td>7:15pm</td>
<td>4,000</td>
<td>$10.00</td>
<td>$18.00</td>
<td>$22.00</td>
</tr>
<tr>
<td>Saturday, October 31</td>
<td>6:31pm</td>
<td>7:15pm</td>
<td>4,000</td>
<td>$10.00</td>
<td>$18.00</td>
<td>$22.00</td>
</tr>
<tr>
<td>Sunday, November 1</td>
<td>5:30pm</td>
<td>6:15pm</td>
<td>4,500</td>
<td>$10.00</td>
<td>$16.00</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

Total tickets: 45,000
Food and Beverage at Grandstand Pavilion—Fundraiser for the Ingham County Fair Foundation.
The Fair would buy all supplies and items needed for the Pavilion, the Foundation would staff and get the
appropriate licenses for alcoholic beverages. After the fair recovers all expenses, the profits would be split
50/50, similar to the arrangements made for the Beer Tent during Fair week with a non-profit.

Cider Donuts
Hot Mulled Cider
Cold Cider
Coffee
Hot Chocolate
Fall Themed Beer
Additional Expenses: Hot Cups 7 ounce
    Urns

Marketing:
Once the contract is executed by the BOC and Debbie Katz Productions, we will begin to announce the event on
Social Media. In order to hype up the event, tickets will go on sale one week after the announcement.

$1,000 Social Media Beginning September 1
    Facebook/Instagram
    $1,000 Radio Ads

$5,000 WILX- proposal attached

If ticket sales are lower than anticipated, there could be additional expenses as it relates to marketing.
Introduced by the Human Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO HOST A HALLOWEEN EVENT AT INGHAM COUNTY FAIRGROUNDS

WHEREAS, the Ingham County Fairgrounds hosts multiple events annually in support of the Ingham County Board of Commissioners strategic goals to provide recreational activities offered to the community; and

WHEREAS, due to the COVID-19 pandemic the Ingham County Fair is seeing a significant reduction in off-season revenue in 2020; and

WHEREAS, additional revenue shortfalls are predicted because there will not be a traditional Ingham County Fair in 2020; and

WHEREAS, it is necessary to bring in new and exciting events to provide an entertainment outlet for County residents, and fix the long-term structural revenue issues with the Fair; and

WHEREAS, funds for this event will come from funds currently budgeted for expenses associated with the 2020 Ingham County Fair.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners authorizes a contract with Debbie Katz Productions for the rental of 22 scenes of hand carved pumpkins in an amount not to exceed $125,000.00.

BE IT FURTHER RESOLVED, that the fee structure will be as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Kids Ages 5-12</th>
<th>Kids Age 13-17</th>
<th>Adults 18+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday, October 9</td>
<td>$8.00</td>
<td>$10.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>Saturday, October 10</td>
<td>$10.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>Sunday, October 11</td>
<td>$8.00</td>
<td>$10.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>Friday, October 16</td>
<td>$8.00</td>
<td>$10.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>Saturday, October 17</td>
<td>$10.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>Sunday, October 18</td>
<td>$8.00</td>
<td>$10.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>Friday, October 23</td>
<td>$8.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>Saturday, October 24</td>
<td>$10.00</td>
<td>$14.00</td>
<td>$18.00</td>
</tr>
<tr>
<td>Sunday, October 25</td>
<td>$8.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>Thursday, October 29</td>
<td>$10.00</td>
<td>$16.00</td>
<td>$20.00</td>
</tr>
<tr>
<td>Friday, October 30</td>
<td>$10.00</td>
<td>$18.00</td>
<td>$22.00</td>
</tr>
<tr>
<td>Saturday, October 31</td>
<td>$10.00</td>
<td>$18.00</td>
<td>$22.00</td>
</tr>
<tr>
<td>Sunday, November 1</td>
<td>$10.00</td>
<td>$16.00</td>
<td>$20.00</td>
</tr>
</tbody>
</table>
BE IT FURTHER RESOLVED, that this contract will be for the time period of October 1, 2020 through November 15, 2020.

BE IT FURTHER RESOLVED, that an additional amount not to exceed $25,000 is allocated to marketing and other expenses for this event.

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

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.
TO: Board of Commissioners Human Services & Finance Committees
FROM: Tim Morgan, Parks Director
DATE: July 7, 2020
SUBJECT: Lake Lansing Boat Launch Fees
For the meeting agenda of 7/20/20 Human Services and 7/22/20 Finance

BACKGROUND
Park staff is proposing charging the normal vehicle entrance fee for parking at the Lake Lansing Boat Launch when the regular launch fee does not apply. The following fees are currently charged at the Lake Lansing Boat Launch to launch a watercraft:

Daily Launch Pass - $5
Annual Launch Pass - $55

This resolution proposes charging the regular parking fees for vehicles not launching watercraft on days that allow at the Lake Lansing Boat Launch.

Parking fees are currently collected at Burchfield Park, Hawk Island, Lake Lansing South, Lake Lansing North and Potter Park. The current vehicle entry fees are:

Resident Vehicle Daily - $3
Resident Vehicle Annual - $32
Non-Resident Vehicle Daily - $5
Non-Resident Vehicle Annual - $42

ALTERNATIVES
Leave the remaining fee structure as is. We have been allowing non-launching cars to park at the Lake Lansing Boat Launch during the week but have never charged visitors.

FINANCIAL IMPACT
This could increase revenue at the Lake Lansing Boat Launch by charging regular parking fees during the week.

STRATEGIC PLANNING IMPACT
This resolution supports the overarching long-term objective of striving to make facilities and services user-friendly, specifically Section A. 1(f) - Maintain and improve existing parkland, facilities and features.

OTHER CONSIDERATIONS
None.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution.
Intended by the Human Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE THE REVENUE COLLECTION
OF PARKS VEHICLE ENTRANCE FEES AT THE LAKE LANSING BOAT LAUNCH

WHEREAS, vehicle entrance fees are collected at Burchfield Park, Hawk Island, Lake Lansing North, Lake Lansing South, and Potter Park; and

WHEREAS, the Lake Lansing Boat Launch collects the following fees to launch a watercraft:

   Daily Launch Pass - $5
   Annual Launch Pass - $55; and

WHEREAS, staff is proposing charging the regular parking fees for vehicles not launching watercraft on days that allow at the Lake Lansing Boat Launch.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners approves the revenue collection of the parks vehicle entrance fees at the Lake Lansing Boat Launch for vehicles not launching watercraft on days that allow at the Lake Lansing Boat Launch at the current rates listed below:

   Resident Vehicle Daily - $3
   Resident Vehicle Annual - $32
   Non-Resident Vehicle Daily - $5
   Non-Resident Vehicle Annual - $42

BE IT FURTHER RESOLVED, that the Ingham County Parks will continue its policy of waiving the vehicle entrance fee for anyone for whom the fee would be a hardship.
TO: Board of Commissioners Human Services & Finance Committees
FROM: Tim Morgan, Parks Director
DATE: July 7, 2020
SUBJECT: Burchfield Park Camping Fees for Future Seasons

For the meeting agenda of 7/20/20 Human Services and 7/22/20 Finance

BACKGROUND
Park staff is proposing new camping options for visitors at Burchfield Park for future seasons. Rustic camping would be limited to 4-5 reservable rustic sites, mostly along the river or a short hike off the main trail. The river sites would be unique along the Grand River and encourage paddlers to use the park and make longer treks on the river. The idea is also to build a cabin and/or yurt with some amenities like electric and make them closer to parking lots and bathroom facilities for families and groups to reserve. We believe this would be a popular amenity for the park since there is no water trail camping along the Grand in any direction you go.

ALTERNATIVES
This project would be in line with the Parks Department 5-year Master Plan for capital improvements that improve accessibility and enhance the user experience. The alternative is to not offer camping.

FINANCIAL IMPACT
This could offer a new source of revenue for Burchfield Park. The proposed fees are:

- Rustic Camping in designated areas $15/night
- Yurt/Cabin Camping $85/night
- $200 damage fee for cleanup of campsites

STRATEGIC PLANNING IMPACT
This resolution supports the overarching long-term objective of striving to make facilities and services user-friendly, specifically Section A. 1(f) - Maintain and improve existing parkland, facilities and features, 1(g) - Work to improve accessibility for visitors of all ages and abilities and 1(h) - Enhance existing trails and blueways, and develop new multi-use trails and blueways, that connect parks with recreational, residential, cultural, and business centers throughout Ingham County.

OTHER CONSIDERATIONS
The Ingham County Park Commission supported this resolution at their June 22, 2020 meeting.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution.
INTRODUCED BY THE HUMAN SERVICES AND FINANCE COMMITTEES OF THE:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE FEES FOR CAMPING AT BURCHFIELD PARK

WHEREAS, Board of Commissioners Resolution #11-049 allows the Ingham County Parks Commission to make user fee recommendations to the Ingham County Board of Commissioners for activities within the County Parks; and

WHEREAS, park staff and the Park Commission recommend new fees for camping options at Burchfield Park.

THEREFORE BE IT RESOLVED, that this fee structure becomes effective upon passage of this resolution by the Ingham County Board of Commissioners for camping options at Burchfield Park:

- Rustic Camping in designated areas $15/night (for the 2021 season)
- Yurt/Cabin Camping $85/night (for future season, when yurt/cabins are built)
- $200 damage fee for cleanup of campsites
TO: Board of Commissioners Human Services & Finance Committees
FROM: Tim Morgan, Parks Director
DATE: July 7, 2020
SUBJECT: Burchfield Park Grant

For the meeting agenda of 7/20/20 Human Services and 7/22/20 Finance

BACKGROUND
The county received a 2018 Land and Water Conservation Fund grant from the Michigan Department of Natural Resources for improvements at Burchfield Park. The Purchasing Department solicited proposals from qualified and experienced general contractors to enter into a contract for the purpose of making improvements to Burchfield Park. The scope of work includes, but is not limited to, the construction of sidewalk, kayak launch, ADA parking spaces, drainage improvements, resurfacing of gravel drives and parking lots as well as upgrading restroom buildings.

ALTERNATIVES
This project would be in line with the Parks Department 5-year Master Plan for capital improvements that improve accessibility and enhance the user experience. The developments will benefit the community and increase the use of the facility. The only alternative is to not complete the project.

FINANCIAL IMPACT
Board of Commissioners Resolution #20-027 authorized the acceptance of a Land and Water Conservation Fund grant Project Agreement. The DNR awarded the grant in the amount of $256,500. The County’s financial commitment is $266,500. The DNR does not allow the topographical survey ($10,000) to be included in the grant funding’s financial commitment, this has to be done separately with local funds. The total cost of the project including the County’s financial commitment is $523,000.

Board of Commissioners Resolution #19-307 authorized a contract with ROWE Professional Services Company in the amount of $42,000 for prime professional services to provide all planning services necessary for the design and construction of the project. A total of $2,288 was required for permitting. This leaves a remaining balance of $478,712 for construction.

Nielson Commercial Construction, the as-read low did not provide unit costs so staff recommendation is that this is not a responsive bid. The Evaluation Committee recommends that a contract be awarded to Laux Construction LLC as quoted in the base bid in the amount of $409,902.73 plus a 10% contingency of $40,990.27 for a total construction cost not to exceed $450,893.

STRATEGIC PLANNING IMPACT
This resolution supports the overarching long-term objective of striving to make facilities and services user-friendly, specifically Section A. 1(g) of the Action Plan - Work to improve accessibility for visitors of all ages and abilities.

OTHER CONSIDERATIONS
The Ingham County Park Commission supported this resolution at their June 22, 2020 meeting.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution.
TO:  Board of Commissioners Human Services & Finance Committees

FROM:  Tim Morgan, Parks Director

DATE:  July 7, 2020

SUBJECT:  Burchfield Park Grant

For the meeting agenda of 7/20/20 Human Services and 7/22/20 Finance

BACKGROUND
The county received a 2018 Land and Water Conservation Fund grant from the Michigan Department of Natural Resources for improvements at Burchfield Park. The Purchasing Department solicited proposals from qualified and experienced general contractors to enter into a contract for the purpose of making improvements to Burchfield Park. The scope of work includes, but is not limited to, the construction of sidewalk, kayak launch, ADA parking spaces, drainage improvements, resurfacing of gravel drives and parking lots as well as upgrading restroom buildings.

ALTERNATIVES
This project would be in line with the Parks Department 5-year Master Plan for capital improvements that improve accessibility and enhance the user experience. The developments will benefit the community and increase the use of the facility. The only alternative is to not complete the project.

FINANCIAL IMPACT
Board of Commissioners Resolution 20-027 authorized the acceptance of a Land and Water Conservation Fund grant Project Agreement. The DNR awarded the grant in the amount of $256,500. The County’s financial commitment is $266,500. The DNR does not allow the topographical survey ($10,000) to be included in the grant funding’s financial commitment, this has to be done separately with local funds. The total cost of the project including the County’s financial commitment is $523,000.

Board of Commissioners Resolution 19-307 authorized a contract with ROWE Professional Services Company in the amount of $42,000 for prime professional services to provide all planning services necessary for the design and construction of the project. A total of $2,288 was required for permitting. This leaves a remaining balance of $478,712 for construction.

Nielson Commercial Construction, the as-read low did not provide unit costs so staff recommendation is that this is not a responsive bid. The Evaluation Committee recommends that a contract be awarded to Laux Construction LLC as quoted in the base bid in the amount of $409,902.73 plus a 16.78% contingency of $68,809.27 for a total construction cost not to exceed $478,712.

STRATEGIC PLANNING IMPACT
This resolution supports the overarching long-term objective of striving to make facilities and services user-friendly, specifically Section A. 1(g) of the Action Plan - Work to improve accessibility for visitors of all ages and abilities.

OTHER CONSIDERATIONS
The Ingham County Park Commission supported this resolution at their June 22, 2020 meeting.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution.
TO: Tim Morgan, Parks Director

FROM: James Hudgins, Director of Purchasing

DATE: June 18, 2020

RE: Memorandum of Performance for RFP No. 73-20: Ingham County Burchfield Park Improvements

Per your request, the Purchasing Department sought proposals from qualified and experienced general contractors to enter into a contract for the purpose of making improvements to Burchfield Park.

The scope of work includes, but is not limited to, the construction of sidewalk, kayak launch, ADA parking spaces, drainage improvements, resurfacing of gravel drives and parking lots, as well as, upgrading restroom buildings.

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>44</td>
<td>13</td>
</tr>
<tr>
<td>Vendors responding</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

A summary of the vendors’ costs is located on the next page.

A preconstruction meeting will be required prior to commencement of work since the construction cost exceeds $10,000. Please make sure the Purchasing Department is invited and able to attend the preconstruction meeting to ensure that all contractors comply with the Prevailing Wage Policy and proper bonding.

You are now ready to complete the final steps in the process: 1) evaluate the submissions based on the criteria established in the RFP; 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 and submit 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.
### SUMMARY OF VENDORS’ COSTS

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Local Pref</th>
<th>Total Cost for Completing Work According to RFP, Project Manual and Drawings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nielsen Commercial Construction</td>
<td>Yes, Holt MI</td>
<td>Non-Responsive (missing requested unit costs)</td>
</tr>
<tr>
<td>Laux Construction</td>
<td>Yes, Mason MI</td>
<td>$409,902.73</td>
</tr>
<tr>
<td>LJ Trumble Group</td>
<td>Yes, Lansing MI</td>
<td>$449,996.00</td>
</tr>
<tr>
<td>Moore Trosper Construction Company</td>
<td>Yes, Holt MI</td>
<td>$606,531.41</td>
</tr>
</tbody>
</table>
Agenda Item 5c

Introduced by the Human Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE A CONTRACT WITH LAUX CONSTRUCTION LLC
FOR BURCHFIELD PARK IMPROVEMENTS

WHEREAS, Board of Commissioners Resolution 20-027 authorized the acceptance of a Michigan Natural Resources Land and Water Conservation Fund Grant Project Agreement for the grant application titled Burchfield Park Improvements #26-01803 in the amount of $256,500, plus a local match of $266,500 for a total project amount of $523,000; and

WHEREAS, the Purchasing Department solicited proposals from qualified and experienced general contractors to enter into a contract for the purpose of making improvements to Burchfield Park. The scope of work includes, but is not limited to, the construction of sidewalk, kayak launch, ADA parking spaces, drainage improvements, resurfacing of gravel drives and parking lots as well as upgrading restroom buildings; and

WHEREAS, after careful review and evaluation of the proposals received, the Evaluation Committee recommends that a contract be awarded to Laux Construction LLC as quoted in the base bid in the amount of $409,902.73 plus a 16.78% contingency of $68,809.27 for a total construction cost not to exceed $478,712.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners hereby approves entering into a contract with Laux Construction LLC as quoted in the base bid in the amount of $409,902.73 plus a 16.78% contingency of $68,809.27 for a total construction cost not to exceed $478,712 to enter into a contract for the purpose of making improvements to Burchfield Park.

BE IT FURTHER RESOLVED, there are funds available in line item 228-75999-974000-20P22.

BE IT FURTHER RESOLVED, that the term of the contract shall be from the date of execution until June 30, 2021.

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

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.
TO:           Board of Commissioners Human Services and Finance Committees
FROM:        Linda S. Vail, MPA, Health Officer
DATE:        June 19, 2020
SUBJECT:     Agreement with Drug and Laboratory Disposal Inc.
             For the meeting agendas of July 20, 2020 and July 22, 2020

BACKGROUND
Ingham County Health Department (ICHD) wishes to enter into an agreement with Drug and Laboratory Disposal Inc. (DLD) for hazardous waste hauling services as part of the Household Hazardous Waste Program. This program is offered free of charge as a service to Ingham County residents. A licensed waste hauler is necessary to dispose of hazardous waste collected. A request for proposals for a hazardous waste collector was generated by the Ingham County Purchasing Department. After reviewing all of the options, DLD was selected as the preferred contractor for this service based upon a significant savings compared to the competing bids. This agreement will be effective August 1, 2020 through July 31, 2022 with a two year period renewal option at the rates outlined in DLD’s proposal.

ALTERNATIVES
ICHD could either choose a different vendor or keep the current contract.

FINANCIAL IMPACT
Funds for this contract were included in the FY20 budget. The cost of this agreement is determined by the attached pricing sheet and will vary based on the amounts and types of hazardous waste that is collected through ICHD’s HHW program. Please refer to the attached pricing sheet for the costs of individual wastes.

STRATEGIC PLANNING IMPACT
Strategy 1. Strive to make facilities and services user-friendly.
k. Provide for collection and proper disposal of household hazardous waste through the ICHD’s Environmental Health Division.

OTHER CONSIDERATIONS
There are no other considerations.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval for Ingham County to enter a lease agreement with DLD for providing hazardous waste hauling services effective August 1, 2020 through July 31, 2022 with a two year period renewal option at the rates outlined in DLD’s proposal.
INTRODUCED BY HUMAN SERVICES AND FINANCE COMMITTEES OF THE

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE AN AGREEMENT WITH
DRUG AND LABORATORY DISPOSAL, INC.

WHEREAS, ICHD wishes to enter into an agreement with Drug and Laboratory Disposal Inc. (DLD) for hazardous waste hauling services as part of the Household Hazardous Waste Program; and

WHEREAS, this program is offered free of charge as a service to Ingham County residents; and

WHEREAS, a licensed waste hauler is necessary to dispose of hazardous waste collected; and

WHEREAS, a request for proposals for a hazardous waste collector was generated by the Ingham County Purchasing Department; and

WHEREAS, after reviewing all of the options, DLD was selected as the preferred contractor for this service based upon a significant savings compared to the competing bids; and

WHEREAS, this agreement will be effective August 1, 2020 through July 31, 2022 with a two year period renewal option at the rates outlined in DLD’s proposal; and

WHEREAS, the cost of this agreement will depend on the types and amounts of hazardous waste collected by ICHD’s HHW program; and

WHEREAS, the pricing for various HHW can be found on the attached pricing sheet; and

WHEREAS, the Health Officer recommends entering into a two year contract with a two year period renewal option with Drug & Laboratory Disposal, Inc. for providing hazardous waste hauling services effective August 1, 2020 through July 31, 2022.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners authorizes entering into a three year contract with a two year period renewal option with Drug & Laboratory Disposal, Inc. for providing hazardous waste hauling services effective August 1, 2020 through July 31, 2022 with pricing according to the attached sheet.

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners is hereby authorized to sign any contract documents on behalf of the County after approval as to form by the County Attorney.
## County of Ingham Request for Proposals
### Household Hazardous Waste
### Packet #42-20

**PRICING FORM**
(Please Type or Print Clearly in Ink)

<table>
<thead>
<tr>
<th>Waste Categories</th>
<th>Flat Rate Price Per Pound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerosols</td>
<td>$0.80</td>
</tr>
<tr>
<td>Propane Cylinders – One Pound</td>
<td>$0.85</td>
</tr>
<tr>
<td>Household Fire Extinguishers</td>
<td>$1.10</td>
</tr>
<tr>
<td>Flammable Liquids – Loose Packed</td>
<td>$0.35</td>
</tr>
<tr>
<td>Oil Based Paint – Loose Packed</td>
<td>$0.40</td>
</tr>
<tr>
<td>Flammable Solids</td>
<td>$0.70</td>
</tr>
<tr>
<td>Aerosol Cans</td>
<td>$0.80</td>
</tr>
<tr>
<td>Pesticide Liquid</td>
<td>$0.65</td>
</tr>
<tr>
<td>Pesticide Solid</td>
<td>$0.65</td>
</tr>
<tr>
<td>PCBs</td>
<td>$2.00</td>
</tr>
<tr>
<td>Acids</td>
<td>$0.70</td>
</tr>
<tr>
<td>Bases</td>
<td>$0.70</td>
</tr>
<tr>
<td>Reactive</td>
<td>$2.00</td>
</tr>
<tr>
<td>Poisons, N. O. S.</td>
<td>$0.65</td>
</tr>
<tr>
<td>Oxidizing Substances</td>
<td>$0.70</td>
</tr>
<tr>
<td>PCB Light Ballast</td>
<td>$2.00</td>
</tr>
<tr>
<td>PCB Transformers</td>
<td>$2.00</td>
</tr>
<tr>
<td>Mercury</td>
<td>$3.00</td>
</tr>
<tr>
<td>Fluorescent bulbs and Compact</td>
<td></td>
</tr>
<tr>
<td>fluorescent bulbs</td>
<td></td>
</tr>
<tr>
<td>Household Cleaners</td>
<td>$0.40</td>
</tr>
<tr>
<td>Non-Controlled Medications (current system combines liquid, solid, patch, and inhalers) costs may be broken down in to specific streams</td>
<td>$0.50</td>
</tr>
</tbody>
</table>

|                           |                           |
|                           |                           |
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Ingham County Purchasing Department  Page 25
TO: Board of Commissioners Human Services and Finance Committees
FROM: Linda S. Vail, MPA, Health Officer
DATE: June 18, 2020
SUBJECT: Authorization to Enter an Agreement with Ingham Health Plan Corporation

For the meeting agendas of July 20th and July 22nd, 2020

BACKGROUND
Ingham County Health Department (ICHD) wishes to enter into a provider agreement with Ingham Health Plan Corporation (IHPC) for the period of October 1, 2020 through September 30, 2021. IHPC has historically contracted with ICHD to provide members of the Ingham Health Plan with services from physicians and other professional healthcare providers, and to provide funding for healthcare services to support low-income populations in Ingham County. ICHD previously entered into an agreement with IHPC through Resolution #20-067.

ALTERNATIVES
The alternative would be to not enter into an agreement with Ingham Health Plan Corporation, which could result in the loss of healthcare coverage for more than 1,000 Ingham County Residents.

FINANCIAL IMPACT
This provider agreement will allow IHPC to pay on a fee-for-services basis for primary care services provided to IHPC members assigned to ICHD’s Community Health Centers (CHCs). ICHD will receive the same fee-for-service payment as other IHPC medical providers. The reimbursement amount will be no less than Medicaid reimbursement rates, minus co-payments, deductibles and other similar amounts.

STRATEGIC PLANNING IMPACT
This resolution supports the overarching long-term objective of promoting accessible healthcare, specifically section A.1(e) of the Action Plan – Expand access to healthcare for county residents, with an emphasis on the uninsured and underinsured.

OTHER CONSIDERATIONS
There are no other considerations.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution authorizing ICHD to enter into a provider agreement with IHPC for the period of October 1, 2020 through September 30, 2021.
Agenda Item 6b

Introduced by the Human Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE AN AGREEMENT WITH INGHAM HEALTH PLAN CORPORATION

WHEREAS, Ingham County Health Department (ICHD) wishes to enter into a provider agreement with Ingham Health Plan Corporation (IHPC) for the period of October 1, 2020 through September 30, 2021; and

WHEREAS, IHPC has historically contracted with ICHD to provide members of the Ingham Health Plan with services from physicians and other professional healthcare providers, and to provide funding for healthcare services to support low-income populations in Ingham County; and

WHEREAS, ICHD previously entered into an agreement with IHPC through resolution #20-067; and

WHEREAS, the provider agreement will allow IHPC to pay on a fee-for-services basis for primary care services provided to IHP members assigned to ICHD’s Community Health Centers; and

WHEREAS, ICHD will receive the same fee-for-service payment as other IHP medical providers; and

WHEREAS, the reimbursement amount will be no less than Medicaid reimbursement rates, minus co-payments, deductibles and other similar amounts; and

WHEREAS, the Ingham Community Health Center Board supports this resolution authorizing ICHD to enter into a provider agreement with IHPC for the period of October 1, 2020 through September 30, 2021; and

WHEREAS, the Health Officer recommends that the Board of Commissioners authorize a provider agreement with IHPC for the period of October 1, 2020 through September 30, 2021.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners authorizes ICHD to enter into a provider agreement with IHPC for the period of October 1, 2020 through September 30, 2021.

BE IT FURTHER RESOLVED, that the Chairperson of the Ingham County Board of Commissioners is authorized to sign any necessary contract documents consistent with this resolution upon approval as to form by the County Attorney.
TO: Board of Commissioners Human Services and Finance Committees
FROM: Linda S. Vail, MPA, Health Officer
DATE: June 26, 2020
SUBJECT: FY 21 State of Michigan Comprehensive Agreement
For the meeting agendas of July 20, 2020 and July 22, 2020

BACKGROUND
Ingham County Health Department (ICHD) wishes to enter into a Comprehensive Agreement with Michigan Department of Health and Human Services (MDHHS) to support multiple public health services for an amount just over $6.4 million, effective October 1, 2020 through September 30, 2021. ICHD currently receives funding from MDHHS via the Comprehensive Agreement. This agreement for the delivery of public health services under the Comprehensive Agreement is the principal mechanism for clarifying the roles and responsibilities of the state and local governments. The agreement functions as a vehicle for accepting slightly more than $6.4 million in state and federal grant and formula funding to support multiple public health services. The public health services to be delivered under this agreement include Essential Local Public Health Operations and categorical programs including:

AIDS/HIV Prevention and Care
Bioterrorism Emergency Preparedness
Breast & Cervical Cancer Control Navigation Program
Children Special Health Care Services
Communicable Disease Prevention
Family Planning
Food Vendors and Restaurant Inspections
Immunizations
Lead Safe Homes
Maternal & Child Health Programs
Tobacco Reduction
Tuberculosis Control
Sexually Transmitted Disease Ctrl
Vision & Hearing Screening
The WIC Program

ALTERNATIVES
There are no alternatives.

FINANCIAL IMPACT
The grant amounts, detailed in the agreement, are included in the proposed FY 21 ICHD budget.

STRATEGIC PLANNING IMPACT
This resolution supports the long-term objection of Promoting Accessible Healthcare, specifically section A.1(e) of the Action Plan – Expand access to healthcare for county residents, with an emphasis on the uninsured and underinsured.

OTHER CONSIDERATIONS
The resolution also authorizes subcontracts in the Breast and Cervical Cancer Control Navigation Program and Nurse Family Partnership programs. The resolution includes authorization for a number of service contracts to perform outreach activities to potential and current Medicaid beneficiaries in the following categories:
Medicaid Outreach and Public Awareness
Facilitating Medicaid Eligibility Determination
Program Planning, Policy Development and Interagency Coordination Related to Medical Svcs
Referral, Coordination, and Monitoring of Medicaid Services
Medicaid-Specific Training on Outreach Eligibility Services
Arranging for Medicaid-related Transportation and Provision of Medicaid-related Translation

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution to support this agreement with Michigan Department of Health & Human Services (MDHSS) in an amount just over $6.4 million effective October 1, 2020 through September 30, 2021.
Introduced by the Human Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE A 2020-2021 AGREEMENT WITH THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE DELIVERY OF PUBLIC HEALTH SERVICES UNDER THE COMPREHENSIVE AGREEMENT

WHEREAS, Ingham County Health Department (ICHD) wishes to enter into a Comprehensive Agreement with Michigan Department of Health and Human Services (MDHHS) to support multiple public health services for an amount just over $6.4 million, effective October 1, 2020 through September 30, 2021; and

WHEREAS, the responsibility for protecting the health of the public is a shared responsibility between the State and County governments in Michigan; and

WHEREAS, MDHHS and local health departments enter into contracts to clarify the role and responsibilities of each party in protecting public health; and

WHEREAS, MDHHS and Ingham County have proposed a 2020 – 2021 Agreement for the delivery of public health services under the Comprehensive Agreement process to clarify roles and responsibilities, including funding relations; and

WHEREAS, the Health Officer has recommended that the Board of Commissioners authorize the Amendment.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners authorizes a 2020 – 2021 Agreement with MDHHS for the delivery of public health services under the Comprehensive Agreement Process.

BE IT FURTHER RESOVED, that the agreement shall be effective October 1, 2020 through September 30, 2021.

BE IT FURTHER RESOLVED, that the scope of services included in this agreement shall include essential Local Public Health Services, and several categorical public health programs identified in the attachments to the Agreement.

BE IT FURTHER RESOLVED, that approximately $6.4 million of state/federal funds will be made available to Ingham County through the Comprehensive Agreement, and that Ingham County’s contribution to expenditures associated with the agreement and budget shall not exceed levels appropriated in the County’s 2020 Budget for these purposes.

BE IT FURTHER RESOLVED, that the Board of Commissioners authorizes Memorandums of Understanding (MOU) and/or subcontracts for the period of October 1, 2020 - September 30, 2021 with specialty physicians, laboratories and health care institutions and other service providers necessary to implement the Breast and Cervical Cancer Control Navigation Programs in Clinton, Gratiot, Ingham, Ionia, Jackson, Livingston, Washtenaw, Genesee, Lapeer and Shiawasee Counties, which is a program included in the Comprehensive Agreement.
BE IT FURTHER RESOLVED, that the Board of Commissioners authorize a subcontract for the period of October 1, 2020 – September 30, 2021 with the Nurse Family Partnership; to provide technical support, training and materials specific to the Nurse Family Partnership model which is a program included in the Comprehensive Agreement.

BE IT FURTHER RESOLVED, that service contracts are authorized with the providers named below to support outreach activities to potential and current Medicaid beneficiaries in the following categories:

- Medical Outreach and Public Awareness
- Facilitating Medicaid Eligibility Determination
- Program Planning, Policy Development and Interagency Coordination Related to Medicaid Svcs
- Referral, Coordination and Monitoring of Medicaid Services
- Medicaid-Specific Training on Outreach Eligibility and Services
- Arranging for Medicaid-related Transportation and Provision for Medicaid-related Translation

These service contracts braid together requirements and funds from multiple sources including the County and Medicaid Administration (Federal Share). The braided contracts shall be authorized up to the amounts identified below for the period of October 1, 2020 – September 30, 2021:

- Allen Neighborhood Center $53,782
- Northwest Initiative $53,782
- South Side Community Coalition $46,075
- Child & Family Charities $37,010
- Cristo Rey $58,663

BE IT FURTHER RESOLVED, that the Health Officer, Linda S. Vail, MPA, Health Officer is authorized to submit the 2020 -2021 Comprehensive Agreement electronically through the Mi-E Grants system after approval as to form by the County Attorney.

BE IT FURTHER RESOLVED, that the Controller/Administrator is authorized to amend the Health Department’s Budget in order to implement this resolution.

BE IT FURTHER RESOLVED, that the Board Chairperson in authorized to sign contracts, subcontracts associated with the Comprehensive Agreement after review by the County Attorney.
TO: Board of Commissioners Human Services and Finance Committees  
FROM: Linda S. Vail, MPA, Health Officer  
DATE: June 24, 2020  
SUBJECT: Authorization to accept RW D COVID-19 funding award from HRSA  
For the meeting agenda of July 20, and July 22, 2020

BACKGROUND  
Ingham County Health Department’s (ICHD’s) Community Health Centers (CHCs) wish to accept a funding award totaling $35,514.00 from the U.S. Department of Health Resources and Services Administration (HRSA). These funds are a one-time HRSA award effective April 1, 2020 through March 31, 2021. This one time funding will support ICHD’s CHCs immediate response to COVID-19 among people with HIV and the nation’s most vulnerable populations.

ALTERNATIVES  
The alternative to accepting this award would be to identify funding within our existing budget to support the Ryan White Part D COVID-19 response to the coronavirus.

FINANCIAL IMPACT  
This HRSA award totaling $35,514.00 is effective April 1, 2020 through March 31, 2021. The funding shall be used to support CHC response to COVID-19 among people with HIV and the nation’s most vulnerable populations.

STRATEGIC PLAN  
This resolution supports the overarching long-term objective of promoting accessible healthcare, specifically section A.1(e) of the Action Plan – Expand access to healthcare for county residents, with an emphasis on the uninsured and underinsured.

OTHER CONSIDERATIONS  
There are no other considerations.

RECOMMENDATION  
Based on the information presented, I respectfully recommend that the Ingham County Board of Commissioners authorize acceptance of the funding award totaling $35,514.00 from the U.S. Department of Health Resources and Services Administration (HRSA) effective April 1, 2020 through March 31, 2021.
WHEREAS, Ingham County Health Department’s (ICHD’s) Community Health Centers (CHCs) wish to accept a funding award totaling $35,514.00 from the U.S. Department of Health Resources and Services Administration (HRSA); and

WHEREAS, this is an additional RW D COVID-19 HRSA award for April 1, 2020 through March 31, 2021; and

WHEREAS, this one time funding to support ICHD’s CHCs immediate response to COVID-19 among people with HIV and the nation’s most vulnerable populations; and

WHEREAS, this resolution supports the overarching long-term objective of promoting accessible healthcare, specifically section A.1(e) of the Action Plan – Expand access to healthcare for county residents, with an emphasis on the uninsured and underinsured; and

WHEREAS, the Ingham Community Health Center Board of Directors supports acceptance of a funding award totaling $35,514.00 from HRSA effective April 1, 2020 through March 31, 2021; and

WHEREAS, the Health Officer recommends that the Board of Commissioners authorize acceptance of a funding award totaling $35,514.00 from HRSA effective April 1, 2020 through March 31, 2021.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners authorizes acceptance of a funding award totaling $35,514.00 from HRSA effective April 1, 2020 through March 31, 2021.

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

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners is hereby authorized to sign any contract documents on behalf of the county after approval as to form by the County Attorney.
TO: Board of Commissioners Human Services and Finance Committees  
FROM: Linda S. Vail, MPA, Health Officer  
DATE: June 25, 2020  
SUBJECT: AUTHORIZATION TO ACCEPT U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH RESOURCES AND SERVICES ADMINISTRATION PROVIDER RELIEF FUNDS  
For the meeting agendas of July 20th and July 22nd, 2020

BACKGROUND  
Ingham County Health Department’s (ICHD’s) Community Health Centers (CHCs) wish to accept a funding award of $281,039.03 from the U.S. Department of Health Resources and Services Administration (HRSA), Provider Relief Fund. This funding support is for the period of June 19, 2020 through March 31, 2021.

ALTERNATIVES  
This is funding allocated to ICHC by the HRSA Provider Relief Fund so there are no other alternatives.

FINANCIAL IMPACT  
This funding will reimburse ICHC only for health care related expenses or lost revenues that are attributable to coronavirus.

STRATEGIC PLANNING IMPACT  
This resolution supports the overarching long-term objective of promoting accessible healthcare, specifically section A.(e) of the Action Plan – Expand access to healthcare for county residents, with an emphasis on the uninsured and underinsured

OTHER CONSIDERATIONS  
There are no other considerations.

RECOMMENDATION  
Based on the information presented, I respectfully recommend approval of the attached resolution to support the acceptance of this HRSA Provider Relief Fund award of $281,039.03 for the period of June 19, 2020 through March 31, 2021.
WHEREAS, Ingham County Health Department’s (ICHD’s) Community Health Centers (CHCs) wish to accept Provider Relief Program funds through the U.S. Department of Health Resource and Services Administration (HRSA) for the grant period of June 19, 2020 through March 31, 2021; and

WHEREAS, Provider Relief funds allow for ICHC reimbursement only for health care related expenses or lost revenues that are attributable to coronavirus; and

WHEREAS, ICHD has received the HRSA Provider Relief funding award for the budget period of June 19, 2020 through March 31, 2021 in the amount up to $281,039.03; and

WHEREAS, the Ingham County Community Health Center Board has reviewed and recommends the acceptance of the HRSA Provider Relief funding award; and

WHEREAS, the Health Officer recommends that the Board of Commissioners authorize the acceptance of the HRSA Provider Relief funding award in the amount of $281,039.03.

THEREFORE BE IT RESOLVED, that the Board of Commissioners authorizes the acceptance of the HRSA Provider Relief funding award in the amount of $281,039.03 for the budget period of June 19, 2020 through March 31, 2021.

BE IT FURTHER RESOLVED, that the Controller/Administrator is authorized to make any necessary budget adjustments to the Health Department’s budget consistent with this resolution.
TO: Board of Commissioners Human Services and Finance Committees
FROM: Linda S. Vail, MPA, Health Officer
DATE: June 17, 2020
SUBJECT: Resolution to Accept HRSA Provider Relief Funds
For the meeting agendas of July 20th and July 22nd, 2020

BACKGROUND
Ingham County Health Department (ICHD) and Ingham Community Health Centers (ICHC) wish to accept a funding award of $52,169.59 from the U.S. Department of Health and Human Services Administration (HRSA), Provider Relief Fund. This funding will provide needed support to ICHD’s CHCs due to revenues lost as a result of the coronavirus and will be effective April 17, 2020 through December 31, 2020.

ALTERNATIVES
This is funding is necessary to support ongoing operations of the CHCs.

FINANCIAL IMPACT
This funding will reimburse ICHC only for health care related expenses or lost revenues that are attributable to coronavirus.

STRATEGIC PLANNING IMPACT
This resolution supports the overarching long-term objective of promoting accessible healthcare, specifically section A.(e) of the Action Plan – Expand access to healthcare for county residents, with an emphasis on the uninsured and underinsured

OTHER CONSIDERATIONS
There are no other considerations.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval of the attached resolution to support the acceptance of this HRSA Provider Relief Fund award of $52,169.59 for the period of April 17, 2020 through December 31, 2020
Resolutions 2020-006

WHEREAS, Ingham County Health Department (ICHD) and Ingham Community Health Centers (ICHC) wish to accept Provider Relief Program funds through the U.S. Department of Health and Human Services Health Resource and Services (HRSA) for the grant period of April 17, 2020 through December 31, 2020; and

WHEREAS, Provider Relief funds will allow for ICHC reimbursement of only health care related expenses or lost revenues that are attributable to coronavirus; and

WHEREAS, ICHD has received the HRSA Provider Relief funding award for the budget period of April 17, 2020 through December 31, 2020 in an amount not to exceed $52,169.59 and

WHEREAS, the Ingham County CHC Board has reviewed and recommends the acceptance of the HRSA Provider Relief funding award; and

WHEREAS, the Health Officer recommends that the Board of Commissioners authorize the acceptance of the HRSA Provider Relief funding award in the amount of $52,169.59 effective April 17, 2020 through December 31, 2020.

Therefore be it resolved, that the Board of Commissioners authorizes the acceptance of the HRSA Provider Relief funding award in the amount of $52,169.59 effective April 17, 2020 through December 31, 2020.

Be it further resolved, that the Controller/Administrator is authorized to make any necessary budget adjustments to the Health Department’s budget consistent with this resolution.
TO: Board of Commissioners Human Services and Finance Committees
FROM: Linda S. Vail, MPA, Health Officer
DATE: June 23, 2020
SUBJECT: Authorization to Extend to extend OB/GYN Physician Services Agreement with Edward w. Sparrow Hospital Association
For the meeting agenda of July 20th and July 22nd, 2020

BACKGROUND
Ingham County Health Department's (ICHD) Community Health Centers (CHCs) have maintained an agreement with Edward Sparrow Hospital Association (Sparrow) for 1.0 FTE physician services, including oversight of mid-level providers and medical administration support to ICHD’s Women’s Health Services, at an amount not exceeding $100,000 annually, effective July 1, 2017 through June 30, 2020. ICHD wishes to extend the agreement with Sparrow for 3 additional years effective July 1, 2020 through June 30, 2023, in an amount not to exceed $100,000.00 annually.

ALTERNATIVES
There are no alternatives to provide full-time OB/GYN physician coverage to the Women’s Health Operations within the budget terms.

FINANCIAL IMPACT
The costs of this agreement are included in the approved FY 2020 Budget and the recommended FY 2021 Budget. The extension for this agreement does not increase any cost beyond what is budgeted.

STRATEGIC PLAN
This resolution supports the overarching long-term objective of promoting accessible healthcare, specifically section A.1(e) of the Action Plan – Expand access to healthcare for county residents, with an emphasis on the uninsured and underinsured

OTHER CONSIDERATIONS
There are no other considerations.

RECOMMENDATION
Based on the information presented, I respectfully recommend approval to authorize an extension to the agreement with Sparrow for providing 1.0 FTE physician services, including oversight of mid-level providers and medical administration support to ICHD Women’s Health Services for an amount not to exceed $100,000 annually, effective July 1, 2020 through June 30, 2023.
Agenda Item 6g

Introduced by the Human Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO EXTEND OB/GYN PHYSICIAN SERVICES AGREEMENT WITH EDWARD W. SPARROW HOSPITAL ASSOCIATION

WHEREAS, through Resolution #17-327, the Ingham County Health Department (ICHD) and the Edward W. Sparrow Hospital Association (Sparrow) entered an agreement for providing 1.0 FTE physician services, including oversight of mid-level providers and medical administration support to ICHD Women’s Health Services, for an amount not to exceed $100,000 annually, effective July 1, 2017 through June 30, 2020; and

WHEREAS, the extended agreement will be effective July 1, 2020 through June 30, 2023 in an amount not to exceed $100,000.00 annually; and

WHEREAS, the cost of this agreement are included in the approved FY 2020 Budget and the recommended FY 2021 Budget; and

WHEREAS, the Health Officer and the Ingham Community Health Center Board support the continuation of this agreement.

THEREFORE BE IT RESOLVED, that the Board of Commissioners authorizes an extension to the agreement with Sparrow for providing 1.0 FTE physician services, including oversight of mid-level providers and medical administration support to ICHD Women’s Health Services, at an amount not to exceed $100,000 annually, effective July 1, 2020 through June 30, 2023.

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.
TO: Board of Commissioners Human Services and Finance Committees  
FROM: Linda S. Vail, MPA, Health Officer  
DATE: June 24, 2020  
SUBJECT: Authorization to Enter Into Agreement with Michigan State University College of Nursing for Pediatric Nurse Practitioner

For the meeting agendas of: July 20th, July 21st and July 22nd, 2020

BACKGROUND
Ingham County Health Department (ICHD) wishes to enter into an agreement with Michigan State University’s College of Nursing (MSU CON), to provide a pediatric nurse practitioner (NP) at the Willow Community Health Center, and to be paid a maximum of $31,467.32 a year, effective September 1, 2020 through August 31, 2021. The amount being paid is equivalent to salaries and benefits for a 0.20 FTE nurse practitioner. The contracted Pediatric NP will work up to one eight hour shift per week and deliver a scope of services and care to patients at the Willow Health Center located at 306 W. Willow St. in Lansing MI 48906.

ALTERNATIVES
There are no alternatives.

FINANCIAL IMPACT
The financial impact will be a cost of $31,467.32 and will be covered by billable services.

STRATEGIC PLANNING IMPACT
This resolution supports the overarching long-term objective of promoting accessible healthcare, specifically section A.1(e) of the Action Plan – Expand access to healthcare for county residents, with an emphasis on the uninsured and underinsured.

OTHER CONSIDERATIONS
There are no other considerations.

RECOMMENDATION
Based on the information presented, I respectfully recommend that the Ingham County Board of Commissioners authorize approval to enter into an agreement with Michigan State University’s College of Nursing (MSU CON), to provide a pediatric nurse practitioner (NP) at the Willow Community Health Center, to be paid no more than $31,467.32 a year, effective September 1, 2020 through August 31, 2021.
Resolutions

Agenda Item 6h

Introduced by the Human Services and Finance Committees of the:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE AN AGREEMENT WITH MICHIGAN STATE UNIVERSITY COLLEGE OF NURSING FOR PEDIATRIC NURSE PRACTITIONER SERVICES

WHEREAS, Ingham County Health Department (ICHD) wishes to enter into an agreement with Michigan State University’s College of Nursing (MSU CON), to provide a pediatric nurse practitioner (NP) at the Willow Community Health Center, and to be paid a maximum of $31,467.32 a year, effective September 1, 2020 through August 31, 2021; and

WHEREAS, the amount being paid is equivalent to salaries and benefits for a .20 FTE nurse practitioner; and

WHEREAS, the contracted Pediatric NP will work up to one eight hour shift per week; and

WHEREAS, the NP will deliver a scope of services and care to patients at the Willow Health Center located at 306 W. Willow St. in Lansing MI 48906; and

WHEREAS, the financial impact will be a cost of $31,467.32 and will be covered by billable services; and

WHEREAS, the Ingham Community Health Center Board of Directors supports entering into an agreement with MSU CON, to provide a pediatric nurse practitioner (NP) at the Willow Community Health Center, and to be paid a maximum of $31,467.32 a year, effective September 1, 2020 through August 31, 2021; and

WHEREAS, the Health Officer recommends that the Board of Commissioners authorize an agreement with MSU CON, to provide a pediatric nurse practitioner (NP) at the Willow Community Health Center, and to be paid a maximum of $31,467.32 a year, effective September 1, 2020 through August 31, 2021.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners authorize an agreement with MSU CON, to provide a pediatric nurse practitioner (NP) at the Willow Community Health Center, and to be paid a maximum of $31,467.32 a year, effective September 1, 2020 through August 31, 2021.

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

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners is hereby authorized to sign any contract documents on behalf of the county after approval as to form by the County Attorney.
RESOLUTION AUTHORIZING THE INGHAM COUNTY RACIAL EQUITY TASKFORCE TO ACCEPT DONATIONS

WHEREAS, the Board of Commissioners created the Ingham County Racial Equity Taskforce to achieve community-centered solutions to address the legacy of racial injustices faced by Black communities; and

WHEREAS, the Ingham County Racial Equity Taskforce would like to raise funds and seek donations in order to assist in promoting and accomplishing the goals of the Taskforce.

THEREFORE BE IT RESOLVED, that the Ingham County Board of Commissioners hereby authorizes the Ingham County Racial Equity Taskforce to raise funds and accept donations for the purpose of promoting and assisting the Taskforce with accomplishing its goals to achieve equitable outcomes in wealth accumulation and income, education, safety, health and other measures of well-being among all Black Ingham County residents.

BE IT FURTHER RESOLVED, that the Controller/Administrator is authorized to establish an account for the Ingham County Racial Equity Taskforce for donations and related expenditures.
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 Resolution 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: 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.
Introduces 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 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.
Agenda Item 10a

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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<tbody>
<tr>
<td>Alaiedon</td>
<td>$0.00</td>
<td>$45,000.00</td>
<td>$45,000.00</td>
<td>Asphalt wedging of Every 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, Fitchburg 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 wedging and spot maintenance paving to extent of budget. All roads to be chip-sealed first for &quot;Texas Underseal&quot; 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 on Noble Road between Meech Road and M-52, plus on other Leroy Township local roads to be determined to extent of budget.</td>
<td>$33,300.00</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>
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<tr>
<td>Vevay</td>
<td>$41,488.72</td>
<td>Estimated after completing 2019 work in 2020.</td>
<td>$45,000.00</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 supplying 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 include 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.
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
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
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 and 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.
**Vendor Name:** Michigan Chloride Sales, LLC  
**Local Vendor:** No, St Louis MI  
*DELIVERED TO EASTERN DISTRICT GARAGE STORAGE TANK*

<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.*

<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>
</tr>
</thead>
<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>
</tr>
<tr>
<td>32%</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>
<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*

**Vendor Name:** Great Lakes Chloride, Inc.  
**Local Vendor:** No, Grand Haven MI  
*DELIVERED TO EASTERN DISTRICT GARAGE STORAGE TANK*

<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>$0.45</td>
<td>$0.46</td>
<td>$0.47</td>
</tr>
<tr>
<td>32%</td>
<td>$0.49</td>
<td>$0.50</td>
<td>$0.51</td>
</tr>
<tr>
<td>38%</td>
<td>$0.54</td>
<td>$0.55</td>
<td>$0.56</td>
</tr>
</tbody>
</table>

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

<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>
</tr>
</thead>
<tbody>
<tr>
<td>28%</td>
<td>$0.49</td>
<td>$0.65</td>
<td>$0.50</td>
<td>$0.66</td>
<td>$0.51</td>
<td>$0.67</td>
</tr>
<tr>
<td>32%</td>
<td>$0.53</td>
<td>$0.69</td>
<td>$0.54</td>
<td>$0.70</td>
<td>$0.55</td>
<td>$0.71</td>
</tr>
<tr>
<td>38%</td>
<td>$0.59</td>
<td>$0.74</td>
<td>$0.60</td>
<td>$0.75</td>
<td>$0.61</td>
<td>$0.76</td>
</tr>
</tbody>
</table>

*approximate annual usage of 250,000 gallons*

**Vendor Name:** Chloride Solutions LLC  
**Local Vendor:** Yes, Webberville, MI  
*DELIVERED TO EASTERN DISTRICT GARAGE STORAGE TANK*

<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>$0.18</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>
</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.*

<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>
</tr>
</thead>
<tbody>
<tr>
<td>28%</td>
<td>$0.22</td>
<td>$0.23</td>
<td>$0.23</td>
<td>$0.24</td>
<td>$0.24</td>
<td>$0.25</td>
</tr>
<tr>
<td>32%</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
<td>No Bid</td>
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<tr>
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<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*
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:

<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>18</td>
<td>1</td>
</tr>
<tr>
<td>Vendors responding</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

The following grid is a summary of the vendors’ costs:

<table>
<thead>
<tr>
<th>VENDOR NAME</th>
<th>LOCAL PREFERENCE</th>
<th>GRAND TOTAL ALL 3 LOCATIONS FOR 3 YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan Chloride Sales LLC</td>
<td>No, St. Louis MI</td>
<td>$18,360.00</td>
</tr>
<tr>
<td>Chloride Solutions LLC</td>
<td>Yes, Webberville, MI</td>
<td>$29,880.00</td>
</tr>
<tr>
<td>Great Lakes Chloride Inc.</td>
<td>No, Grand Haven, MI</td>
<td>$34,920.00</td>
</tr>
</tbody>
</table>

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
de 672 N. M-52
Webberville, MI. 48892
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:  Yeas: Celentino, Crenshaw, Grebner, Nolan, Koenig, Sebolt, Maiville  
Nays: None  Absent: None  Approved 9/19/2017

FINANCE:  Yeas: 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.
Agenda Item 11a

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:    7/15/2020
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.
Introduced 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.
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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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 an 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).

1.40  **“NMSN”** means a national medical support notice, as defined in section 401 of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105-200).

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
a special election to that effect prior to the date that such compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

(3) under another arrangement agreed upon between the Participant and the Administrator, e.g., the Administrator may fund coverage during the leave and withhold “catch-up” amounts on a pre-tax or after-tax basis from the Participant’s compensation upon the Participant’s return.

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 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.

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 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.
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 reimbursted, 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
(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;

(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.

(c) 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 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 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 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
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

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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 are rehired 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 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;
(8) 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;

(9) 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;

(10) 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

(11) 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.

(1) 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.

(2) 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.

(3) 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.

(1) 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
described in Section C-2; and (b) if you terminate participation, it shall mean the portion of the Plan Year prior to and including the date participation terminates, as described in Section C-3. A different Coverage Period may be established by the Administrator and communicated to you.

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 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 in excess of $550.00 [as adjusted pursuant to Section D-23] remaining in 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.
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 cases 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 handling 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 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...
o 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.

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 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 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.
INTRODUCED BY 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.
July 13, 2020

TO: Finance Committee

FROM: Michael A. Townsend, Budget Director

RE: Financial Reserve Status

In 2002, the Board of Commissioners adopted a policy on financial reserves. The purpose of the policy is to maintain adequate financial reserves so as to provide for the stable operation of the county government; to assure that the county’s financial obligations will be met; and to assure continuation of a strong credit rating. Reserves addressed in the policy are the General Fund, the Budget Stabilization Fund, and the Public Improvement Fund.

RESERVE STATUS AS OF 12/31/19
The reserves in the Budget Stabilization Fund, General Fund, and Public Improvement Fund as of 12/31/19 total $28.9 million. This equates to 10.8% of the $267.3 million in total budgeted expenditures for 2020. As of 12/31/19 the General Fund has $12.1 million more than the policy’s minimum target and the Public Improvement Fund has $1.3 million more than the policy minimum. The Budget Stabilization Fund is $223,031 below its minimum target level.

The policy requires that the County Controller annually advise the Finance Committee of the status of the balances in the funds, and as appropriate, provide recommendations for maintaining the balance at appropriate levels.

Attached please find a copy of the policy, and an analysis of funds as required. The analysis shows:

- The balance in the Budget Stabilization Fund as of 12/31/18 is $10.6 million, or 12.7% of the average of the last five years’ General Fund budgets. It is below the desired minimum of 13%. The maximum allowable amount as defined by policy is 15%. Since the adoption of the financial reserve policy, the Board of Commissioners has generally maintained the percentage at around 14%. It should be noted that Public Act 169 of 2016 increased the legally allowed maximum to 20%.

- The unassigned balance in the General Fund as of 12/31/19 is $16.3 million, or 19.2% of the previous year’s total General Fund expenditures. The desired minimum is 5%, or $4.3 million. Last year’s balance at the time of the analysis was $14.9 million. Overall, General Fund revenues and expenditures were almost even in 2019, with expenditures slightly higher by $618,465.

- The balance in the Public Improvement Fund as of 12/31/19 is $2.1 million. It is $1.3 million above the minimum desired level of $817,599, which is equivalent to 1/10 mill of the property tax levy. The Public Improvement Fund is used for major capital improvements to county facilities, which includes more than 750,000 square feet of facility space for offices, courts, and clinics; the jail, and parks properties.
GENERAL FUND BALANCE THROUGH 2020
The amended 2019 budget had assumed the use of $3.5 million in General Fund unreserved fund balance. The actual change in General Fund unreserved balance increased by $1.5 million (from $14.8 to $16.3 million.) The 2019 expenses finished the year at $3 million below budget.

The 2020 budget assumes the use of $2.1 million in General Fund surplus. However, the effects of the current pandemic may increase this amount with estimates of $2 – 3 million at this time. The 2021 budget continual use of fund balance is anticipated at a reduced amount with major reductions in expenses currently under consideration.

RECOMMENDATIONS
• Although it is currently below its historical level of 14% of the General Fund budget, the Budget Stabilization Fund is also below the minimum target. With the expected use of General Fund balance due to the pandemic for the next few years, a minimal transfer to the Budget Stabilization Fund of $225,000 is being recommended to restore the minimum target.

• Due to the projected fall below our minimum target, a transfer of $520,236 to the Public Improvement Fund is being recommended. This will allow minimal to be used for 2021 capital projects ($1,778,541) is budgeted in 2020), however it will maintain the targeted amount.

• It is planned that the 2021 Controller Recommended Budget will include a continued use of fund balance.

SUMMARY
A transfer of $.75 million is recommended as part of this year’s Financial Reserve Policy Review. As currently projected, the General Fund unassigned reserves could be $11.5 million at the end of 2020. The $11.5 million should be sufficient to cover any use of fund balance resulting from pandemic and historical expenses or revenue shortfalls. The $11.5 million represents 13.5% of the previous year’s (2019) General Fund expenditures. The $10.56 million in the Budget Stabilization Fund will be increased slightly to maintain the minimum target.

These significant reserves would still allow Ingham County to sustain our bond rating, address ongoing revenue uncertainties, and allow the county to continue to budget a relatively insignificant portion of the fund balance to offset projected annual shortfalls.

Another reason for Ingham County to maintain a relatively high fund balance in the General Fund and the Budget Stabilization Fund is to address cash flow issues. As of 2007, the County collects its General Fund property tax revenue in July, therefore, this revenue is not available until eight or nine months after the start of the fiscal year. Maintaining our current level of reserves provides additional cash. If these reserves were not available, the County would be forced to issue tax anticipation notes in order to continue operations until the taxes are collected.

Please contact me if you have any questions.

cc: Jared Cypher
    Teri Morton
    Tori Meyer
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<th><strong>GENERAL FUND</strong></th>
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<tr>
<td>12/31/19 Unassigned Balance</td>
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<td>12/31/19 Minimum Target (5% of 2019 GENERAL FUND expenses)</td>
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<td>12/31/19 Unassigned Balance as a % of 2019 Expenses</td>
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<td>12/31/20 Projected Balance</td>
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<td>2020 Proposed Transfer from Fund Balance</td>
<td>(745,236)</td>
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<td>12/31/20 Proposed Unassigned Fund Balance</td>
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<td>12/31/20 Minimum Target (5% of 2019 GENERAL FUND expenses)</td>
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<td>2020 Proposed Unassigned Balance as % of 2019 Expenses</td>
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<td>Surplus in Relation to Minimum Target</td>
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<th><strong>BUDGET STABILIZATION FUND (GENERAL FUND Restricted)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12/31/19 Balance</td>
<td>10,562,365</td>
</tr>
<tr>
<td>Minimum Target (13% of last 5 years’ GENERAL FUND Budgets)</td>
<td>10,785,396</td>
</tr>
<tr>
<td>Maximum Target (15% of last 5 years’ GENERAL FUND Budgets)</td>
<td>12,444,687</td>
</tr>
<tr>
<td>Amount Below Minimum Target</td>
<td>(223,031)</td>
</tr>
<tr>
<td>Amount Below Maximum Target</td>
<td>(1,882,322)</td>
</tr>
<tr>
<td>Target %</td>
<td>12.7%</td>
</tr>
<tr>
<td>Proposed Transfer in from General Fund</td>
<td>225,000</td>
</tr>
<tr>
<td>12/31/20 Proposed Balance</td>
<td>10,787,365</td>
</tr>
<tr>
<td>Surplus in Relation to Minimum Target</td>
<td>1,969</td>
</tr>
<tr>
<td>Amount Below Maximum Target</td>
<td>(1,882,322)</td>
</tr>
<tr>
<td>Target %</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PUBLIC IMPROVEMENT FUND (in GENERAL FUND Assigned)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12/31/19 Balance</td>
<td>2,078,305</td>
</tr>
<tr>
<td>Minimum Target (1/10 mill of the property tax levy)</td>
<td>817,599</td>
</tr>
<tr>
<td>2019 Surplus in Relation to Minimum Target</td>
<td>1,260,706</td>
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<tr>
<td>2020 Budgeted Use of Fund Balance</td>
<td>(1,778,541)</td>
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<tr>
<td>12/31/20 Projected Balance</td>
<td>299,764</td>
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<tr>
<td>Proposed Transfer in from General Fund</td>
<td>520,236</td>
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<tr>
<td>12/31/20 Proposed Balance</td>
<td>820,000</td>
</tr>
<tr>
<td>Minimum Target (1/10 mill of the property tax levy)</td>
<td>817,599</td>
</tr>
<tr>
<td>2019 Surplus in Relation to Minimum Target</td>
<td>2,401</td>
</tr>
</tbody>
</table>
INTRODUCED BY THE FINANCE COMMITTEE OF THE:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION ADOPTING A POLICY ON FINANCIAL RESERVES

RESOLUTION #02-017

WHEREAS, it is in the best interests of the Ingham County government; its taxpayers, and its residents to maintain sufficient financial reserves to provide for the stable operation of the county government; to assure that the county’s financial obligations will be met; and to assure continuance of a strong credit rating; and

WHEREAS, it has been recommended by the County Controller and the county’s financial consultants that a policy be adopted establishing the desired level of financial reserves that are appropriate to provide for the stable operation of the county government; to assure that the county’s financial obligations will be met; and to assure continuance of a strong credit rating; and

WHEREAS, the Board of Commissioners is committed to maintaining its financial reserves at an appropriate level and to managing its expenditures as necessary to adjust to its revenues.

THEREFORE BE IT RESOLVED, that the County Board of Commissioners establishes the following goals for establishing and maintaining an appropriate level of financial reserves:

It is the goal of the County that the Budget Stabilization Fund be funded at the legal maximum of 15% of the average of the last five years’ budgets, or 15% of the current year’s budget, whichever is less; and that such balance be maintained at no less than 13%.

It is the goal of the County that the unreserved undesignated balance in the General Fund not be less than 5% of the total General Fund expenses of the preceding year.

It is the goal of the County to maintain sufficient reserves in the Public Improvement Fund to address annual needs for maintaining county facilities in an appropriate state of repair. The desired level of funding in this fund is determined to be 1/10 mill of the property tax levy.

The County Controller shall annually advise the Finance Committee of the status of the balances in the funds, and as appropriate, shall provide recommendations for maintaining the balances at appropriate levels.

FINANCE: Yeas: Grebner, Stid, Swope, Hertel
Nays: None    Absent: Krause, Schafer, Minter    Approved 1/16/02
INTRODUCED BY THE FINANCE COMMITTEE OF THE:

INGHAM COUNTY BOARD OF COMMISSIONERS

RESOLUTION TO AUTHORIZE BUDGET ADJUSTMENTS FOR 2020 BASED ON THE ANNUAL EVALUATION OF THE COUNTY’S FINANCIAL RESERVE POLICY

WHEREAS, the Board of Commissioners has determined that it is in the best interests of the Ingham County government; its taxpayers, and its residents to maintain sufficient financial reserves to provide for the stable operation of the county government; to assure that the County’s financial obligations will be met; and to assure continuance of a strong credit rating; and

WHEREAS, the Board of Commissioners, through Resolution #02-17 has adopted a Financial Reserve Policy to guide decisions regarding the maintenance of sufficient financial reserves; and

WHEREAS, the Financial Reserve Policy and the status of county reserves is to be reviewed on an annual basis; and

WHEREAS, such a review has been done by the Controller’s Office, based on 2019 year end balances, and a report with recommendations has been given to the Finance Committee.

THEREFORE BE IT RESOLVED, that the 2020 budget be amended to authorize a transfers totaling $745,236 from the General Fund unassigned balance to the Public Improvements Fund in the amount of $520,236 and to the Budget Stabilization Fund in the amount of $225,000 in order to provide adequate funds for infrastructure maintenance and improvements and meet minimum targets.

BE IT FURTHER RESOLVED, that the Controller is authorized to make the necessary budget adjustments and transfers.