

EATON COUNTY BOARD OF COMMISSIONERS

October 15, 2014

The Eaton County Board of Commissioners met in regular session at the County Facilities, in the City of Charlotte, Wednesday, October 15, 2014.

Chairman Mulder called the meeting to order at 7:00 PM.

The Pledge of Allegiance to the Flag was given by all.

Commissioner Eakin gave the invocation.

Roll call. Commissioners present; Michael Hosey, Blake Mulder, Terrance Augustine, Howard T. Spence, James Osieczonek, Jane M. Whitacre, Glenn Freeman, Joseph Brehler, Walter Miars, Roger Eakin, Wayne Ridge, L. Daryl Baker, Dale Barr, Jeremy Whittum, Roger Harris. Commissioners absent: None

Agenda Amendments:

Commissioner Eakin requested the addition of the Ways and Means of item #6 Committee Appointments.

Commissioner Baker moved the agenda be approved as amended. Seconded by Commissioner Eakin. Carried.

Commissioner Eakin moved the minutes of September 9, 2014 and September 17, 2014 be approved as presented. Seconded by Commissioner Baker. Carried.

Communications.

Letter of "Intent to Plan" from City of Eaton Rapids, Eaton Rapids Township and Hamlin Township Council of Governments regarding their shared planning effort in the creation of an Area Master Plan (on file).

Chairman Mulder moved the approval of #14-10-106 Resolution to commemorate Lieutenant Richard Bushong on His Twenty-Five Year Commitment to The Eaton County Sheriff's Office and Citizens of Eaton County.

WHEREAS, Lieutenant Bushong began his employment with the Eaton County Sheriff's Office in 1989. His service to the Sheriff's Office was exemplified through his prior military service in the United State Army assigned as a member Military Police corps.

WHEREAS, Eleven years of service with dedication and devotion Lieutenant Bushong was promoted to the rank of Sergeant in 1999.

WHEREAS, Continued service and devotion Lieutenant Bushong achieved technical and tactical proficiency, in conjunction with his personal sacrifice to earn his Bachelor's Degree in Criminal Justice from Siena Heights University, earned the designation of certified jail manager and was promoted to the rank of Lieutenant in 2012.

WHEREAS, A twenty-five year commitment culminated with many accolades and accommodations. Lieutenant Bushong was awarded two lifesaving awards.

NOW, THEREFORE LET IT BE RESOLVED Lieutenant Bushong's twenty-five years of service to the Eaton County Sheriff's Office demonstrates great credit upon himself, his family, the Eaton County Sheriff's Office and the citizenry of Eaton County.

Seconded by Commissioner Hosey. Carried.

Chairman Mulder moved the approval of #14-10-107 Resolution of Appreciation for Chief Deputy Fredrick K. McPhail.

WHEREAS, Fredrick McPhail retired from Eaton County on October 3, 2014 after 25 years of service; and

WHEREAS, Fred worked in the Sheriff's Office from February 22, 1989 until his retirement; and

WHEREAS, throughout his career Fred provided dedicated and honorable service to the residents of Eaton County during which time his leadership was recognized in his promotions, to the positions of Sergeant in June 2000, and Captain in January 2001; and

WHEREAS, Fred was appointed to the position of Undersheriff on January 1, 2005 and served in that capacity during the administration of Sheriff Michael Raines; and

WHEREAS, the Eaton County Board of Commissioners seeks to recognize and express appreciation for Fred's many years of public service.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Commissioners does hereby thank Fred for years of exceptional service to Eaton County and expresses its best wishes to him in the next chapter of his life; and

BE IT FURTHER RESOLVED, that this resolution of appreciation and support be duly recorded and attached to the permanent records of the County on this 15th day of the month of October in the year 2014.

Seconded by Commissioner Whittum. Carried.

Public Comment: none

Commissioner Ridgé moved the approval of the following Health and Human Services Committee Appointments:

Department of Human Services

Leonard Peters, three-year term expiring December 31, 2017

Human Services Collaborative Council

Donna Webb, two-year term expiring December 31, 2016

Becky Carson, two-year term expiring December 31, 2016

Seconded by Commissioner Barr. Carried.

Commissioner Whittum moved the approval of #14-10-108 Community Mental Health Jail Diversion Services Agreement. (on file)

Seconded by Commissioner Brehler. Carried.

Commissioner Whittum moved the approval of #14-10-109 Resolution to Appoint County Medical Examiner and Approve Service Agreement.

WHEREAS, the Board of Commissioners, by resolution created the Office of the County Medical Examiner; and

WHEREAS, Dr. Michael Markey, a duly licensed physician in the State of Michigan has indicated his interest in continuing to serve the County as Medical Examiner; and WHEREAS, the Public Safety Committee is recommending the appointment of Dr. Markey as County Medical Examiner, effective January 1, 2015, for the four year term expiring December 31, 2018; and

WHEREAS, Dr. Philip Croft and Dr. John Bechinski have indicated their willingness in serving the County as Deputy Medical Examiners.

NOW, THEREFORE BE IT RESOLVED, that the Board of Commissioners appoints Dr. Michael Markey, as County Medical Examiner to a term expiring December 31, 2018; and

BE IT FURTHER RESOLVED, that the Board of Commissioners appoints Dr. Philip Croft and Dr. John Bechinski as Deputy Medical Examiners; and

BE IT FURTHER RESOLVED, that the Board of Commissioners approves the Medical Examiner Services Agreement with Sparrow Hospital Association for the term of the appointment; and

BE IT FURTHER RESOLVED, that the Chairman of the Board of Commissioners is authorized to sign any necessary documents.

Seconded by Commissioner Osieczonek. Carried.

Commissioner Baker moved the approval of the following Public Works & Planning Committee Appointments

Zoning Board of Appeals

Charamy Cleary, three-year term expiring December 31, 2017

Construction Code Board of Appeals

Bill Richardson, three-year term expiring December 31, 2017

Clyde Swanson, three-year term expiring December 31, 2017

Edward Seifert, three-year term expiring December 31, 2017

Planning Commission

Marilyn Rutter, three-year term expiring December 31, 2017

Jeanne Rohrs, three-year term expiring December 31, 2017

Ronald Wilson, three-year term expiring December 31, 2017

EATRAN

Charlene Wagner, three-year term expiring December 31, 2017

Housing Advisory Committee

Donna Davenport, two-year term expiring December 31, 2016

Denise Dunn, two-year term expiring December 31, 2016

Mary Bowen, two-year term expiring December 31, 2016

Robert Worgul, two-year term expiring December 31, 2016

Bob Brown, two-year term expiring December 31, 2016

Purchase of Development Rights Selection

Andrea Stay, two-year term expiring December 31, 2016

David Roberts, two-year term expiring December 31, 2016

Duane Ross, two-year term expiring December 31, 2016

Seconded by Commissioner Augustine. Carried. Nays: Spence

Commissioner Baker moved the approval of #14-10-110 Resolution to Approve Michigan Department of Environmental Quality Scrap Tire Recycling Grant Application.

WHEREAS, the Resource Recovery Department has been established for the development and administration of the County Solid Waste Management Plan under Act 641, and WHEREAS, key components of the Resource Recovery Department include increasing the amount of materials recycled, and

WHEREAS, the Michigan Department of Environmental Quality Scrap Tire Recycling Grant is designed to provide assistance in the removal of residential tires, and

WHEREAS, the Resource Recovery Department offers two Scrap Tire collection events annually,

WHEREAS, the Scrap Tire Grant funding request is up to \$10,000, with no matching funds required.

NOW, THEREFORE BE IT RESOLVED, that the Board of Commissioners approves the application of the Scrap Tire grant; and

BE IT FURTHER RESOLVED, that the Controller be authorized to approve any necessary budget amendments to increase expenditures and increase grant revenue if the grant is approved by the Department of Environmental Quality; and

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners or his designee is authorized to sign the necessary documents.

Seconded by Commissioner Freeman. Carried.

Commissioner Eakin moved the approval of Apportionment Report (on file).

Seconded by Commissioner Freeman. Carried.

Commissioner Eakin moved the approval #14-10-111 Resolution to Approve County Section 125 Plan Amendment (on file).

Seconded by Commissioner Augustine. Carried.

Commissioner Eakin moved the approval #14-10-112 Resolution to Approve Personnel Policy Amendment.

WHEREAS, the Board of Commissioners has adopted a Personnel Policy for employees; and WHEREAS, the Ways & Means Committee has reviewed and is recommending approval of the proposed revisions to the previously adopted personnel policy, to be effective immediately; and

NOW, THEREFORE BE IT RESOLVED, that the Board of Commissioners approves the attached revisions to the Personnel Policy, effective immediately, as presented.

Seconded by Commissioner Baker. Carried.

Commissioner Eakin moved the approval of #14-10-113 Resolution to Approve 2013/2014 Budget Amendments.

WHEREAS, the Eaton County 2014/2015 Appropriations Act of September 17, 2014 states that any amendment to increase a salary and/or a Capital Outlay line-item in excess of \$2,500.00 or any amendment to increase the total budget of any fund or department in excess of \$2,500.00 shall be amended by the Board of Commissioners, except that any amendment to decrease the General Fund Contingency shall be approved by the Board of Commissioners; and

WHEREAS, such amendments are needed in order to comply with the Uniform Budgeting and Accounting Act of 1978, P.A. 621.

NOW, THEREFORE BE IT RESOLVED, that the following budget amendments be approved and added to the 2014/2015 Eaton County Budget:

GENERAL FUND

WAGES AND FRINGES

Increase	Circuit	\$ 20,800
Increase	District	\$ 43,000
Increase	Friend of the Court	\$ 26,000
Increase	Probate	\$ 9,500
Increase	Juvenile	\$ 16,000
Increase	County Clerk	\$ 14,000
Increase	Controller	\$ 21,000
Increase	Information Systems	\$ 28,500
Increase	Equalization	\$ 14,500
Increase	Prosecuting Attorney's Office	\$ 55,000
Increase	Prosecuting Attorney's Office - ECU	\$ 22,500
Increase	Register of Deeds	\$ 22,500
Increase	County Treasurer	\$ 9,500
Increase	MSU Extension	\$ 1,800
Increase	Building and Grounds	\$ 7,500
Increase	Drain Commissioner's Office	\$ 18,000
Increase	Sheriff's Office	\$ 50,000
Increase	Sheriff's Office Corrections Division	\$ 14,000
Increase	Community Development	\$ 8,500
Increase	Veterans	\$ 3,000
Increase	Transfers-Out - Wage and Fringe	\$ 33,500

CONTINGENCY

Decrease	Contingency	\$ 169,100
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REVENUE

Increase	Federal CRP Revenue	\$ 20,000
Increase	State Incentive Revenue	\$ 100,000
Increase	Miscellaneous Court Costs - District	\$ 150,000

To increase Wage and Fringe departmental budgets for salary study implementation effective January 11, 2015 with use of Contingency and reinstated revenue from the updated CRP calculation based on increase to wages, State Incentive share of the CRP Grant and Miscellaneous Court Costs fix by the Legislature.

Implementation included consideration of the elected officials on the same basis as the employee population. This amends the 2014/2015 Adopted Budget resolution #14-9-103 for the salaries of the Elected Officials effective January 11, 2015 as follows:

Clerk/Register of Deeds	\$ 68,910
Drain Commissioner	\$ 68,910
Prosecuting Attorney	\$105,331
Sheriff	\$ 95,410
Treasurer	\$ 68,910

SPECIAL REVENUE FUNDS

PARKS AND RECREATION - 208

Increase	Wage and Fringe	\$	9,500
Increase	Transfers-In	\$	9,500

FRIEND OF THE COURT - 215

Increase	Wage and Fringe	\$	1,500
Increase	Transfers-In	\$	1,500

RESOURCE RECOVERY - 228

Increase	Wage and Fringe	\$	3,500
Increase	Fund Balance Carryover	\$	3,500

CONSTRUCTION CODE - 240

Increase	Wage and Fringe	\$	7,500
Increase	Fund Balance Carryover	\$	7,500

CENTRAL DISPATCH - 261

Increase	Wage and Fringe	\$	10,000
Increase	Fund Balance Carryover	\$	10,000

VERTICAL DRUG PROSECUTION - 267

Increase	Wage and Fringe	\$	4,500
Increase	Transfers-In	\$	4,500

STOP (DOMESTIC VIOLENCE) - 270

Increase	Wage and Fringe	\$	3,000
Increase	Transfers-In	\$	3,000

COMMUNITY CORRECTIONS - 276

Increase	Wage and Fringe	\$	3,000
Increase	Transfers-In	\$	3,000

CHILD CARE FUND - 292

Increase	Wage and Fringe	\$	24,000
Increase	Transfers-In - General Fund	\$	12,000
Increase	Transfers-In - Juvenile Millage	\$	12,000

JUVENILE MILLAGE - 296

Increase	Transfers-Out	\$	12,000
Increase	Fund Balance Carryover	\$	12,000

To increase Wage in Fringe in Special Revenue Fund budgets for salary study implementation.

PUBLIC IMPROVEMENT - 245

Increase	Equipment	\$	207,012
Increase	Fund Balance Carryover	\$	207,012

To increase the total budget for the completion of 2013/2014 projects carried over into 2014/2015.

Seconded by Commissioner Augustine. Discussion held. Carried. Nays: Barr.

Commissioner Eakin moved the approval of Claim and Purchases of \$344,647.14.
Seconded by Commissioner Brehler. Carried.

Commissioner Eakin moved the approval of the following Ways & Means Committee Appointments:

Historical Commission

Jan Sedore, three-year term expiring December 31, 2017

Joann Nehmer, three-year term expiring December 31, 2017

Seconded by Commissioner Hosey. Carried.

Public Comment: Alan Miller 1102 Timber Creek, Grand Ledge, MI 48813 spoke regarding his retirement from Lansing State Journal and thanked the county officials for their service.

No Unfinished Business, Old Business or New Business.

Commissioner Comment: Commissioner Osieczonek spoke regarding the retirement of Alan Miller from Lansing State Journal. Commissioner Spence spoke regarding the Annual Delta Township Community Awards Reception at the Crowne Plaza Hotel in Lansing on October 30, 2014.

Chairman Mulder adjourned the meeting to Wednesday November 19, 2014 at 7:00 p.m.

Blake Mulder

Chairman of the Board of Commissioners

Diana Bosworth

Clerk of the Board of Commissioners

EATON COUNTY BOARD OF COMMISSIONERS

OCTOBER 15, 2014

**RESOLUTION TO COMMEMORATE LIEUTENANT RICHARD BUSHONG ON HIS
TWENTY-FIVE YEAR COMMITMENT TO THE EATON COUNTY SHERIFF'S
OFFICE AND CITIZENS OF EATON COUNTY.**

Introduced by Commissioner Blake Mulder

Commissioner Mulder moved the approval of the following resolution. Seconded by Commissioner Hosey.

WHEREAS, Lieutenant Bushong began his employment with the Eaton County Sheriff's Office in 1989. His service to the Sheriff's Office was exemplified through his prior military service in the United State Army assigned as a member Military Police corps.

WHEREAS, Eleven years of service with dedication and devotion Lieutenant Bushong was promoted to the rank of Sergeant in 1999.

WHEREAS, Continued service and devotion Lieutenant Bushong achieved technical and tactical proficiency, in conjunction with his personal sacrifice to earn his Bachelor's Degree in Criminal Justice from Siena Heights University, earned the designation of certified jail manager and was promoted to the rank of Lieutenant in 2012.

WHEREAS, A twenty-five year commitment culminated with many accolades and accommodations. Lieutenant Bushong was awarded two lifesaving awards.

NOW, THEREFOR LET IT BE RESOLVED Lieutenant Bushong's twenty-five years of service to the Eaton County Sheriff's Office demonstrates great credit upon himself, his family, the Eaton County Sheriff's Office and the citizenry of Eaton County. Carried.

14-10-107

EATON COUNTY BOARD OF COMMISSIONERS

**RESOLUTION OF APPRECIATION FOR
CHIEF DEPUTY FREDRICK K. McPHAIL**

October 15, 2014

Introduced by Commissioner Blake Mulder

Commissioner Mulder moved the approval of the following resolution. Seconded by Commissioner Whittum.

WHEREAS, Fredrick McPhail retired from Eaton County on October 3, 2014 after 25 years of service; and

WHEREAS, Fred worked in the Sheriff's Office from February 22, 1989 until his retirement; and

WHEREAS, throughout his career Fred provided dedicated and honorable service to the residents of Eaton County during which time his leadership was recognized in his promotions, to the positions of Sergeant in June 2000, and Captain in January 2001; and

WHEREAS, Fred was appointed to the position of Undersheriff on January 1, 2005 and served in that capacity during the administration of Sheriff Michael Raines; and

WHEREAS, the Eaton County Board of Commissioners seeks to recognize and express appreciation for Fred's many years of public service.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Commissioners does hereby thank Fred for years of exceptional service to Eaton County and expresses its best wishes to him in the next chapter of his life; and

BE IT FURTHER RESOLVED, that this resolution of appreciation and support be duly recorded and attached to the permanent records of the County on this 15th day of the month of October in the year 2014. Carried.

**JAIL DIVERSION
SERVICE AGREEMENT**

between

**Community Mental Health The Authority of Clinton-Eaton-Ingham Counties,
Sheriff's Office of Eaton County
Prosecutor's Office of Eaton County
Trial Court Chief Judge of Eaton County
Eaton County Board of Commissioners**

Commissioner Whittum moved the approval of the following resolution. Seconded by
Commissioner Brehler.

Community Mental Health of Clinton, Eaton and Ingham Counties (hereinafter referred to as the "The Authority") and its contract agencies, to the extent of their respective contractual obligations to the board, the County of Eaton (hereinafter referred to as the "County"), the Eaton County Sheriff's Office (hereinafter referred to as the "Sheriff"), the Eaton County Prosecutor's office (hereinafter referred to as the "Prosecutor"), Trial Court Chief Judge of Eaton County Courts (hereinafter referred to as "Trial Court Chief Judge") agrees to cooperate in planning, program development and service delivery.

PURPOSE

This Agreement is designed 1) to maximize jail diversion efforts ensuring that persons coming in contact with the Sheriff and Prosecutor receive appropriate and necessary mental health services; 2) to assist the Sheriff and Prosecutor in assessing and evaluating inmates and subjects in order to provide better medical and custodial care as prescribed by law; 3) to coordinate services to county residents increasing quality, speed of delivery and cost effectiveness; and 4) to maximize humane treatment of mentally ill citizens in the least restrictive environment possible and 5) to make information on Jail Diversion available to citizens, family members and other stakeholders.

The intention of Jail Diversion is, whenever appropriate, to assist in the diversion to alternative services of those persons with severe and persistent mental illness, serious emotional disturbance or developmental disabilities who have been accused of or who have committed misdemeanors and non-violent felonies.

The Authority will develop Jail Diversion services consistent with Section 207 of the Michigan Mental Health Code and 2014 PA 28 in cooperation with representatives of the local law enforcement agencies.

The Authority will monitor Quality Improvement initiatives, as identified by all parties involved by sampling specific markers submitted by Authority employees via a computer based form. Data and other pertinent exchange of ideas occur in quarterly Jail Diversion meetings.

GENERAL PROVISIONS

The Authority, County, Sheriff and Prosecutor each agree to these General Provisions:

1. Work cooperatively to divert persons with serious mental illness, serious emotional disturbance or developmental disability from possible jail incarceration when appropriate.
2. Promote and foster public awareness of Jail Diversion Services.
3. Make informational materials available regarding Jail Diversion services.
4. Provide training to the staff of the parties to this Agreement as needed.
5. Exchange relevant case information where there is a need to know, pursuant to all statutory requirements of confidentiality, including the Health Insurance Portability and Accountability Act of 1996.
 - A) In receiving, storing, processing or otherwise dealing with any information from the other agency/program about clients in the other agency/program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records (P.A.258 of 1974, Section 748(3); P.A. 368 of 1978; 42 CFR Part 2; 45 CFR Parts 160 and 164; P.A. Act 488 of 1989) and the provisions of the Health Insurance Portability and Accountability Act of 1996; PL 104-191, as amended.
 - B) They will undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations (P.A. 258 of 1974, Section 748 (3); P.A. 368 of 1978; 42 CFR part 2; 45 CFR Parts 160 and 164; P.A. Act 488 of 1989; and P.L 104-191, as amended).
6. Participate in a review of the combined Jail Diversion efforts initiated under this Agreement.
7. Forensic services are not provided under the terms of this Agreement.
8. Case Management services are not provided under the terms of this Agreement.
9. This Agreement is effective October 1, 2014, and shall remain in effect until terminated by any party with 60 days written notice to other parties.

The parties to this Agreement, as required by law shall not discriminate against an employee, applicant for employment, or recipient of services under this Agreement, on account of race, color, religion, age, national origin, sex, sexual orientation, gender identity, disability, height weight, marital status or political affiliation. Breach of this provision shall be a material breach of this Agreement. To make available for use and distribution informational materials on each other's services as they relate to mental health problems and service needs.

The Authority further agrees to:

1. Maintain emergency mental health services, by phone or in person seven days a week, twenty four hours per day.
2. Provide diagnosis and screening of individuals referred for psychiatric inpatient admission.
3. Provide screening and assistance in regard to the petition process for individuals through in need of involuntary hospital admission.
4. Provide jail-based treatment services to individuals referred by the Sheriff or Prosecutor who meet standards of service eligibility and/or medical necessity. Jail-based treatment services are deemed completed when 1) the individual's symptom(s) are stabilized and no longer needed jail based services; 2) the individual has been referred to a psychiatric inpatient facility; 3) the individual has been accepted into a Mental Health Court; or 4) the individual is not longer lodged in the jail.
5. Train officers and staff in the identification of mentally ill or developmentally disabled individuals and the community resources available for treating those individuals.
6. Provide direct day-to-day program administration of the Authority employees.

The Sheriff further agrees to:

1. Contact the Authority first for all requests for inpatient psychiatric hospitalization.
2. Participate to the extent appropriate in treatment planning and progress evaluation after referring an inmate to the Authority.
3. Refer inmates when mental health services may be necessary or advisable.
4. Allow the Authority Jail Diversion staff up to 48 hours to observe, monitor and complete a mental health assessment to determine eligibility for diversion
5. Make medical records of referred inmates available to the Authority staff, Michigan Office of Community Health staff or third party insurance carriers, in accordance with applicable confidentiality laws or regulations.

6. Provide a private area for the Authority staff to meet with referred inmates.
7. Initiate petitions when an inmate meets criteria for involuntary hospitalization.
8. Transport an inmate to the Authority Crisis Services Office (formerly Emergency Services) or to an appropriate mental health facility as determined by the Authority when presented with a signed order for transport or a petition for admission and a physician's certificate.

The Prosecutor further agrees to:

1. Allow the Authority Jail Diversion staff up to 48 hours to observe, monitor and complete a mental health assessment to determine eligibility for diversion unless an arrestee's or defendant's constitutional rights would be affected.
2. Receive recommendations from the Authority staff regarding the alternative disposition of charges or suspension of prosecution of individuals appropriate for diversion from jail.

The Trial Court Chief Judge further agrees to:

1. Provide the venue for adjudication of involuntary commitment petitions.
2. Provide orders for transport for an assessment
3. Provide assignment of counsel when needed for persons who are subject of the petition.
4. Provide jail diversion services to persons in police custody who require mental health treatment provided by the Authority (Mental Health Court).
5. Provide coordinated court supervision for enrolled participants.

CERTIFICATION OF THE AUTHORITY TO SIGN AGREEMENT

The persons signing on behalf of the parties hereto certify by their signature that they are duly authorized to sign this Agreement on behalf of said parties and that this Agreement has been authorized by said parties.

IN WITNESS WHEREOF, the authorized representatives of the parties hereto have fully executed this Agreement on the day and the year first above written. Carried.

Community Mental Health Authority of Clinton, Eaton and Eaton Counties

Executive Director

Date

Eaton County Sheriff

Date

Eaton County Prosecutor

Date

Trial Court Chief Judge, Eaton County Courts

Date

Eaton County Board of Commissioners

Date

EATON COUNTY BOARD OF COMMISSIONERS

OCTOBER 15, 2014

RESOLUTION TO APPOINT COUNTY MEDICAL EXAMINER AND APPROVE SERVICE AGREEMENT

Introduced by the Public Safety Committee

Commissioner Whittum moved the approval of the following resolution. Seconded by Commissioner Osieczonek.

WHEREAS, the Board of Commissioners, by resolution created the Office of the County Medical Examiner; and

WHEREAS, Dr. Michael Markey, a duly licensed physician in the State of Michigan has indicated his interest in continuing to serve the County as Medical Examiner; and

WHEREAS, the Public Safety Committee is recommending the appointment of Dr. Markey as County Medical Examiner, effective January 1, 2015, for the four year term expiring December 31, 2018; and

WHEREAS, Dr. Philip Croft and Dr. John Bechinski have indicated their willingness in serving the County as Deputy Medical Examiners.

NOW, THEREFORE BE IT RESOLVED, that the Board of Commissioners appoints Dr. Michael Markey, as County Medical Examiner to a term expiring December 31, 2018; and

BE IT FURTHER RESOLVED, that the Board of Commissioners appoints Dr. Philip Croft and Dr. John Bechinski as Deputy Medical Examiners; and

BE IT FURTHER RESOLVED, that the Board of Commissioners approves the Medical Examiner Services Agreement with Sparrow Hospital Association for the term of the appointment; and

BE IT FURTHER RESOLVED, that the Chairman of the Board of Commissioners is authorized to sign any necessary documents. Carried.

EATON COUNTY BOARD OF COMMISSIONERS

OCTOBER 15, 2014

**RESOLUTION TO APPROVE MICHIGAN DEPARTMENT OF ENVIRONMENTAL QUALITY
SCRAP TIRE RECYCLING GRANT APPLICATION**

Introduced by the Public Works and Planning Committee

Commissioner Baker moved the approval of the following resolution. Seconded by Commissioner Freeman.

WHEREAS, the Resource Recovery Department has been established for the development and administration of the County Solid Waste Management Plan under Act 641, and

WHEREAS, key components of the Resource Recovery Department include increasing the amount of materials recycled, and

WHEREAS, the Michigan Department of Environmental Quality Scrap Tire Recycling Grant is designed to provide assistance in the removal of residential tires, and

WHEREAS, the Resource Recovery Department offers two Scrap Tire collection events annually,

WHEREAS, the Scrap Tire Grant funding request is up to \$10,000, with no matching funds required.

NOW, THEREFORE BE IT RESOLVED, that the Board of Commissioners approves the application of the Scrap Tire grant; and

BE IT FURTHER RESOLVED, that the Controller be authorized to approve any necessary budget amendments to increase expenditures and increase grant revenue if the grant is approved by the Department of Environmental Quality; and

BE IT FURTHER RESOLVED, that the Chairperson of the Board of Commissioners or his designee is authorized to sign the necessary documents. Carried.

**SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT**

Commissioner Eakin moved the approval of the following resolution. Seconded by Commissioner Augustine.

The undersigned Employer hereby adopts the Section 125 Flexible Benefit Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	EATON COUNTY
Address:	1045 INDEPENDENCE BLVD CHARLOTTE, MI 48813
Employer Identification Number:	38-6004847
Nature of Business:	Government
Name of Plan:	EATON COUNTY FLEXIBLE BENEFIT PLAN
Plan Number:	501

B. EFFECTIVE DATE

Original effective date of the Plan:	March 15, 2002
If Amendment to existing plan, effective date of amendment:	January 1, 2015

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item F.

Length of Service:	First day of the month following 30 days of service.
Minimum Hours:	All employees with 30 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 0 years.

D. PLAN YEAR

The current plan year will begin on January 1, 2015 and end on December 31, 2015. Each subsequent plan year will begin on January 1 and end on December 31.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

The maximum amount available to each Participant for the purchase of elected benefits with non-elective contributions will be:

All but \$20 of the medical cost for the employee + dependents' medical, dental, and vision premiums. \$100.00 per month up to \$1,200 per year directly as taxable compensation. The payment shall be made on a monthly basis, on the first payday of the month following coverage.

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will be paid to the Participant as taxable cash.

**Elective Contributions
(Salary Reduction):**

The maximum amount available to each Participant for the purchase of elected benefits through salary reduction will be:

60% of compensation per entire plan year.

Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

F. **AVAILABLE BENEFITS:** Each of the following components should be considered a plan that comprises this Plan.

1. **Group Medical Insurance** -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

BlueCross/BlueShield

Eligibility Requirements for Participation, if different than Item C.

2. **Disability Income Insurance** -- The terms, conditions, and limitations for the Disability Income Insurance will be as set forth in the insurance policy or policies described below: (See Section VI of the Plan Document)

American Fidelity Assurance Company

Eligibility Requirements for Participation, if different than Item C.

3. **Cancer Coverage** -- The terms, conditions, and limitations for the Cancer Coverage will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

American Fidelity Assurance Company C-9 and subsequent policies

Eligibility Requirements for Participation, if different than Item C.

4. **Dental/Vision Insurance** -- The terms, conditions, and limitations for the Dental/Vision Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

**Delta Dental
Vision Service Plan**

Eligibility Requirements for Participation, if different than Item C.

5. **Group Life Insurance** which will be comprised of Group-term life insurance and Individual term life insurance under Section 79 of the Code.

The terms, conditions, and limitations for the Group Life Insurance will be as set forth in the insurance policy or policies described below: (See Section VII of the Plan Document)

N/A

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, N/A exceed \$50,000.

Eligibility Requirements for Participation, if different than Item C.

6. **Dependent Care Assistance Plan** -- The terms, conditions, and limitations for the Dependent Care Assistance Plan will be as set forth in Section IX of the Plan Document and described below:

Minimum Contribution - \$ 200.00 per Plan Year

Maximum Contribution - \$ 5000.00 per Plan Year

Recordkeeper: **American Fidelity Assurance Company**

Eligibility Requirements for Participation, if different than Item C.

N/A

7. **Medical Expense Reimbursement Plan** -- The terms, conditions, and limitations for the Medical Expense Reimbursement Plan will be as set forth in Section VIII of the Plan Document and described below:

Minimum Coverage - \$ 200.00 per Plan Year

Maximum Coverage - \$ 2500.00 per Plan Year

Recordkeeper: **American Fidelity Assurance Company**

Restrictions: N/A

Grace Period: The provisions in Section 8.06 of the Plan to permit a Grace Period with respect to the Medical Expense Reimbursement Plan **are not** elected.

Carryover Provision: The provisions in Section 8.07 of the Plan to permit a Carryover with respect to the Medical Expense Reimbursement Plan are elected.

HEART Act: The provisions in Section 8.08 of the Plan to permit the Qualified Reservist Distribution of the Heroes Earnings Assistance and Relief Tax Act (HEART) **are** elected.

Debit Card: The provisions in Section 8.05 of the Plan to permit the offer of the Debit Card with respect to the Medical Expense Reimbursement Plan are elected.

Eligibility Requirements for Participation, if different than Item C.

8. **Health Savings Accounts** – The Plan permits contributions to be made to a Health Savings Account on a pretax basis in accordance with Section X of the Plan and the following provisions:

HSA Trustee – N/A

Maximum Contribution – As indexed annually by the IRS.

Limitation on Eligible Medical Expenses – For purposes of the Medical Reimbursement Plan, Eligible Medical Expenses of a Participant that is eligible for and elects to participate in a Health Savings Account shall be limited to expenses for:

N/A

Eligibility Requirements for Participation, if different than Item C.

- a. An Employee must complete a Certification of Health Savings Account Eligibility which confirms that the Participant is an eligible individual who is entitled to establish a Health Savings Account in accordance with Code Section 223(c)(1).
- b. Eligibility for the Health Savings Account shall begin on the later of (i) first day of the month coinciding with or next following the Employee's commencement of coverage under the High Deductible Health Plan, or (ii) the first day following the end of a Grace Period available to the Employee with respect to the Medical Reimbursement Accounts that are not limited to vision and dental expenses (unless the participant has a \$0.00 balance on the last day of the plan year).
- c. An Employee's eligibility for the Health Savings Account shall be determined monthly.

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of Michigan. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted this _____ day of _____, 20__.

EATON COUNTY
(Name of Employer)

Witness: [Signature] By: [Signature]

Title: County Controller Title: Chairman
Board of Commissioners

APPENDIX A

Related Employers that have adopted this Plan

Name(s):
N/A

THIS DOCUMENT IS NOT COMPLETE WITHOUT SECTIONS I THROUGH XIII

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SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

The Employer is establishing this Flexible Benefit Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

- 2.01 **Administrator** The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).
- 2.02 **Beneficiary** Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.
- 2.02A **Carryover** The amount equal to the lesser of (a) any unused amounts from the immediately preceding Plan Year or (b) five hundred dollars (\$500), except that in no event may the Carryover be less than five dollars (\$5).
- 2.03 **Code** Internal Revenue Code of 1986, as amended.
- 2.04 **Dependent** Any of the following:
(a) **Tax Dependent:** A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom

Code Section 152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Student on a Medically Necessary Leave of Absence: With respect to any plan that is considered a group health plan under Michelle's Law (and not a HIPAA excepted benefit under Code Sections 9831(b), (c) and 9832(c)) and to the extent the Employer is required by Michelle's Law to provide continuation coverage, a Dependent includes a child who qualifies as a Tax Dependent (defined in Section 2.04(a)) because of his or her full-time student status, is enrolled in a group health plan, and is on a medically necessary leave of absence from school. The child will continue to be a Dependent if the medically necessary leave of absence commences while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the group health plan's benefits coverage. Written physician certification that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary is required at the Administrator's request. The child will no longer be considered a Dependent as of the earliest date that the child is no longer on a medically necessary leave of absence, the date that is one year after the first day of the medically necessary leave of absence, or the date benefits would otherwise terminate under either the group health plan or this Plan. Terms related to Michelle's Law, and not otherwise defined, will have the meaning provided under the Michelle's Law provisions of Code Section 9813.

(c) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30, 2010 (subject to any other limitations of the Plan).

Dependent for purposes of the Dependent Care Reimbursement Plan is defined in Section 9.04(a).

- 2.05 **Effective Date** The effective date of this Plan as shown in Item B of the Adoption Agreement.
- 2.06 **Elective Contribution** The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.
- 2.07 **Eligible Employee** Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.
- 2.08 **Employee** Any person employed by the Employer on or after the Effective Date.
- 2.09 **Employer** The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 11.01 and 11.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
- 2.10 **Employer Contributions** Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
- 2.11 **Entry Date** The date that an Employee is eligible to participate in the Plan.
- 2.12 **ERISA** The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
- 2.13 **Fiduciary** The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
- 2.14 **Health Savings Account** A "health savings account" as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
- 2.15 **HSA Trustee** The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
- 2.16 **Highly Compensated** Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
- 2.17 **High Deductible Health Plan** A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).
- 2.18 **HIPAA** The Health Insurance Portability and Accountability Act of 1996, as amended.

- 2.19 **Insurer** Any insurance company that has issued a policy pursuant to the terms of this Plan.
- 2.20 **Key Employee** Any Participant who is a "key employee" as defined in Section 416(i) of the Code.
- 2.21 **Non-Elective Contribution** A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.
- 2.22 **Participant** An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.
- 2.23 **Plan** The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.
- 2.24 **Plan Year** The Plan Year as specified in Item D of the Adoption Agreement.
- 2.25 **Policy** An insurance policy issued as a part of this Plan.
- 2.26 **Preventative Care** Medical expenses which meet the safe harbor definition of "preventative care" set forth in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.
- 2.27 **Recordkeeper** The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.
- 2.28 **Related Employer** Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

- 3.01 **ELIGIBILITY:** Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent.

Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.

- 3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder.

- 3.03 TERMINATION OF PARTICIPATION: A Participant shall continue to participate in the Plan until the earlier of the following dates:

- (a) The date the Participant terminates employment by death, disability, retirement or other separation from service; or
- (b) The date the Participant ceases to work for the Employer as an eligible Employee; or
- (c) The date of termination of the Plan; or
- (d) The first date a Participant fails to pay required contributions while on a leave of absence.

- 3.05 SEPARATION FROM SERVICE: The existing elections of an Employee who separates from the employment service of the Employer shall be deemed to be automatically terminated and the Employee will not receive benefits for the remaining portion of the Plan Year.

- 3.06 QUALIFYING LEAVE UNDER FAMILY LEAVE ACT: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's existing coverage under the Plan with respect to benefits under Section V and Section VIII of the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

SECTION IV

CONTRIBUTIONS

- 4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.
- 4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:
- (a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:
- (1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
 - (2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
 - (3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
 - (4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
 - (5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.
- (b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f) or Section 2701(f) of the Public Health Service Act, then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that

the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

- (c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.
- (d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.
- (e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.
- (f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.
- (g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

- (h) Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Plan, or may not be modified with respect to the Medical Expense Reimbursement Plan if the Plan is being administered by a Recordkeeper other than the Employer, unless the Employer and the Recordkeeper otherwise agree in writing.

4.03 OTHER EXCEPTIONS TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes and apply to all qualified benefits except for Medical Expense Reimbursement Plans, as follows:

- (a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.
- (b) Significant curtailment of coverage.
- (i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.
- (ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.
- (c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.
- (d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.
- (e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

- 4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.
- 4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.
- 4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.
- 4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

- 5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.
- 5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.
- 5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.
- 5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.
- 5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.
- 5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.
- 5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

- 5.08 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

SECTION VI

DISABILITY INCOME BENEFIT PLAN

- 6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.
- 6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.
- 6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.
- 6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.
- 6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.
- 6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

- 7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.
- 7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.
- 7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.
- 7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.
- 7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement. Any individual policies purchased by the Employer for the Participant will be owned by the Participant.

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

- 8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.
- 8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.
- 8.03 TERMS, CONDITIONS, AND LIMITATIONS:
- (a) Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.
 - (b) Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.
 - (c) Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.
 - (d) Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.
 - (e) Forfeiture. Subject to Section 8.06 and 8.07, any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the

Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

- (f) COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ("COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.
- (g) Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.
- (h) Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan (increased by any Carryover to the Plan Year), shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.
- (i) Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).
- (j) Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount

by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

(k) Continuation Coverage for Certain Dependent Children. In the event that benefits under the Medical Expense Reimbursement Plan does not qualify for the exception from the portability rules of HIPAA, then, effective for Plan Years beginning on or after October 9, 2009, notwithstanding the foregoing provisions, coverage for a Dependent child who is enrolled in the Medical Expense Reimbursement Plan as a student at a post-secondary educational institution will not terminate due to a medically necessary leave of absence before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the Plan.

For purposes of this paragraph, "medically necessary leave of absence" means a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that: (i) commences while the child is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) causes the child to lose student status for purposes of coverage under the terms of the Plan. A written certification must be provided by a treating physician of the dependent child to the Plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

8.04 ELIGIBLE MEDICAL EXPENSES:

(a) (a) Eligible Medical Expense in General. The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his Dependents (subject to the restrictions in Sections 8.04(b) and (c)) during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, or from any other source. Notwithstanding the above, capital expenditures are not Eligible Medical Expenses under this Plan. Further, notwithstanding the above, effective January 1, 2011, only the following drugs or medicines will constitute Eligible Medical Expenses:

- (i.) Drugs or medicines that require a prescription;
- (ii.) Drugs or medicines that are available without a prescription ("over-the-counter drugs or medicines") and the Participant or Dependent obtains a prescription;
- and
- (iii.) Insulin.

(b) Expenses Incurred After Commencement of Participation. Only medical care expenses incurred by a Participant or the Participant's Dependent(s) on or after the date such Participant commenced participation in the Medical Expense Reimbursement Plan shall constitute an Eligible Medical Expense.

(c) Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and

(b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 8.04(b)).

(d) Health Savings Accounts. If the Employer has elected in Item F.8 of the Adoption Agreement to allow Eligible Employees to contribute to Health Savings Accounts under the Plan, then for a Participant who is eligible for and elects to contribute to a Health Savings Accounts, Eligible Medical Expenses shall be limited as set forth in Item F.8 of the Adoption Agreement.

8.05 USE OF DEBIT CARD: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses (other than over-the-counter drugs or medicines) under the Medical Expense Reimbursement Plan, the provisions described in this Section shall apply. However, beginning January 1, 2011, a Debit Card may not be used to purchase drugs or medicines over-the-counter.

(a) Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:

- (i) 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 Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.
- (ii) 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 the Recordkeeper (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.

(b) Status of Charges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

(c) Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

- (i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.
- (ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.
- (iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

- (iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.
- (v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

(d) Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of such cards set forth in Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

- 8.06 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.
- 8.07 Carryover: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Carryover with respect to the Medical Reimbursement Plan, the provisions of this Section 8.07 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2013-71, the Carryover for a Participant who has an amount remaining unused as of the end of the run-off period for the Plan Year, may be used to pay or reimburse Eligible Medical Expenses during the following entire Plan Year. The Carryover does not count against or otherwise affect the Maximum benefit set forth in Section 8.03 (b). Eligible Medical Expenses incurred during a Plan Year shall be reimbursed first from unused contributions for the current Plan Year, and then from any Carryover carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run-off period, (b) must be counted against any Carryover amount from the prior Plan Year, and (c) cannot exceed the maximum Carryover from the prior Plan Year. If the Employer elects to apply Section 8.06 in Section F.7 of the Adoption Agreement, this Section 8.07 shall not apply.
- 8.08 QUALIFIED RESERVIST DISTRIBUTIONS: Notwithstanding anything in the Plan to the contrary, an individual who, by reason of being a member of a reserve component (as defined in 37 U.S.C. § 101), is ordered or called to active duty for a period in excess of 179 days or for an indefinite period may elect to receive a distribution of all or a portion of the unused Elective Contributions in his or her Account relating to the Medical Expense Reimbursement Plan if the distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year that includes the date of such order or call. If the distribution is for the entire amount of unused

Elective Contributions available in the Medical Expense Reimbursement Plan, then no additional reimbursement requests will be processed for the remainder of the Plan Year.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

- 9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.
- 9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.
- 9.03 TERMS, CONDITIONS, AND LIMITATIONS:
- (a) Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.
 - (b) Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.
 - (c) For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be \$250 per month in the case of one Dependent and \$500 per month in the case of two or more Dependents.
 - (d) Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

- (e) Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.
- (f) Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.
- (g) Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

- (a) "Dependent" (for purposes of this Section IX) means any individual who is:
 - (i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or
 - (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.
- (b) "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:
 - (i) provides care for more than six individuals (other than individuals who reside at the facility);
 - (ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and
 - (iii) satisfies all applicable laws and regulations of a state or unit of local government.
- (c) "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:
 - (i) incurred for the care of a Dependent of the Participant or for related household services;
 - (ii) paid or payable to a Dependent Care Service Provider; and
 - (iii) 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.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying

child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

(d) "Dependent Care Service Provider" (for purposes of this Section IX) means:

- (i) a Dependent Care Center, or
- (ii) a person who provides care or other services described in Section 9.04(b) and who is not a related individual described in Section 129(c) of the Code.

SECTION X

HEALTH SAVINGS ACCOUNTS

10.01 PURPOSE: If elected by the Employer in Section F.8 of the Adoption Agreement, the Plan will permit pre-tax contributions to the Health Savings Account, and the provisions of this Article X shall apply.

10.02 BENEFITS: A Participant can elect benefits under the Health Savings Accounts portion of this Plan by electing to pay his or her Health Savings Account contributions on a pre-tax salary reduction basis. In addition, the Employer may make contributions to the Health Savings Account for the benefit of the Participant.

10.03 TERMS, CONDITIONS AND LIMITATION:

- (a) Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.
- (b) Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

10.04 RESTRICTIONS ON MEDICAL REIMBURSEMENT PLAN: If the Employer has elected in Section F.8 of the Adoption Agreement both Health Savings Accounts under this Plan and the Medical Expense Reimbursement Plan, then the Eligible Medical Expenses that may be reimbursed under the Medical Reimbursement Plan for Participants who are eligible for and elect to participate in Health Savings Accounts shall be limited as set forth in Section F.8 of the Adoption Agreement.

10.05 NO ESTABLISHMENT OF ERISA PLAN: It is the intent of the Employer that the establishment of Health Savings Accounts are completely voluntary on the part of Participants, and that, in accordance with Department of Labor Field Assistance Bulletin 2004-1, the Health Savings Accounts are not "employee welfare benefit plans" for purposes of Title I of ERISA.

SECTION XI

AMENDMENT AND TERMINATION

- 11.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.
- 11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

- 12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.
- 12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.
- 12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:
- (a) General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.
 - (b) Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.
 - (c) Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

- 12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.
- 12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.
- 12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.
- 12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.
- 12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.
- 12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.
- (a) Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special

circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

- (b) Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review, unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.
- (c) Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

12.10 SPECIAL CLAIMS REVIEW PROCEDURE: The provisions of this Section 12.10 shall be applicable to claims under the Group Medical Reimbursement Plan and the Group Medical Insurance Plan, effective on the first day of the first Plan Year beginning on or after July 1, 2002, but in no event later than January 1, 2003, provided such plans are subject to ERISA.

- (a) Benefit Denials: The Administrator is responsible for evaluating all claims for reimbursement under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan.

The Administrator will decide a Participant's claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Participant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The Participant will be given 45 days in which to complete an incomplete claim. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Administrator denies the claim, in whole or in part, the Participant will be furnished with a written notice of adverse benefit determination setting forth:

- I. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;
3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and
4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

(b) Appealing Denied Claims: If the Participant's claim is denied in whole or in part, he may appeal to the Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Administrator's initial notice of adverse benefit determination, or else the participant will lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Participant's written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant may also ask additional questions and make written comments, and may review (on request and at no charge) documents and other information relevant to his appeal. The Administrator will review all written comment the Participant submits with his appeal.

(c) Review of Appeal: The Administrator will review and decide the Participant's appeal within a reasonable time not longer than 60 days after it is submitted and will notify the Participant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with the Participant's appeal will be provided.) If the decision on appeal affirms the initial denial of the Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial,
2. The specific Plan provision(s) on which the decision is based,
3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,
4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

5. A statement of the Participant's right to bring suit under ERISA § 502(a).

12.11 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

12.12 PROTECTED HEALTH INFORMATION. The provisions of this Section will apply only to those portions of the Plan that are considered a group health plan for purposes of 45 CFR Parts 160 and 164. The Plan may disclose PHI to employees of the Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164. The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and use of, electronic PHI, in accordance with Subpart C of 45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Employer will:

- not use or disclose PHI other than as permitted or required by the plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by it on behalf of the Plan, in accordance with Subpart C of 45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents including a subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available PHI in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- 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 or his designee upon request for purposes of determining compliance with 45 CFR Section 164.504(f);
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which the 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; and,
- ensure that the adequate separation required in paragraph (f)(2)(iii) of 45 CFR Section 164.504 is established.

For purposes of this Section, "PHI" is "Protected Health Information" as defined in 45 CFR Section 160.103, which means individually identifiable health information, except as provided in paragraph (2) of the definition of "Protected Health Information" in 45 CFR Section 160.103, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XIII

MISCELLANEOUS PROVISIONS

- 13.01 INABILITY TO LOCATE PAYEE: If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.
- 13.02 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.
- 13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent'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 or Dependent.
- 13.04 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.
- 13.05 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.
- 13.06 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.
- 13.07 CONSTRUCTION:
- (a) Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.
 - (b) Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

- 13.08 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.
- 13.09 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.

PD 0514

EATON COUNTY BOARD OF COMMISSIONERS

OCTOBER 15, 2014

RESOLUTION TO PERSONNEL POLICY AMENDMENT

Introduced by the Ways & Means Committee

Commissioner Eakin moved the approval of the following resolution. Seconded by Commissioner Baker.

WHEREAS, the Board of Commissioners has adopted a Personnel Policy for employees; and

WHEREAS, the Ways & Means Committee has reviewed and is recommending approval of the proposed revisions to the previously adopted personnel policy, to be effective immediately; and

NOW, THEREFORE BE IT RESOLVED, that the Board of Commissioners approves the attached revisions to the Personnel Policy, effective immediately, as presented. Carried.

EATON COUNTY BOARD OF COMMISSIONERS

OCTOBER 15, 2014

**RESOLUTION TO APPROVE
2014/2015 BUDGET AMENDMENTS**

Introduced by the Ways and Means Committee

Commissioner Eakin moved the approval of the following resolution. Seconded by Commissioner Augustine.

WHEREAS, the Eaton County 2014/2015 Appropriations Act of September 17, 2014 states that any amendment to increase a salary and/or a Capital Outlay line-item in excess of \$2,500.00 or any amendment to increase the total budget of any fund or department in excess of \$2,500.00 shall be amended by the Board of Commissioners, except that any amendment to decrease the General Fund Contingency shall be approved by the Board of Commissioners; and

WHEREAS, such amendments are needed in order to comply with the Uniform Budgeting and Accounting Act of 1978, P.A. 621.

NOW, THEREFORE BE IT RESOLVED, that the following budget amendments be approved and added to the 2014/2015 Eaton County Budget:

<u>GENERAL FUND</u>	<u>WAGES AND FRINGES</u>	
Increase	Circuit	\$ 20,800
Increase	District	\$ 43,000
Increase	Friend of the Court	\$ 26,000
Increase	Probate	\$ 9,500
Increase	Juvenile	\$ 16,000
Increase	County Clerk	\$ 14,000
Increase	Controller	\$ 21,000
Increase	Information Systems	\$ 28,500
Increase	Equalization	\$ 14,500
Increase	Prosecuting Attorney's Office	\$ 55,000
Increase	Prosecuting Attorney's Office – ECU	\$ 22,500
Increase	Register of Deeds	\$ 22,500
Increase	County Treasurer	\$ 9,500
Increase	MSU Extension	\$ 1,800
Increase	Building and Grounds	\$ 7,500
Increase	Drain Commissioner's Office	\$ 18,000
Increase	Sheriff's Office	\$ 50,000
Increase	Sheriff's Office Corrections Division	\$ 14,000
Increase	Community Development	\$ 8,500
Increase	Veterans	\$ 3,000
Increase	Transfers-Out - Wage and Fringe	\$ 33,500
	<u>CONTINGENCY</u>	
Decrease	Contingency	\$ 169,100
	<u>REVENUE</u>	
Increase	Federal CRP Revenue	\$ 20,000
Increase	State Incentive Revenue	\$ 100,000
Increase	Miscellaneous Court Costs – District	\$ 150,000

To increase Wage and Fringe departmental budgets for salary study implementation effective January 11, 2015 with use of Contingency and reinstated revenue from the updated CRP calculation based on increase to wages, State Incentive share of the CRP Grant and Miscellaneous Court Costs fix by the Legislature.

Implementation included consideration of the elected officials on the same basis as the employee population. This amends the 2014/2015 Adopted Budget resolution #14-9-103 for the salaries of the Elected Officials effective January 11, 2015 as follows:

Clerk/Register of Deeds	\$ 68,910
Drain Commissioner	\$ 68,910
Prosecuting Attorney	\$105,331
Sheriff	\$ 95,410
Treasurer	\$ 68,910

SPECIAL REVENUE FUNDS

PARKS AND RECREATION - 208

Increase	Wage and Fringe	\$ 9,500
Increase	Transfers-In	\$ 9,500

FRIEND OF THE COURT - 215

Increase	Wage and Fringe	\$ 1,500
Increase	Transfers-In	\$ 1,500

RESOURCE RECOVERY - 228

Increase	Wage and Fringe	\$ 3,500
Increase	Fund Balance Carryover	\$ 3,500

CONSTRUCTION CODE - 240

Increase	Wage and Fringe	\$ 7,500
Increase	Fund Balance Carryover	\$ 7,500

CENTRAL DISPATCH - 261

Increase	Wage and Fringe	\$ 10,000
Increase	Fund Balance Carryover	\$ 10,000

VERTICAL DRUG PROSECUTION - 267

Increase	Wage and Fringe	\$ 4,500
Increase	Transfers-In	\$ 4,500

STOP (DOMESTIC VIOLENCE) - 270

Increase	Wage and Fringe	\$ 3,000
Increase	Transfers-In	\$ 3,000

COMMUNITY CORRECTIONS - 276

Increase	Wage and Fringe	\$ 3,000
Increase	Transfers-In	\$ 3,000

CHILD CARE FUND - 292

Increase	Wage and Fringe	\$ 24,000
Increase	Transfers-In – General Fund	\$ 12,000
Increase	Transfers-In – Juvenile Millage	\$ 12,000

JUVENILE MILLAGE - 296

Increase	Transfers-Out	\$ 12,000
Increase	Fund Balance Carryover	\$ 12,000

To increase Wage in Fringe in Special Revenue Fund budgets for salary study implementation.

PUBLIC IMPROVEMENT - 245

Increase	Equipment	\$ 207,012
Increase	Fund Balance Carryover	\$ 207,012

To increase the total budget for the completion of 2013/2014 projects carried over into 2014/2015. Ayes: Hosey, Augustine, Spence, Osieczonek, Whitacre, Freeman, Brehler, Miars, Eakin, Ridge, Baker, Whittum, Harris, Mulder. Nays: Barr. Carried.