AGENDA

HUMAN RESOURCES COMMITTEE MEETING

September 16, 2014

5:00 P.M. – 1201 S. Washington Ave.
REO Town Depot

Call to Order

Roll Call

Public Comments on Agenda Items

1. Human Resources Committee Meeting Minutes of 6/10/14

2. Benefit Plan Document Update

3. PA 152 Statutorily Required Insurance Co-Pay

4. Planning HR Committee's Work for the Next Year **(INFORMATION ONLY)**

Other

Adjourn

HUMAN RESOURCE COMMITTEE
June 10, 2014

The Human Resource Committee of the Lansing Board of Water and Light met at the BWL Headquarters-REO Town Depot located at 1201 S. Washington Ave., Lansing, MI, at 6:00 p.m. on Tuesday, June 10, 2014.

Human Resource Committee Chairperson Tracy Thomas called the meeting to order and asked the Secretary to call the roll. The following members were present: Commissioners Tracy Thomas, Anthony McCloud, Cynthia Ward and Sandra Zerkle. Also present: Commissioners Margaret Bossenbery, Dennis Louney, Tony Mullen and David Price.

Absent: None

Public Comments

There were no public comments.

Approval of Minutes

Motion by Commissioner Ward, seconded by Commissioner Zerkle to approve the Human Resource Committee meeting minutes of May 20, 2014.

Action: Carried unanimously.

FY 2014 Board Appointee Performance

a. Corporate Secretary

Human Resource Chair Thomas stated that he would like to continue with the evaluation of the appointed employees and asked if there was any business or any dialogue regarding the Corporate Secretary's review. Chair Thomas said that he would like to recommend that the Board restore the assistant that the Corporate Secretary had in the past and for it for consideration to be under the direction of the Board.

After some discussion regarding the Assistant for the Corporate Secretary the following motion occurred.

Motion by Commissioner Zerkle, Seconded by Commissioner McCloud to forward a recommendation to the Finance Committee to appropriate in the budget a full time employee to assist the Corporate Secretary.

Commissioner Zerkle, **rescinded** her motion and stated that she would reintroduce the motion under other later in the Agenda.

After dialogue regarding the Corporate Secretary's evaluation Human Resource Chair Tracy Thomas provided another opportunity for the Commissioners to express any thoughts or opinion or have dialogue regarding the Corporate Secretary's review.

Motion by Commissioner Zerkle and seconded by Commissioner McCloud to forward the resolution for the reappointment of Ms. Griffin to the Charter position of Corporate Secretary for fiscal year 2014-2015 to the full Board for consideration.

Action: Carried Unanimously

FY 2014 Board Appointee Performance

a. Internal Auditor

Internal Auditor Phil Perkins requested a closed session for the purpose of receiving his contractual year-end performance evaluation as permitted by the Open Meetings Act exemption MCL 15.268(a).

Motion by Commissioner McCloud, seconded by Commissioner Zerkle to go into closed session.

Roll Call Vote: Yeas: Commissioners' Thomas, McCloud, Ward and Zerkle
Nays: None

Human Resource Chair Tracy Thomas conveyed to Internal Auditor Perkins the following:

"Before we go into closed session, please know that you may rescind your request at any time. You must verbally or directly rescind your request, at which time closed session will end immediately and we will continue consideration of your evaluation in open session."

The Human Resource Committee meeting went into closed session at 6:21 p.m.

Motion by Commissioner Zerkle, seconded by Commissioner McCloud that the Human Resource Committee return to open session.

Action: Carried unanimously

The Human Resource Committee meeting reconvened in open session at 7:05 p.m.

Upon conclusion of the closed sessions, Human Resource Committee Chair Thomas conveyed that now would be the time for any dialogue regarding any business dealing with the Internal Auditor's review. There being none, the meeting proceeded.

Motion by Commissioner McCloud and seconded by Commissioner Zerkle to forward the resolution for the reappointment of Mr. Perkins to the Charter position of Internal Auditor for fiscal year 2014-2015 to the full Board for consideration.

Action: Motion Carried

FY 2014 Board Appointee Performance

a. General Manager

General Manager J. Peter Lark requested a closed session for the purpose of receiving his contractual year-end performance evaluation as permitted by the Open Meetings Act exemption MCL 15.268(a).

Motion by Commissioner Zerkle, seconded by Commissioner McCloud to go into closed session.

Roll Call Vote: Yeas: Commissioners' Thomas, McCloud, Ward and Zerkle
Nays: None

Human Resource Chair Tracy Thomas conveyed to General Manager Lark the following:

"Before we go into closed session, please know that you may rescind your request at any time. You must verbally or directly rescind your request, at which time closed session will end immediately and we will continue consideration of your evaluation in open session."

The Human Resource Committee meeting went into closed session at 7:10 p.m.

Motion by Commissioner Zerkle, seconded by Commissioner McCloud that the Human Resource Committee return to open session.

The Human Resource Committee meeting reconvened in open session at 8:28 p.m.

Upon conclusion of the closed sessions, Human Resource Committee Chair Thomas conveyed that now would be the time for any dialogue regarding any business dealing with the Internal Auditor's review. There being none, the meeting proceeded

Motion by Commissioner McCloud and seconded by Commissioner Zerkle to forward the resolution for the reappointment of Mr. Lark to the Charter position of General Manager for fiscal year 2013-2014 to the full Board for consideration.

Action: Motion Carried (3/1 Ward)

Other

Commissioner Zerkle thanked Human Resource Chair Thomas for his due diligence on the evaluation process. She stated that this was a difficult process and appreciates all the efforts that he has put into this process. Chair Zerkle also requested that a recommendation be forwarded to the Finance Committee to appropriate funds in the 2015 budget for an assistant for the corporate secretary.

Motion by Commissioner McCloud, Seconded by Commissioner Ward to forward a recommendation to the Finance Committee to appropriate in the budget for a full time employee to assist the Corporate Secretary.

Motion by Chair Thomas, Seconded by Commissioner Zerkle to make a friendly amendment to the main Motion to include that the employee would be under the direction of the Board of Commissioners.

Action: Motion Carried with Friendly Amendment

Adjourn

The Human Resource Committee meeting adjourned at 8:48 p.m.

Respectfully submitted,
Tracy Thomas, Chair
Human Resource Committee

Executive Summary
Regarding the
Cafeteria Plan
and the
Post-Retirement Benefit Plan

(*prepared for the Human Resources Committee of Lansing Board of Water and Light***)**

The purpose of this Executive Summary is to summarize the proposed actions related to the Lansing Board of Water and Light Cafeteria Plan and the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light, and to provide a proposed resolution for those actions, for the Human Resources Committee of the Lansing Board of Water and Light.

Background

The Lansing Board of Water and Light has maintained the Lansing Board of Water and Light Cafeteria Plan (the "Cafeteria Plan") and the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light (the "Post-Retirement Benefit Plan") for many years. The general purpose of the Cafeteria Plan is to allow employees to pay for certain portions of their health care costs (e.g., health insurance premiums, flexible spending dollars, and dependent care expenses) with pre-tax dollars. The purpose of the Post-Retirement Benefit Plan is to provide certain post-retirement health care benefits to qualifying retirees.

Action Requested

At this time, both the Cafeteria Plan and the Post-Retirement Benefit Plan have proposed amendments. The Cafeteria Plan is simply being amended (in the form of a restatement) for regulatory purposes since the current Plan documents were drafted prior to the issuance of the most recent government regulations. There are only technical and mechanical concepts being incorporated in the Cafeteria Plan. For example, the limit on a participant's use of flexible spending dollars has been reduced to $2,500 per year as required by the regulations, and the regulations also made slight adjustments to definitions, discrimination testing rules, and substantiation requirements for expense reimbursements. The Cafeteria Plan restatement also simplifies administration by converting five separate documents into one Plan document.

The Post-Retirement Benefit Plan is being amended to incorporate certain Plan design changes to make it consistent with the manner in which it has, and will, be administered. For example, this Plan now provides for premium cost sharing by retirees, it eliminates certain required connections to the prior pension plan, and it preserves certain powers of the Board. Many of these design changes have already been approved by the Board.

It is requested that the Human Resources Committee review this information and request the Board to approve the amendments and to authorize the appropriate officers (or their delegates) to execute the Amendments and any related ancillary documents. Draft resolutions are also included for Board approval.

If there are any questions related to any of the matters addressed in this Executive Summary, those questions can be directed to Ms. Brandie Ekren, Esq. (General Counsel; (517) 702-6725) or Ms. Gennie Eva (Director of Finance; 517-702-6176).

Attachments:

1. Exhibit A – Proposed Resolutions for the Adoption of the Amendments to the Cafeteria Plan and the Post-Retirement Benefit Plan

2. Exhibit B –The Lansing Board of Water and Light Cafeteria Plan (As Restated October 1, 2014)

3. Exhibit C- (*Existing)* Lansing Board of Water and Light Cafeteria Plan (As Restated March 27, 2007) – 5 documents

    a. Lansing Board of Water and Light Cafeteria Plan (*Umbrella Document*)
    b. Lansing Board of Water and Light Premium Only Plan
    c. Lansing Board of Water and Light Medical Reimbursement Plan
    d. Lansing Board of Water and Light Dependent Care Plan
    e. Lansing Board of Water and Light Cash Option Plan

4. Exhibit D - Amendment to the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light (October 1, 2014)

5. Exhibit E –Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light (As Restated March 27, 2007)

Exhibit A
to
Executive Summary

PROPOSED RESOLUTION
for the
Adoption of the Amendments to the Cafeteria Plan and Post-Retirement Benefit Plan

WHEREAS, the Lansing Board of Water and Light (the "BWL") maintains the Lansing Board of Water and Light Cafeteria Plan (the "Cafeteria Plan") and the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light (the "Post-Retirement Benefit Plan"), for the benefit of certain of its employees and retirees; and

WHEREAS, the BWL desires to amend the Cafeteria Plan (for certain technical regulatory changes) and the Post-Retirement Benefit Plan (for certain plan design changes for consistency with Plan operations and administration).

NOW THEREFORE, the BWL does hereby authorize, approve and adopt the following resolutions:

> RESOLVED, that the Amendment and Restatement of the Cafeteria Plan (as of October 1, 2014, in the form attached hereto) is hereby adopted and approved; and
>
> BE IT FURTHER RESOLVED, that the Amendment to the Post-Retirement Benefit Plan (as of October 1, 2014, in the form attached hereto) is hereby adopted and approved; and
>
> BE IT FURTHER RESOLVED, that the officers of the BWL, and their designee(s), are hereby authorized and directed to take such actions and to implement and execute such documents and instruments (including the amendments referenced above as well as ancillary documentation) as necessary or desirable to effectuate the intent of these resolutions.

Exhibit B
to
Executive Summary

The Lansing Board of Water and Light Cafeteria Plan, as Restated (October 1, 2014)

[SEE ATTACHED]

ADOPTION AGREEMENT
for the
LANSING BOARD OF WATER AND LIGHT CAFETERIA PLAN

The undersigned adopting employer hereby adopts this Plan. The Plan is intended to qualify as a cafeteria plan under Code section 125. The Plan shall consist of this Adoption Agreement, its related Basic Plan Document and any related Appendix and Addenda to the Adoption Agreement. Unless otherwise indicated, all Section references are to Sections in the Basic Plan Document.

COMPANY INFORMATION

1. Adopting Employer (Plan Sponsor): **Lansing Board of Water and Light, 1201 S. Washington Ave., Lansing, MI 48910**

2. Plan Sponsor entity type - Government Agency

PLAN INFORMATION

A. GENERAL INFORMATION.

1. **Plan name**: **Lansing Board of Water and Light Cafeteria Plan**

2. **Effective Date:**
2a. Original effective date of Plan: **August 1, 1987**
2b. Is this a restatement of a previously-adopted plan? - **Yes**
2c. Effective date of Plan restatement: **October 1, 2014**; provided, however, that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

3. **Plan Year** means each 12-consecutive month period ending on **August 31**. If the Plan Year changes, any special provisions regarding a short Plan Year should be placed in the Addendum to the Adoption Agreement.

4. Is the Plan Subject to ERISA? No

Plan Features

5. **Premium Conversion Account**. Contributions to fund a Premium Conversion Account are permitted (Section 4.01).

6. The types of Contracts for which a Participant may seek reimbursement under Section 4.01: Employer Group Medical, Dental, and other benefits as provided on the election and administration forms.

7. **Health Care Reimbursement Account**. Contributions to fund a Health Care Reimbursement Account are permitted.

8. **HSA Account.** Contributions to fund an HSA Account are permitted (Section 4.08): No

9. **Dependent Care Assistance Account**. Contributions to fund a Dependent Care Assistance Account are permitted (Section 4.03): Yes
NOTE: The maximum amount of expense that may be contributed/reimbursed in any Plan Year for the Dependent Care Assistance Account is the maximum amount permitted by federal tax law ($5,000 or $2,500 if the Participant is married and filing a separate federal tax return).

10. **Adoption Assistance Account**. Contributions to fund an Adoption Assistance Account are not permitted. (Section 4.04).

B. ELIGIBILITY.

Exclusions/Modifications

1. The term "Eligible Employee" shall include all full-time Employees (regularly scheduled to work at least 30 hours per week, and as further defined in the Employer's policies, and including Employees on the Voluntary Work Reduction Program as provided by the Employer or who would be remunerated except for an authorized leave of absence as a full-time employee under the Personnel Policy), unless otherwise provided in an applicable collective bargaining agreement.

2. An Employee shall be an Eligible Employee with respect to the Premium Conversion Account if the Employee is eligible to participate in the benefit plans described in **A.6**.

Service Requirements

3. Minimum age requirement for an Eligible Employee to become eligible to be a Participant in the Plan: None.

4. Minimum service requirement for an Eligible Employee to become eligible to be a Participant in the Plan: None.

5. Frequency of entry dates: first day of each calendar month after date of hire, if election forms have been timely submitted.

6. An Eligible Employee shall become eligible to become a Participant in the Plan with respect to the Premium Conversion Account at the same date as he or she becomes eligible to participate in the benefits described in **A.6.**

Transfers/Rehires

7. Permit Participants who are no longer Eligible Employees (for reasons other than Termination) to continue to participate in the Plan until the end of the Plan Year (Section 3.02): Yes (otherwise, a Participant who has a change in job classification or a transfer that results in the Participant no longer qualifying as an Eligible Employee shall cease to be a Participant as of the effective date of such change of job classification or transfer).

8. Automatically reinstate benefit elections for Terminated Participants who are rehired within 30 days of Termination and permit new benefit elections for Terminated Participants who are rehired more than 30 days after Termination (Section 3.03(a)): No, a Terminated Participant shall not be able to participate in the Plan until the first entry date following reemployment.

C. BENEFITS

Premium Conversion

1a. There is no automatic enrollment for the Premium Conversion Account.

1b. This Plan provides automatic adjustment of Participant elections for changes in the cost of Contracts pursuant to the terms of Treas. Reg. 1.125-4.

Health Care Reimbursement

2. The maximum salary reduction amount that can be contributed to a Health Care Reimbursement Account in any Plan Year: The maximum amount permitted under Code section 125(i) (currently, $2,500).

3. Specify whether a Participant shall continue making contributions after Termination of employment for the remainder of the Plan Year: Yes - Continue contributions on an after-tax basis and reimbursements will be allowed for the remainder of the Plan Year.

NOTE: Any required COBRA elections described in Section 4.06 shall supersede this **C.3**.

4. Indicate whether a Participant may revise a Health Care Reimbursement Account election upon a change of status: Yes - without limitation
NOTE: The rules regarding the revision of Health Care Reimbursement Account elections in this **C.4** are also subject to the conditions and limitations provided in **C.12**.

Health Care Reimbursement - Eligible Expenses

5. A Participant may only be reimbursed from his or her Health Care Reimbursement Account for expenses that are incurred by: the Participant, spouse and dependents - the Participant, his or her spouse and all dependents within the meaning of Code section 152 as modified by Code section 105(b), and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday. The eligible expenses are as provided in the Basic Plan Document and any list provided by the Plan Administrator.
NOTE: The Plan Administrator may extend coverage for children until the end of the calendar year in which a child turns age 26.

6. Describe method to coordinate coverage in the Plan with Health Savings Accounts (Section 6.01(j)): None. Coverage in the Plan is not limited or the Plan is not used in conjunction with a Health Savings Account.

7. Describe method to coordinate coverage in the Plan with a Company-sponsored health reimbursement arrangement ("HRA") for expenses that are reimbursable under both this Plan and the HRA (Section 6.01(e)): None. Plan is not used in conjunction with a Company-sponsored HRA.

Company Contributions

8. Indicate whether the Company may contribute to the Plan (Section 4.09): No.

9. Indicate whether the Plan permits Participants (but not spouses or beneficiaries) to elect cash in lieu of benefits for portions of the year eligible only: Yes; [additionally, notwithstanding anything to the contrary contained herein, and unless prohibited by law, a Retiree (as defined in the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light) may also participate in the cash in lieu benefit only, according to Plan Administrator procedures for such cash in lieu benefits. For cash-in-lieu to apply, a participant must be eligible for health and prescription drug coverage under a collective bargaining agreement, the health and prescription drug plans for active employees, or the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light. If an eligible participant begins employment on the first work day of the calendar month, that shall be his/her participation date for this benefit, if otherwise qualified.

Elections

NOTE: The Plan Administrator may establish a minimum dollar amount or percentage of Compensation for all elections provided that such minimum is non-discriminatory.

10. When may continuing Participants make elections regarding contributions (Section 4.06(b)): Pursuant to Plan Administrator procedures.

11. The election for a continuing Participant who fails to make an election within the prescribed period shall be determined in accordance with the following (Section 4.06(c)-(d)): Continue same election. Elections for the applicable Plan Year shall be the same as the elections made in the prior Plan Year.

12. When may Participants modify elections regarding contributions (Section 4.07(a)): At any time permitted under Treas. Reg. section 1.125-4 and in accordance with pursuant to Plan Administrator procedures.

13a. A Participant may elect to continue coverage on a pre-tax or after tax basis for non-medical benefits when on leave of absence under the FMLA (Section 4.06(f)): Yes - A Participant may continue coverage for all benefits to which he is entitled when on FMLA leave.

13b. A Participant may elect to continue coverage on a pre-tax or after tax basis pursuant to **C.13a** when on a leave of absence other than a leave of absence under the FMLA: No.

Dependent Care Spend Down

14. Indicate whether Employees that cease to Participate in the cafeteria plan may continue to be reimbursed for eligible dependent care expenses through the end of the Plan Year (or grace period if applicable): Yes

D. PLAN OPERATIONS

The Plan Administrator may establish an enrollment period for use prior to the beginning of the Plan Year, and unless otherwise established, this period shall be 60 days, to be used in accordance with its forms and administration procedures.

Claims

1. Claims for reimbursement for an active Participant must be filed with the Plan Administrator (Section 6.01) within **120** days following the last day of each Plan Year.

2a. The Plan provides for a 2-1/2 month grace period described in IRS Notice 2005-42 immediately following the end of each Plan Year (Section 4.05(c)).

2b. Enter the Accounts that are eligible for the grace period: any permitted by law.

2c. Claims are due also within the same number of days after the end of the grace period.

3. The Company may provide debit, credit, and/or other stored-value cards for Health Care Reimbursement Accounts and/or Dependent Care Assistance Accounts (Section 6.01(i)).

Qualified Reservist Distributions (HEART Act)

4. Permit Qualified Reservist Distributions: No

Plan Administrator

5. Designation of Plan Administrator (Section 7.01): Plan Sponsor (not a Committee appointed by Plan Sponsor)

6. Type of indemnification for the Plan Administrator (Section 7.02): Standard as provided in Section 7.02.

E. EXECUTION PAGE

Failure to properly fill out the Adoption Agreement may result in the failure of the Plan to achieve its intended tax consequences.

The Plan shall consist of this Adoption Agreement, its related Basic Plan Document #125 and any related Appendix and Addendum to the Adoption Agreement.

The undersigned agree to be bound by the terms of this Adoption Agreement and Basic Plan Document and acknowledge receipt of same.

The Plan Sponsor caused this Plan to be executed this _____ day of _____, 2014.

LANSING BOARD OF WATER AND LIGHT:

Signature:_____

Print Name: _____

Title/Position:_____

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LANSING BOARD OF WATER AND LIGHT
CAFETERIA PLAN
BASIC PLAN DOCUMENT

LANSING BOARD OF WATER AND LIGHT
CAFETERIA PLAN
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ARTICLE 1
INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of premiums and contributions to spending accounts that are excludable from gross income under Code section 125, reimbursement of certain medical expenses that are excludable from gross income under Code section 105(b) and reimbursement of certain dependent care expenses that are excludable from gross income under Code section 129, and reimbursement of certain adoption expenses that are excludable from gross income under Code section 137.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Company on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Company whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2
DEFINITIONS

"Account" means the balance of a hypothetical account established for each Participant as of the applicable date. "Account" or "Accounts" shall include to the extent provided in the Adoption Agreement, a Premium Conversion Account, a Health Care Reimbursement Account, a Dependent Care Assistance Account, an Adoption Assistance Account and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

"Adoption Agreement" means the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

"Adoption Assistance Account" means the Account established with respect to the Participant's election to have adoption expenses reimbursed by the Plan pursuant to Section 4.04.

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"Company" means the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

"Compensation" means the cash wages or salary paid to a Participant. If the Adoption Agreement indicates that the Plan is a simple cafeteria plan as defined in Code section 125(j), "Compensation" shall mean Section 414(s) Compensation (defined below).

"Contract" means an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. Contract shall not include any product which is advertised, marketed, or offered as long-term care insurance. As of January 1, 2014, "Contract" may not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employee's Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

"Dependent Care Assistance Account" means the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Section 4.03.

"Effective Date" shall have the meaning set forth in the Adoption Agreement.

"Eligible Employee" means any Employee employed by the Company, subject to the modifications and exclusions described in the Adoption Agreement. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Company is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Company in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by the Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the trade or business shall not become eligible to participate in the Plan until the Plan Sponsor specifically authorizes such participation.

"Employee" means any individual who is employed by the Employer. The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock of an S corporation.

"Employer" means the Company or any other employer required to be aggregated with the Company under Code sections 414(b), (c), (m) or (o); provided, however, that "Employer" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993 as amended from time to time.

"Health Care Reimbursement Account" means the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Section 4.02.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

"Participant" means an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

"Plan Administrator" means the person(s) designated pursuant to the Adoption Agreement and Section 7.01.

"Plan Sponsor" means the entity described in the Adoption Agreement.

"Plan Year" means the 12-consecutive month period described in the Adoption Agreement.

"Premium Conversion Account" means the Account established with respect to the Participant's election to have premiums reimbursed by the Plan pursuant to Section 4.01.

"Section 414(s) Compensation" means compensation as defined in Code section 414(s) and Treas. Reg. section 1.414(s)-1. The period used to determine an Employee's compensation for a Plan Year must be either the Plan Year or the calendar year ending within the Plan Year. Whichever period is selected by the Plan Administrator must be applied uniformly to determine the compensation of every eligible Employee under the Plan for that Plan Year. The Plan Administrator may, however, limit the period taken into account under either method to that portion of the Plan Year or calendar year in which the Employee was an eligible Employee, provided that this limit is applied uniformly to all eligible.

"Termination" and "Termination of Employment" means any absence from service that ends the employment of the Employee with the Company.

ARTICLE 3
PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Employee as of the Effective Date who was eligible to participate in the Plan immediately prior to the Effective Date shall be a Participant eligible to make benefit elections pursuant to Article 4 on the Effective Date. Each other Eligible Employee who was not a Participant in the Plan prior to the Effective Date shall become a Participant eligible to make benefit elections pursuant to Article 4 on the date specified in the Adoption Agreement; provided that he is an Eligible Employee on such date. Notwithstanding the foregoing, a Participant shall be eligible to make elections only for the Accounts as are specifically authorized in the Adoption Agreement.

Section 3.02 TRANSFERS

If a change in job classification or a transfer results in an individual no longer qualifying as an Eligible Employee, such Employee shall cease to be a Participant for purposes of Article 4 (or shall not become eligible to become a Participant) as of the effective date of such change of job classification or transfer; unless otherwise provided in the Adoption Agreement. Should such Employee again qualify as an Eligible Employee, he shall be eligible to participate as of the first day of the subsequent Plan Year; unless earlier participation is required by applicable law or permitted pursuant to the change of status provisions of Section 4.07(a). If an Employee who was not previously an Eligible Employee becomes an Eligible Employee, he shall be eligible to participate on the first entry date following the later of the effective date of such subsequent change of status or the date the Employee meets the eligibility requirements of this Article 3.

Section 3.03 TERMINATION AND REHIRES

(a) Participants. If a Participant has a Termination of Employment, such Employee shall cease to be a Participant for purposes of Article 4 as of his Termination of Employment. The Plan Administrator may continue participation for purposes of Article 4.01 until the end of the calendar month coincident with or next following his Termination of Employment or other timeframe according to established Plan Administrator procedures. Unless otherwise provided in the Adoption Agreement, if an individual who has satisfied the applicable eligibility requirements set forth in Article 3 as of his Termination date, and who is subsequently reemployed by the Company as an Eligible Employee, shall resume or become a Participant as of the later of the first day of the subsequent Plan Year or the first entry date following reemployment. Notwithstanding the foregoing and if so provided in the Adoption Agreement, the Plan Administrator shall automatically reinstate benefit elections for Terminated Participants who are rehired within 30 days of Termination and permit new benefit elections for Terminated Participants who are rehired more than 30 days after Termination.

(b) Non-Participants. An Eligible Employee who has not satisfied the applicable eligibility requirements set forth in Article 3 on his Termination date, and who is subsequently reemployed by the Company as an Eligible Employee, shall be eligible to participate on the first entry date following the later of the effective date of such reemployment or the date the individual meets the eligibility requirements of this Article 3.

Section 3.04 PROCEDURES FOR ADMISSION

The Plan Administrator shall prescribe such forms and may require such data from Participants as are reasonably required to enroll a Participant in the Plan or to effectuate any Participant elections made pursuant to Article 4.

ARTICLE 4
ACCOUNTS

Section 4.01 PREMIUM CONVERSION ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Premium Conversion Account described in Subsection (b). The amount of such contributions to and the premiums that may be reimbursed from the Premium Conversion Account shall not exceed the employee-paid portion of premiums payable under the Contracts specified in the Adoption Agreement. If a Contract is offered in conjunction with a Company-sponsored benefit plan, a Participant shall be eligible to make contributions to the Premium Conversion Account with respect to that Contract only if he or she is also eligible to participate in the applicable Company-sponsored plan. The Account established under this Section 4.01 is intended to qualify under Code Sections 79 and 106(a) to the extent so indicated in the Adoption Agreement and shall be interpreted in a manner consistent with such Code sections. Elections for Code section 79 coverage shall be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

(b) Premium Conversion Account. Each Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for amounts applied to employee-paid portion of applicable premiums. However, the Plan Administrator will not direct the Company to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

(c) Conflicts. In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions which must be satisfied to become covered, if any, the benefits Participants are entitled to and the circumstances under which coverage terminates.

Section 4.02 HEALTH CARE REIMBURSEMENT ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Health Care Reimbursement Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Health Care Reimbursement Account described in Subsection (b). The amount of such salary reduction contributions to the Health Care Reimbursement Account shall not exceed the maximum annual limit described in the Adoption Agreement. The Account established under this Section 4.02 is intended to qualify as a health flexible spending arrangement under Code Sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

(b) Health Care Reimbursement Account. Each Participant's Health Care Reimbursement Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for expenses described in Subsection (c). The entire annual amount elected by the Participant on the salary reduction agreement for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Reimbursement Account provided that the amounts elected in the salary reduction agreement have been paid as provided in the salary reduction agreement.

(c) Eligible Expenses. Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Health Care Reimbursement Account for expenses that are: (i) incurred in the Plan Year (except as provided in Section 4.05(c)), (ii) incurred while the Participant participates in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses that are not covered, paid or reimbursed from any other source.

(1) For purposes of Code section 105(b), unless otherwise provided in the Adoption Agreement, dependents shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) For purposes of Code section 105(b), unless otherwise provided in the Adoption Agreement, expenses for a child (as defined in section 152(f)(1)) of the Participant may be covered until his or her 26th birthday although the Plan Administrator may extend coverage until the end of the calendar year in which the child turns age 26.

(3) Effective January 1, 2011, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(d) Qualified Reservist Distributions.

(1) If the Plan allows Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his Health Care Reimbursement Account specified in the Adoption Agreement provided that such amount was in existence on or after June 18, 2008. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such 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 which includes the date of such order or call. A Participant ordered or called to active duty before June 18, 2008 is eligible for a Qualified Reservist Distribution if the Participant's period of active duty continues after June 18, 2008 and meets the duration requirements of IRS Notice 2008-82. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(2) The Plan shall permit a Participant to submit Health Care Reimbursement Account claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Company shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(3) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 4.03 DEPENDENT CARE ASSISTANCE ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Dependent Care Assistance Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Dependent Care Assistance Account described in Subsection (b). The Account established under this Section 4.03 is intended to qualify as a dependent care assistance program under Code Section 129 and shall be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.

(b) Dependent Care Assistance Account. Each Participant's Dependent Care Assistance Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for expenses described in Subsection (c). However, the Plan Administrator will not direct the Company to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Dependent Care Assistance Account.

(c) Eligible Expenses.

(1) In General. A Participant may be reimbursed from his or her Dependent Care Assistance Account to the extent that such reimbursement: (i) is incurred in the Plan Year (except as provided in Section

4.05(c), (ii) is incurred while the Participant participates in the Plan, and (iii) qualifies as dependent care expenses; provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.

(2) Dependent Care Expenses. Dependent care expenses are defined as expenses incurred for the care of a qualifying individual. A qualifying individual is either: (i) a dependent who is under age 13, or (ii) the Participant's spouse or dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are dependent care expenses only if they allow the Participant to be gainfully employed. Dependent care expenses include expenses for household services and expenses for the care of a qualifying individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the qualifying individual stays overnight. Expenses described in this Subsection which are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least 8 hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

(3) Limits. The maximum amount of expense that may be contributed/reimbursed in any taxable year for the Dependent Care Assistance Account is $5,000 ($2,500 if the Participant is married and filing a separate return). The amount payable may also not be greater than the amount of the Participant's earned income or the earned income of his or her spouse. In the case of a spouse who is a student or a qualifying individual, Code section 21(d)(2) shall apply in determining earned income.

(d) If the Plan allows Employees that cease to be Participants in the plan to spend down unused Dependent Care Assistance Account expenses, Employees that cease to Participate in the Plan (due to Termination or any other reason) may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs (or grace period if provided in the Plan) to the extent the claims do not exceed the balance of the Dependent Care Assistance Account.

Section 4.04 ADOPTION ASSISTANCE ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Adoption Assistance Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Adoption Assistance Account described in Subsection (b). The Account established under this Section 4.04 is intended to qualify as an adoption assistance program under Code Section 137 and shall be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.

(b) Adoption Assistance Account. Each Participant's Adoption Assistance Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for reimbursements described in Subsection (c). However, the Plan Administrator will not direct the Company to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Adoption Assistance Account.

(c) Eligible Expenses.

(1) In General. A Participant may be reimbursed from his or her Adoption Assistance Account to the extent that such reimbursement is (i) incurred in the Plan Year (except as provided in Section 4.05(c), (ii) incurred while the Participant participates in the Plan, and (iii) qualifies as adoption assistance; provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.

(2) Adoption Assistance. Adoption assistance is defined as reasonable and necessary adoption fees, court costs, attorney fees and other expenses which are (i) directly related to the legal adoption of an eligible child by the Participant and (ii) not incurred in violation of state or federal law or in carrying out any

surrogate parenting arrangement. An eligible child includes a child under age 18 or a child who is physically or mentally incapable of caring for himself/herself. However, an eligible child does not include a child of the Participant's spouse. In the case of an adoption of a child who is not a citizen or resident of the United States, any adoption expense with respect to such adoption is not reimbursable until such adoption becomes final.

(3) Limits. The maximum amount of expense that may be contributed/reimbursed for the Adoption Assistance Account for any Plan Year beginning in a calendar year is the maximum amount permitted by federal tax law for that calendar year. The annual limit shall be reduced for adoption assistance expenses incurred any prior Plan Year.

Section 4.05 FORFEITURES/TRANSFERS

(a) Forfeitures. Any balance remaining in a Participant's Account at the end of any Plan Year (or after the grace period if Subsection (c) applies) shall be forfeited and shall remain the property of the Company. Except as expressly provided herein, any balance remaining in a Participant's Account on his date of Termination shall be forfeited and shall remain the property of the Company. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the time period specified in Section 6.01(b).

(b) Transfers. Amounts may not be transferred between Accounts.

(c) Grace Period. If the Adoption Agreement provides for a 2-1/2 month grace period, effective for grace periods beginning on or after the date specified in the Adoption Agreement and notwithstanding anything to the contrary in the Plan, the unused contributions that remain in a Participant's Account at the end of a Plan Year may be used to reimburse expenses that are incurred during the grace period. The grace period shall commence on the first day of the subsequent Plan Year and shall end on the fifteenth day of the third calendar month of the subsequent Plan Year. Unless otherwise provided in the Adoption Agreement, the grace period shall apply to all Accounts in which the Participant is eligible to Participate. Payment or reimbursement of unused benefits shall be subject to the following terms and conditions:

(1) Same Account. Unused contributions remaining at the end of a Plan Year relating to a particular Account may only be used to reimburse expenses incurred with respect to that Account.

(2) No Cash Out. Unused contributions remaining at the end of a Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit.

(3) No Carryforward. Any unused contributions remaining at the end of a Plan Year that exceed the expenses for a particular Account that are incurred during the grace period may not be carried forward to any subsequent period (including any subsequent Plan Year) and shall be forfeited.

(4) Construction. This Section 4.05(c) is to be construed in accordance with IRS Notice 2005-42 and any superseding guidance.

Section 4.06 ELECTIONS

(a) New Participants. The Plan Administrator shall provide, where possible, an election form to a Participant before such Participant meets the eligibility requirements of Article 3. In order to participate in the Plan in the initial Plan Year, the Participant must return the completed election form to the Plan Administrator on or before such date as specified by the Plan Administrator. However, any election shall not be effective until a pay period following the later of such Participant's effective date of participation pursuant to Article 3 or the date of the receipt of the election form by the Plan Administrator and shall be limited to the expenses incurred after the effective date of the election.

(b) Continuing Participants. Prior to the commencement of each Plan Year, the Plan Administrator shall provide an election form to each Participant and to each other individual who is expected to become a Participant at the beginning of such Plan Year. In order to participate in the Plan in the applicable Plan Year, the Participant must return the completed election form to the Plan Administrator on or before such date specified in the

Adoption Agreement, which date shall be no later than the beginning of the first pay period for which the individual's Compensation reduction agreement will apply.

(c) Failure to Return Election Form. The failure of a Participant described in Subsection (a) to return a completed election form to the Plan Administrator on or before the specified due date shall constitute an election to receive his or her full Compensation in cash for the remainder of the Plan Year. The failure of a Participant described in Subsection (b) to return a completed election form to the Plan Administrator on or before the specified due date shall constitute an election not to participate for the applicable Plan Year unless a default election is otherwise specified in the Adoption Agreement or under Subsection (d).

(d) Premium Conversion Special Election Rules. If elected in the Adoption Agreement, a Participant shall be deemed to elect to contribute the entire amount of any premiums payable by the Participant for the benefits described in Section 4.01 unless he or she affirmatively elects otherwise before such date specified by the Plan Administrator. If elected in the Adoption Agreement, a Participant's election for benefits described in Section 4.01 shall be automatically adjusted for any change in the cost of premiums pursuant to the terms of Treas. Reg. 1.125-4.

(e) Form of Elections. All elections shall be made in written form unless the Plan Administrator provides procedures for such elections to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(f) Leave of Absence/FMLA/USERRA. If the Plan is subject to FMLA or the Plan Administrator determines that the Plan is subject to FMLA, the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law unless otherwise specified in the Adoption Agreement. To the extent provided in the Adoption Agreement, the Plan Administrator shall also permit a Participant taking unpaid Non-FMLA leave to continue the benefits specified in the Adoption Agreement. Participants continuing participation pursuant to the foregoing shall pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave. The Plan Administrator shall also permit Participants to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

(g) COBRA. If the Plan is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan is subject to COBRA, a Participant shall be entitled to continuation coverage as prescribed in Code Section 4980B (and the regulations thereunder) or such applicable state statutes.

(h) Procedures. A Participant shall make the elections described in this Section in such form and manner as may be prescribed by the Plan Administrator and at such time in advance as the Plan Administrator may require. Such procedures may include, without limitation, a minimum annual and per-pay period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

Section 4.07 REVOCATION OF ELECTIONS

(a) By Participant. Any election made under this Article 4 shall be irrevocable by the Participant during the Plan Year unless revocation is required by the provisions of the Federal Family and Medical Leave Act or other applicable law and is permitted under Treas. Reg. 1.125-4 and the provisions of the Adoption Agreement. If the Adoption Agreement provides that elections may be modified at any time permitted under Treas. Reg. section 1.125-4, elections may be modified upon the occurrence of any of the following events:

(1) HIPAA Special Enrollment Rights. Participant may revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f).

(2) Change in Status. A Participant may revoke an election during a period of coverage with respect to a qualified benefits plan (as defined in Treas. Reg. 1.125-4(i)(8)) and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) a change in status described in Subsections (A)-(F) occurs; and (ii) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a qualified benefits plan.

(A) Legal Marital Status. Events that change a Participant's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.

(B) Number of Dependents. Events that change a Participant's number of dependents, including the following: birth; death; adoption; and placement for adoption.

(C) Employment Status. Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite and, the extent permitted in Treas. Reg. 1.125-4 and Section 3.03, change in employment status resulting in gaining or losing eligibility under the Plan.

(D) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Events that cause a Participant's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(E) Residence. A change in the place of residence of the Participant, spouse, or dependent.

(F) Adoption Assistance. For purposes of adoption assistance provided through Section 4.04 of the Plan, the commencement or termination of an adoption proceeding.

(3) Judgment, Decree, or Order. A Participant may modify an election pursuant to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant; provided that the modification:

(A) changes the Participant's election to provide coverage for the child if the order requires coverage for the child under the Plan; or

(B) cancels coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child; and that coverage is, in fact, provided.

(4) Entitlement to Medicare or Medicaid. A Participant may modify an election for benefits attributable to a Company-sponsored accident or health plan if the Participant, spouse, or dependent becomes entitled to coverage under Medicare or Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines). The Participant may make a prospective election change to cancel or reduce coverage of that Participant, spouse, or dependent under the accident or health plan. Corresponding rights to commence or increase benefits under the accident or health plan shall be granted in the case of loss of coverage under Medicare or Medicaid.

(5) Significant Cost or Coverage Changes. A Participant may modify an election for benefits, other than those provided in Section 4.02, as a result of changes in cost or coverage pursuant to Treas. Reg. section 1.125-4.

(6) FMLA. A Participant taking leave under the FMLA may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

(b) By Plan Administrator. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Subsection shall be carried out in a uniform and non-discriminatory manner.

(c) Automatic Termination of Election. Any election made under this Section shall automatically terminate on the date specified in Sections 3.02 or 3.03.

(d) Plan Administrator Discretion. The Plan Administrator reserves the right to determine whether a Participant has experienced an event that would permit an election change under this Section 4.07 and whether the Participant's requested election change is consistent with such event.

Section 4.08 HEALTH SAVINGS ACCOUNTS SPECIAL RULES

(a) In General. Notwithstanding anything in the Plan to the contrary, this Section 4.08 shall apply to the extent that the Adoption Agreement allows the Plan to fund Health Savings Accounts within the meaning of Code section 223 ("HSA Contributions").

(b) HSA Account. The Plan Administrator shall establish an HSA Account to separately account for contributions/payments used to fund Health Savings Accounts. Each Participant's HSA Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for payments to the applicable Health Savings Account.

(c) No Forfeitures. Any balance remaining in a Participant's HSA Account at the end of any Plan Year shall be carried forward and used to fund such benefits in any subsequent Plan Year.

(d) Benefit Limited to Account Balance. The Plan Administrator shall not direct the Company to fund a Health Savings Account to the extent the payment exceeds the balance of a Participant's HSA Account.

(e) Period of Coverage. The mandatory twelve month period of coverage shall not apply to HSA Contributions.

(f) Modifications of Elections. A Participant who elects to make HSA Contributions may start or stop the election or increase or decrease the election at any time as long as the change is effective prospectively (i.e., after the request for the change is received). The Plan Administrator may place additional restrictions on the election of HSA Contributions; provided, however, that the same restrictions shall apply to all Participants.

(g) HSA Comparability Rules. Any contribution to an HSA from the Plan shall comply with Treas. Reg. section 54.4980G-5 and any superseding guidance.

Section 4.09 EMPLOYER CONTRIBUTIONS

The Company may contribute to the Plan to the extent provided in the Adoption Agreement. Such contributions shall be credited to the applicable Account at such time as determined by the Company.

ARTICLE 5
LIMITATIONS ON CONTRIBUTIONS

Section 5.01 NONDISCRIMINATION

If the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the following nondiscrimination requirements of Code sections 125(b), 79(d), 105(h) and 129(d)(2), (3), (4), and (8) shall be treated as met during such year.

(a) Cafeteria Plan. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 125(e)) as to benefits provided or eligibility to participate.

(b) Group Term Life. The Plan may not discriminate in favor of key employees (within the meaning of Code section 416(i)(1)) as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.

(c) Health Care Reimbursement Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 105(h)(5)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.02.

(d) Dependent Care Assistance Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.03.

(e) Adoption Assistance Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.04.

Section 5.02 LIMITATIONS ON CONTRIBUTIONS

(a) Cafeteria Plan. Key employees (within the meaning of Code section 416(i)(1)) may not receive more than 25% of the aggregate benefits provided for all employees under the Plan.

(b) Dependent Care Assistance Accounts. Shareholders or owners owning more than 5% of the capital or profits interest of the Employer may not receive more than 25% of the aggregate benefits provided for all employees under the Plan with respect to the Account described in Section 4.03. The average benefits provided under Section 4.03 to Participants who are not highly compensated employees must be at least 55 percent of the average benefits provided to highly compensated employees of the Company.

(c) Adoption Assistance Accounts. Shareholders or owners owning more than 5% of the capital or profits interest of the Employer may not receive more than 5% of the aggregate benefits provided for all employees under the Plan with respect to the Account described in Section 4.04.

ARTICLE 6
REIMBURSEMENTS

Section 6.01 PROCEDURES FOR REIMBURSEMENT

(a) Benefits Provided by Contracts. All claims for benefits that are provided under Contracts shall be made by the Participant to the company issuing such contract.

(b) Timing of Claims. Reimbursements and/or payments shall only be made for expenses incurred in the applicable Plan Year while the Participant participates in the Plan. Except as otherwise expressly provided herein, no reimbursement and/or payment shall be made for any expenses relating to services rendered before participation or after Termination of Employment for any reason. All claims for reimbursement and/or payment must be made within the time periods specified in the Adoption Agreement.

(c) Documentation. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(d) Payment. To the extent that the Plan Administrator approves the claim, the Company shall: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Accounts established hereunder. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

(e) Coordination with HRA. A Participant who is also eligible to participate in a Code section 105 health reimbursement arrangement ("HRA") sponsored by the Company shall not be entitled to payment/reimbursement under the Health Care Reimbursement Account for expenses that are reimbursable under both the Health Care Reimbursement Account and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the Health Care Reimbursement Account if before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the Health Care Reimbursement Account have been paid.

(f) Death. If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

(g) Form of Claim/Notice. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(h) Refunds/Indemnification. If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Company for any liability the Company may incur for making such

payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (ii) offset other benefits payable hereunder.

(i) Debit, Credit or Other Stored Value Cards. To the extent provided in the Adoption Agreement, the Company may enter into an agreement with a financial institution to provide a Participant with a debit, credit or other stored value card to provide immediate payment of reimbursements available under Section 4.02 and/or Section 4.03 provided that the use of such card complies with IRS Revenue Ruling 2003-43 (to the extent not superseded by IRS Notice 2006-69), IRS Notice 2006-69, IRS Notice 2007-2, IRS Notice 2008-104, IRS Notice 2010-59, IRS Notice 2011-5 and any superseding guidance. A Participant may obtain benefits under Sections 4.02 and 4.03 without the use of the card.

(j) HSA Coordination. Except as otherwise provided in the Adoption Agreement, benefits under this Plan shall not be coordinated with coverage in a high deductible health plan to facilitate participation in Health Savings Accounts.

(k) Plan Administrator Procedures. The Plan Administrator may establish procedures regarding the documentation to be submitted in a claim for reimbursement and/or payment and may also establish any other procedures regarding claims for reimbursement and/or payment provided that the procedures do not violate ERISA section 503 if the Adoption Agreement indicates the plan is subject to ERISA. Such procedures may include, without limitation, requirements to submit claims periodically throughout the Plan Year.

Section 6.02 CLAIMS PROCEDURE FOR HEALTH CARE REIMBURSEMENT ACCOUNT

(a) A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) This Section 6.02(b) shall apply for any claim for benefits under the Health Care Reimbursement Account.

(1) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(2) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, and (E): (I) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule,

guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (II) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

(4) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) Exhaustion of Remedies. Before a suit can be filed in federal court, claims must exhaust internal remedies.

(c) Additional Internal and External Claims Procedure for Health Care Reimbursement Account.

(1) Applicability. This Section shall apply for any claim for benefits under the Health Care Reimbursement Account if (A) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (B) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(2) Effective Date. This Section shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(3) Internal Claims Process. The requirements under Section 6.02(b) shall apply as the internal appeals process except as modified below. This section is intended to satisfy the requirements of DOL Reg. 2590.715-2719 and any superseding guidance.

(A) Adverse Benefit Determination. An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(B) Full and Fair Review. A Claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(C) Notice. A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(4) Deemed Exhaustion of Internal Claims Process. If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the claimant may initiate an external review under Section 6.02(c)(5) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

(5) External Claims Process.

(A) State External Claims Process. If the Adoption Agreement specifies that the Plan is not subject to ERISA and the State external claims process includes at a minimum the consumer protections in the NAIC Uniform Model Act then the plan must comply with the applicable State claims review process.

(B) Federal External Claims Process. The plan must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance if Subsection (c)(5)(A) above is not applicable.

(d) Notwithstanding anything to the contrary, if the Adoption Agreement specifies that (1) the Plan is not subject to ERISA and (2) the Plan does not constitute a group health plan as defined in Treas. Reg. section 54.9801-2 or the Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

Section 6.03 CLAIMS PROCEDURES FOR NON-HEALTH BENEFITS

(a) This Section 6.03 shall apply for any claim for benefits under Accounts other than the Health Care Reimbursement Account.

(b) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the

Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(c) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

(d) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(f) Notwithstanding anything to the contrary, if the Adoption Agreement specifies that the Plan is not subject to ERISA, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

Section 6.04 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 6.05 MISSING 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 Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

ARTICLE 7
PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA (if the Adoption Agreement provides that the Plan is subject to ERISA), and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of Employees and of the status of rights of Participants;

(ix) to adjust Accounts in order to correct errors or omissions;

(x) to determine the validity of any judicial order;

(xi) to retain records on elections and waivers by Participants;

(xii) to supply such information to any person as may be required;

(xiii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Company.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Company shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA to the extent that the Adoption Agreement provides the Plan is subject to ERISA.

Section 7.03 HIPAA PRIVACY RULES

(a) Application. This Section 7.03 shall only apply in the event that this Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy rules.

(b) Privacy Policy. The Plan shall adopt a HIPAA privacy policy, the terms of which are incorporated herein by reference.

(c) Business Associate Agreement. The Plan will enter into a business associate agreement with any persons as may be required by applicable law as determined by the Plan Administrator.

(d) Notice of Privacy Practices. The Plan will provide each Participant with a notice of privacy practices to the extent required by applicable law.

(e) Disclosure to the Company.

(1) In General. This Subsection permits the Plan to disclose protected health information ("PHI"), as defined in the HIPAA privacy rules, to the Company to the extent that such PHI is necessary for the Company to carry out its administrative functions related to the Plan.

(2) Permitted Disclosure. The Plan may disclose the PHI to the Company that is necessary for the Company to carry out the following administrative functions related to the Plan: eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The Company may use and disclose the PHI provided to it from the Plan only for the administrative purposes described in this Subsection.

(3) Limitations. The Company agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:

(A) Use and Further Disclosure. The Company shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Plan, the Company shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

(B) Agents and Subcontractors. The Company shall require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the Company with respect to such information.

(C) Employment-Related Actions. Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the Company shall not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Company.

(D) Reporting of Improper Use or Disclosure. The Company shall promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.

(E) Adequate Protection. The Company shall provide adequate protection of PHI and separation between the Plan and the Company by: (i) ensuring that only those employees who work in the human resources department of the Company on issues related to the healthcare components of the Plan will have access to the PHI provided by the Plan; (ii) restricting access to and use of PHI to only the employees identified in clause (i) above and only for the administrative functions performed by the Company on behalf of the Plan that are described herein; (iii) requiring any agents of the Plan who receive PHI to abide by the Plan's privacy rules; and (iv) using the Company's established disciplinary procedures to resolve issues of noncompliance by the employees identified in clause (i) above.

(F) Return or Destruction of PHI. If feasible, the Company shall return or destroy all PHI received from the Plan that the Company maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(G) Participant Rights. The Company shall provide Participants with the following rights: (i) the right to access to their PHI in accordance with 45 C.F.R. §164.524; (ii) the right to amend their PHI upon request (or the Company will explain to the Participant in writing why the requested amendment was denied) and incorporate any such amendment into a Participant's PHI in accordance with 45 C.F.R. §164.526; and (iii) the right to an accounting of all disclosures of their PHI in accordance with 45 C.F.R. §164.528.

(H) Cooperation with HHS. The Company shall make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Plan's compliance with the HIPAA privacy rules.

(4) Certification. By executing the accompanying Adoption Agreement, the Company hereby certifies that the Plan documents have been amended in accordance with 45 C.F.R. §164.504(f), and that the Company shall protect the PHI as described in Subsection 3 herein.

(5) Security Standards Requirement. To comply with the Security Standards regulations that were published on February 21, 2003, the Company must:

(A) 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;

(B) ensure that the adequate separation required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(C) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(D) report to the Plan any security incident of which it becomes aware.

(6) Amendment. Notwithstanding any other provision of the Plan, this Section may be amended in any way and at any time by the Privacy Officer.

(7) Effective Dates. Subsections (1) – (4) and Subsection (6) apply to the Plan no later than April 14, 2003, or such other date that the HIPAA Privacy Regulations apply to the Plan. Section (5) applies to the Plan no later than April 20, 2005, or such other date that the HIPAA Security Regulations apply to the Plan.

Section 7.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

If the plan is not subject to ERISA any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 7.05 HIPAA PORTABILITY RULES

In the event the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the requirements of Code section 9801 et. Seq. including the requirement to cover children until the attainment of age 26 if the Plan makes dependent coverage of children available. The Plan Administrator shall only provide a certificate of creditable coverage if the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2.

ARTICLE 8
AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 8.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the Company reserves the right to terminate its participation in this Plan. Each such entity constituting the Company shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company.

ARTICLE 9
MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 9.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Company and the Participant, or as a right of any Employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its Employees, with or without cause.

Section 9.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Company to provide benefits hereunder shall remain part of the general assets of the Company and all payments of benefits under the Plan shall be made solely out of the general assets of the Company.

(b) The Company shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Company may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any Account other than as expressly authorized in the Plan.

Section 9.04 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 9.06 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 9.07 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 9.08 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

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Exhibit C
to
Executive Summary

(*Existing)* Lansing Board of Water and Light Cafeteria Plan
(As Restated March 27, 2007)

[SEE ATTACHED]

LANSING BOARD OF WATER AND LIGHT

CAFETERIA PLAN

AMENDED AND RESTATED

Effective: May 23, 2006

LANSING BOARD OF WATER AND LIGHT

CAFETERIA PLAN

TABLE OF CONTENTS

ARTICLE I - INTRODUCTION

1.1 Purpose of Plan. The purpose of this Plan is to make benefits available to eligible employees of the Lansing Board of Water and Light (BWL) under the Premium Only, Dependent Care Reimbursement and Medical Reimbursement Plans maintained by BWL.

1.2 Cafeteria Plan Status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. This Plan is a governmental plan and is not subject to the Employee Retirement Income Security Act of 1974.

ARTICLE II - DEFINITIONS

2.1 "BWL" means Lansing Board of Water and Light, a municipal corporation organized under the laws of the State of Michigan.

2.2 "Cash Compensation" means payment for work performed, but does not include other benefits.

2.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.4 "Collective Bargaining Agreement" means the current Collective Bargaining Agreement between BWL and a collective bargaining representative for a specified class of eligible employees, which provides for any provisions of the Plan to be maintained for the benefit of the class of eligible employees covered by that agreement. Collective Bargaining Agreement also means any renewal, modification, amendment or successor agreement to the current agreement.

2.5 "Collective Bargaining Unit" means a specified class or classes of employees whose compensation and fringe benefits are described in a Collective Bargaining Agreement between BWL and collective bargaining representative for the specified class or classes of employees.

2.6 "Dependent Care Reimbursement Plan" means the BWL Dependent Care Reimbursement Plan, amended and restated effective May 23, 2006, and as amended from time to time thereafter.

2.7 "Elective Employer Contributions" means contributions made under the Plan pursuant to salary reduction agreements between BWL and Eligible Employees.

2.8 "Eligible Employee" means an Employee of BWL who meets the eligibility requirements specified in the Plan.

2.9 "Employee" means any person who is receiving remuneration from BWL for services rendered to BWL as a full-time regular employee as defined by BWL policy and stated in Appendix A which is attached and made a part of this Plan, or, for members of the Collective Bargaining Unit, as defined in the Collective Bargaining Agreement if different, but Employee for the purposes of this Plan does not include retirees or beneficiaries. Appendix A shall be updated automatically as the definition of full-time regular employee is revised from time to time by BWL.

2.10 "Employer" means the Lansing Board of Water and Light.

2.11 "Highly Compensated Employee" means any person who is a highly compensated employee as defined in Section 125(e) of the Code.

2.12 "Key Employee" means any person who is a key employee as defined in Section 416 of the Code.

2.13 "Medical Reimbursement Plan" means the BWL Medical Reimbursement Plan, amended and restated effective May 23, 2006, and as amended from time to time thereafter.

2.14 "Participant" means any Eligible Employee who participates in the Plan in accordance with Article III.
2.15 "Plan" means the BWL Cafeteria Plan as set forth herein, together with any and all amendments and supplements hereto.
2.16 "Plan Year" means the twelve-consecutive month period ending each August 31st.

ARTICLE III - ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. Each person who meets the definition of Employee as stated herein shall be an Eligible Employee. Each such Eligible Employee shall be eligible to participate in the Plan on the first day of the month following the date of hire or the first working day of the month, provided that person has completed and turned in the benefit election and salary reduction agreement form(s) by the time required by BWL.

3.2 Election. An Eligible Employee shall become a Participant by executing the benefit election and salary reduction agreement form(s) required for the benefit(s) elected. An Eligible Employee shall agree to reduce his or her salary for the Plan Year by the amount elected in the reimbursement plan(s), or as required by the Premium Only Plan in order to be provided the insurance and/or prescription drug option(s) in which the Employee has enrolled. Any Employee that is not an Eligible Employee during the period of 60 days prior to the commencement of each Plan Year, but becomes an Eligible Employee at a later date, must execute the benefit election and salary reduction agreement form(s) required for the benefit(s) elected, in order to participate. The required form(s) must be completed and returned to BWL on or before such date as BWL shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's election(s) will apply.

3.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of (a) the date on which the Plan terminates or (b) the date on which the Participant ceases to be an Eligible Employee eligible to participate under Section 3.1 or (c) the Participant elects to terminate his/her participation under the circumstances permitted by this Plan or (d) the Participant's election expires.

3.4 Reinstatement of Former Participant. A former Participant will become an Eligible Employee again if and when he/she meets the eligibility requirements of Section 3.1, and at that time may make an election again as provided in this Plan.

ARTICLE IV - OPTIONAL BENEFITS

4.1 Benefit Options.

(a) Benefits Offered. Except to the extent that benefits are specified in the Collective Bargaining Agreement for Eligible Employees who are members of the Collective Bargaining Unit, BWL in its discretion will decide for each Plan Year which benefits will be offered through this Plan and the minimum and maximum amounts which may be contributed through salary reduction. Approximately 60 days prior to the commencement of each Plan Year, Eligible Employees will be informed about the benefits which may be elected for the upcoming Plan Year.

(b) Benefit Elections. Approximately 60 days prior to the commencement of each Plan Year, each Eligible Employee will have the opportunity to make elections under this Plan as described in Section 4.3. Any elected taxable cash benefit will be paid pro rata over the year with each pay period. All of the choices are subject to limits and requirements stated throughout the plan documents.

(c) Salary Reduction. Approximately 60 days prior to the commencement of each Plan Year, an Eligible Employee may elect under this Plan, as described in Section 4.3, to receive his/her full compensation for the succeeding Plan Year in cash or to agree to salary reduction for benefits under the Medical Reimbursement Plan, the Dependent Care Reimbursement Plan, and/or the Premium Only Plan.

4.2 Benefits Other than Cash. While the election to receive one or more of the benefits described in Section 4.1 may be made under this Plan, the benefits other than cash will be provided through the Dependent Care Reimbursement Plan, the Medical Reimbursement Plan, and/or the Premium Only Plan. The types and amounts of benefits available, the requirements for participating in the plans, and the other terms and conditions of coverage and benefits under the plans are as set forth from time to time in the Dependent Care Reimbursement Plan, Medical Reimbursement Plan, and Premium Only Plan. The benefit descriptions in such plans and contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

4.3 Election Procedure. Approximately 60 days prior to the commencement of each Plan Year, BWL shall make available the benefit election and salary reduction agreement form(s) to each Employee who is not a Participant and who is eligible to become a Participant at the beginning of the next Plan Year. The election(s) made shall be effective as of the first day of the next Plan Year. In order to participate, each Eligible Employee shall specify his elections, shall agree to participate, and shall agree to a reduction in his/her compensation. The amount of the reduction in the Participant's compensation for the Plan Year for each optional benefit described in Section 4.1(c), other than the taxable cash benefit, shall be the amount elected by the Participant, subject to the limits and requirements of the Dependent Care Reimbursement Plan, the Medical Reimbursement Plan and the Premium Only Plan. Each benefit election and salary reduction agreement form must be completed and returned to BWL on or before such date as BWL shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's elections will apply. Participants who wish to change their elections may do so during the 60 days prior to the commencement of the next Plan Year.

4.4 New Employees. BWL shall provide the benefit election and salary reduction agreement form(s) described in Section 4.3 to a new Employee. In order to participate, the Employee shall specify his election(s), shall agree to participate, and may agree to a reduction in his/her compensation as provided in Section 4.3. The required form(s) must be completed and returned to BWL on or before such date as BWL shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's election(s) will apply.

4.5 Failure to Elect. A Participant failing to return completed form(s) to BWL on or before the specified due date for any succeeding Plan Year of the Plan, shall be deemed to have elected for the new Plan Year the same Premium Only Plan option(s) as he had in the previous Plan Year and any salary reduction required for that option(s) for the new Plan Year, and to have elected that any other Cafeteria Plan benefit will be taxable cash for the new Plan Year. Salary reduction elections will not be renewed automatically for either of the two reimbursement plans.

4.6 Irrevocability of Election by the Participant during the Plan Year. Elections made under the Plan (or deemed to be made under Section 4.5) may not be amended or revoked by the Participant during the Plan Year, except for certain changes in status. A Participant may revoke or amend a benefit election for the balance of a Plan Year and file a new or amended benefit election and salary reduction agreement form(s) only if both the amendment or revocation and the new or amended election are on account of and consistent with the change in status; or as required by law if the

Participant chooses to revoke or file an election for such purpose, for example, for change that corresponds with the special enrollment rights for health insurance under IRC Sec. 9801(f). A change in status for this purpose includes marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse, and such other events that BWL determines will permit a change or revocation of an election during a Plan Year under the Code and regulations and rulings of the Internal Revenue Service. Any new election under this Section 4.6 shall be effective at such time as BWL shall prescribe, but not earlier than the first pay period beginning after the form(s) is completed and returned to BWL.

4.7 Termination. If the Participant leaves BWL's employment, any contributions, cash benefit and/or salary reduction the Participant elected will stop, and he will have the opportunity to elect to end participation in this Plan. If the Participant elects to end participation in this Plan, he will not have to make after-tax contributions to finish out the Plan Year, and will still be able to submit claims for reimbursement of expenses incurred before termination, against the amounts that had been credited to the Participant's reimbursement balance(s) but not used at time of termination. The terms of the Dependent Care Reimbursement Plan and the Medical Reimbursement Plan govern with regard to the required timing of submission of claims after the end of participation. If, the Participant elects to continue to participate in the Cafeteria Plan after he leaves BWL's employment, the Participant will have to continue to make contributions on an after-tax basis for the rest of the Plan Year, at the same time as when he was employed. Then the Participant's participation in the Plan ends except as otherwise provided in the Medical Reimbursement Plan and/or Premium Only Plan. Should the Participant be eligible for continuation health care coverage (COBRA) under Federal law, he cannot make his COBRA contributions on a pre-tax basis under this Plan. BWL will provide the Participant with information regarding continuation health care coverage at the time of termination.

ARTICLE V - ADMINISTRATION OF PLAN

5.1 Administration. It shall be a principal duty of BWL to see that the Plan is carried out, in accordance with its terms, without discrimination among those eligible to participate in the Plan. BWL will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the powers of BWL will include, but will not be limited to, the following final authority and discretion, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of claims procedures;

(b) To interpret the Plan, its interpretation thereof in good faith to be final, conclusive and binding on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants, and such other persons or entities as may be required to assist in administering and supervising the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

Notwithstanding the foregoing, any claim which arises under the Dependent Care Reimbursement Plan, Medical Reimbursement Plan or Premium Only Plan shall not be subject to review under this

Plan, and the authority of BWL under this Section 5.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such other plan.

5.2 Examination of Records. BWL will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

5.3 Reliance on Tables, etc. In administering the Plan, BWL will be entitled to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the Dependent Care Reimbursement, Medical Reimbursement and Premium Only Plans, or by any accountant, counsel, or other expert who is employed or engaged by BWL.

5.4 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by BWL is required, BWL shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

5.5 Final Authority. BWL has final authority and discretion to determine eligibility and benefits and interpret the Plan. Decisions by BWL are final, conclusive and binding.

5.6 Meeting Nondiscrimination Rules. If BWL determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated or Key Employees, BWL shall take such action as BWL deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated or Key Employees with or without the consent of such Employees. To the extent that the Plan and/or certain Participants meet the requirements of any Code section that excludes such plan or participants from nondiscrimination requirements, such nondiscrimination requirements of that Code section shall not be applied by BWL.

ARTICLE VI - AMENDMENT AND TERMINATION OF PLAN

6.1 Amendment of Plan. BWL reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable, by duly authorized action of BWL, but to the extent an amendment affects Eligible Employees who are members of the Collective Bargaining Unit, it shall not be inconsistent with any relevant terms and conditions of the Collective Bargaining Agreement.

6.2 Termination of Plan. BWL has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but BWL will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan in whole or in part at any time without liability, by duly authorized action of BWL, subject to any limitations of the Collective Bargaining Agreement for Eligible Employees who are members of the Collective Bargaining Unit. Upon termination or discontinuance of the Plan, all contributions, elections and reductions in compensation related to the Plan shall terminate.

ARTICLE VII - MISCELLANEOUS

7.1 Information to be Furnished. Participants shall provide BWL with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2 Plan is not a Contract. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

7.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against BWL, except as expressly provided herein.

7.4 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of BWL. Nothing herein will be construed to require BWL to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of BWL from which any payment under the Plan may be made.

7.5 Nonassignability of Rights. The right of any Participant to receive any benefit under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

7.6 No Guarantee of Tax Consequences. BWL makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state and/or local income tax purposes or federal FICA tax purposes, or that any other federal, state or local tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and/or local income tax or other tax purposes, and to notify BWL if the Participant has reason to believe that any such payment is not so excludable.

7.7 Indemnification of BWL by Participants. If any Participant receives one or more benefits that are not for Qualifying Expenses, as defined in each benefit plan, such Participant shall indemnify and reimburse BWL for any liability it may incur for failure to withhold federal, state and/or local income tax or FICA tax from such payment of benefits.

7.8 Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of Michigan, to the extent not pre-empted by Federal law.

7.9 Gender. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Effective: August 1, 1987
Restated and Amended: May 23, 2006.

Appendix A

Definition of Full-Time Regular Employee

BWL policy as stated in the Employee Policies and Benefits Reference Handbook as of May 23, 2006, provides that a Full-Time Regular Employee is the following:

> A Full-Time Regular Employee is one who is hired on a full-time regular status and is receiving remuneration from the Employer for services rendered to the Employer or who would be remunerated except for an authorized leave of absence as a full-time employee under the Personnel Policy.
>
> Full-time means an active employee is regularly scheduled to work at least thirty (20) hours per week for the Employer. Full-time for work reduction and job sharing means an active employee is regularly scheduled to work at least twenty (20) hours per week.

This definition of Full-Time Regular Employee shall be updated automatically as the definition is revised from time to time by BWL and stated in the document named above.

Dox\word\fsa\FINAL CAFETERIA PLAN

LANSING BOARD OF WATER AND LIGHT

PREMIUM ONLY PLAN

AMENDED AND RESTATED

Effective: May 23, 2006

LANSING BOARD OF WATER AND LIGHT

PREMIUM ONLY PLAN

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PREMIUM ONLY PLAN

ARTICLE I - INTRODUCTION

Lansing Board of Water and Light ("BWL") has established this Premium Only Plan as a component plan of the BWL Cafeteria Plan. Except as is otherwise stated herein, this Plan is governed by the terms and conditions of the Cafeteria Plan. This Plan is intended to meet the requirements of the Internal Revenue Code of 1986 as amended and Regulations thereunder. This Plan is a governmental plan and is not subject to the Employee Retirement Income Security Act of 1974.

ARTICLE II - DEFINITIONS

Wherever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

2.1 "BWL" means Lansing Board of Water and Light, a municipal corporation organized under the laws of the State of Michigan.

2.2 "Cafeteria Plan" means the BWL Cafeteria Plan amended and restated effective MAY 23, 2006, as amended from time to time thereafter.

2.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.4 "Collective Bargaining Agreement" means the current Collective Bargaining Agreement between BWL and a collective bargaining representative for a specified class of eligible employees, which provides for any provisions of the Plan to be maintained for the benefit of the class of eligible employees covered by that agreement. Collective Bargaining Agreement also means any renewal, modification, amendment or successor agreement to the current agreement.

2.5 "Collective Bargaining Unit" means a specified class or classes of employees whose compensation and fringe benefits are described in a Collective Bargaining Agreement between BWL and collective bargaining representative for the specified class or classes of employees.

2.6 "Eligible Employee" means any person who meets the definition of Employee and the eligibility requirements of the Cafeteria Plan and the Insurance Plan and/or Supplemental Insurance Plan option(s) elected.

2.7 "Employer" means the Lansing Board of Water and Light.

2.8 "Insurance Plan" means insurance coverage plan(s), including but not limited to such coverage plans as health insurance and life insurance, and a prescription drug coverage plan, maintained by BWL and amended from time to time, and made available by BWL for election under this Plan by Eligible Employees.

2.9 "Insurance Premium Expenses" means amounts which are due as premiums to the Insurance Plan and/or Supplemental Insurance Plan.

2.10 "Participant" means any Eligible Employee who participates in the Plan in accordance with Article III.

2.11 "Plan" means the BWL Premium Only Plan as set forth herein, together with any and all amendments and supplements hereto.

2.12 "Plan Year" means the 12-consecutive-month period ending each August 31st.

2.13 "Supplemental Insurance Plan" means the eligible insurance provided through contract with an insurance company or companies for supplemental health insurance such as indemnity, voluntary indemnity, hospital, intensive care, personal accident indemnity, and related benefits.

ARTICLE III - ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. Each Employee who is eligible under the BWL Cafeteria Plan will be an Eligible Employee for participation in this Plan, provided he or she has enrolled in a timely manner for Insurance Plan and/or Supplemental Insurance Plan coverage.

3.2 Date of Participation. An Eligible Employee will become a Participant upon the effective date of his election and agreement with regard to this Plan.

3.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of (a) the date on which this Plan or the Cafeteria Plan terminates, or (b) the date on which his or her election to participate in this Plan expires or is terminated, or (c) the date of cessation of his participation in the Cafeteria Plan.

3.4 Reinstatement of Former Participant. If a former Participant again becomes eligible under Section 3.1, at that time, he may make an election again as provided in this Plan.

ARTICLE IV - ELECTIONS

4.1 Election Procedure. An Eligible Employee may elect to participate in this Plan by filing a benefit election and salary reduction agreement form in accordance with the procedures established under the Cafeteria Plan. An election to participate in this Plan shall be irrevocable during the Plan Year, except as provided in the Cafeteria Plan.

4.2 Elected Amount. The amount which the Participant must elect under this Plan is the amount needed to pay the Insurance Premium Expenses for the Insurance Plan and/or Supplemental Insurance Plan option(s) elected by the Participant.

4.3 Family and Medical Leave Act ("FMLA"). Notwithstanding any other provision of this Plan, the Plan may (a) permit a Participant to revoke (and subsequently reinstate) his election under this Plan and (b) adjust the Participant's salary reduction amount as a result of such revocation and/or reinstatement, to the extent BWL deems necessary or appropriate to assure the Plan's compliance with the provisions of FMLA. To the extent Employees on non-FMLA leave without pay are permitted to do so, the Plan will allow a Participant taking FMLA leave to agree to pay in advance for amounts the Participant would be required to pay while on leave, or continue to make contributions on the same schedule as while not on leave, or make all required catch-up contributions upon return to work after FMLA leave.

ARTICLE V - PREMIUM ONLY PLAN BALANCES

5.1 Establishment of Plan Balances. BWL will establish and maintain a Premium Only Plan Balance for each Plan Year with respect to each Participant who has elected to participate in this Plan. In no event is this an account into which funds are deposited, maintained and/or reimbursed from.

5.2 Crediting of Plan Balance. There shall be credited to a Participant's Premium Only Plan Balance for each Plan Year, as of each date that compensation is paid to the Participant in such Plan Year, a pro rata amount equal to the Insurance Premium contribution to be made in accordance with the Participant's election and agreement under the Cafeteria Plan. All amounts credited to each such Premium Only Plan Balance shall be the property of BWL until paid out pursuant to Article VI. If premiums under Insurance Plan and/or Supplemental Insurance Plan

increase or decrease during the Plan Year for options in which the Participant had enrolled, the Participant's salary reduction will be adjusted to cover the increases or decreases.

5.3 Debiting of Plan Balance. A Participant's Premium Only Plan balance for each Plan Year shall be debited from time to time in the amount of any payment under Article VI.

5.4 Forfeiture of Plan Balance. The amount credited to a Participant's Premium Only Plan Balance for any Plan Year shall be used only to calculate payments as provided in Article VI. If any amount remains in the Participant's Premium Only Plan Balance for a Plan Year after all payments hereunder, the balance shall not be carried over to the next Plan Year and the Participant shall forfeit all rights with respect to such balance. The remaining elected amount shall not be used to pay premiums to the Insurance Plan and/or Supplemental Insurance Plan due during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of BWL.

ARTICLE VI - PAYMENT OF INSURANCE PREMIUM EXPENSES

6.1 Payment. On behalf of the Participant, each month in a timely manner BWL shall make payment of the Insurance Premium Expenses due for the Insurance Plan and/or Supplemental Insurance Plan option(s) elected by the Participant. Such payment shall be debited to the Participant's Premium Only Plan balance.

6.2 Limitation. Insurance Premium Expenses may only be paid for amounts which are due as premiums for coverage under the Insurance Plan and/or Supplemental Insurance Plan. Under no circumstances shall the amount elected by the Participant be available for reimbursement or payment of any other expense including premiums due for coverage under a plan maintained by any source other than BWL.

ARTICLE VII - TERMINATION OF PARTICIPATION. If a Participant leaves BWL's employment, any Employer contribution and any salary reduction the Participant elected will end for this Plan. Participation in the Premium Only Plan will cease unless the Participant elects to continue to make any required contribution on an after-tax basis for the balance of the Plan Year, at the same time as when the Participant was employed. Any rights to continue coverage in the Insurance Plan and/or Supplemental Insurance Plan, or rights to conversion to individual coverage, shall be governed by the terms of the coverage option(s) in which the Participant had enrolled. Should the Participant be eligible for continuation health care coverage (COBRA) under Federal law, he could not make his COBRA premium contributions on a pre-tax basis. BWL will provide a COBRA-eligible Participant with information regarding continuation health care coverage at the time of termination.

ARTICLE VIII - ADMINISTRATION OF PLAN

8.1 Administration. It shall be a principal duty of BWL to see that the Plan is carried out, in accordance with its terms, without discrimination among those eligible to participate in the Plan. BWL will have full power to administer the Plan in all of its details subject to applicable requirements of law. For this purpose, the powers of BWL will include, but will not be limited to, the following final authority and discretion, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, its interpretation thereof in good faith to be final, conclusive and binding on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be by written instrument.

Notwithstanding the foregoing, any claim for benefits provided through the options in which the Participant has enrolled under the Insurance Plan and/or Supplemental Insurance Plan shall not be subject to review under this Plan, and the authority of BWL under this Section 8.1 shall not extend to any matter as to which the insurer(s) and/or administrator(s) under the Insurance Plan and/or Supplemental Insurance Plan options is empowered to make determinations.

8.2 Examination of Records. BWL will make available to each Participant such of its records as pertain to the Participant, for examination at reasonable times during normal business hours.

8.3 Reliance on Tables, etc. In administering the Plan, BWL will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel or other expert who is employed or engaged by BWL.

8.4 Claims Procedures.

(a) This Plan. Any claim for benefits under this Plan shall be filed in accordance with the provisions of this Plan and such other claim procedures as may be established for this Plan from time to time. Notice of decision on a claim, and if a claim is denied, notice of any appeal procedure established for the Plan, shall be provided to the Participant in writing.

(b) Insurance Plan. Any claim for benefits under the Insurance Plan or Supplemental Insurance Plan must be filed in accordance with the requirements of the insurer or the prescription drug plan from which the benefit is claimed.

8.5 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by BWL is required, BWL shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.6 Final Authority. BWL has final authority and discretion to determine eligibility and benefits and interpret the Plan. Decisions by BWL are final, conclusive and binding.

8.7 Meeting Nondiscrimination Rules. If BWL determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated or Key Employees as defined in the Cafeteria Plan, BWL shall take such action as BWL deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated or Key Employees with or without the consent of such Employees. To the extent that the Plan and/or certain Participants meet the requirements of any Code section that excludes such plan or participants from nondiscrimination requirements, such nondiscrimination requirements of that Code section shall not be applied by BWL.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

9.1 Amendment of Plan. BWL reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable, by duly authorized action of BWL, but to the extent an amendment affects Eligible Employees who are

members of the Collective Bargaining Unit, it shall not be inconsistent with any relevant terms and conditions of the Collective Bargaining Agreement.

9.2 Termination of Plan. BWL has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but BWL will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan in whole or in part at any time without liability, by duly authorized action of BWL, subject to any limitations of the Collective Bargaining Agreement for Eligible Employees who are members of the Collective Bargaining Unit. Upon termination or discontinuance of the Plan, all contributions, elections and reductions in compensation related to the Plan shall terminate.

ARTICLE X - MISCELLANEOUS

10.1 Information to be Furnished. Participants shall provide BWL with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

10.2 Plan is Not a Contract. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer, or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

10.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against BWL, except as expressly provided herein.

10.4 General Assets. The premiums paid hereunder will be paid solely from the general assets of BWL. Nothing herein will be construed to require BWL to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of BWL from which any payment under the Plan may be made.

10.5 Nonassignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.6 No Guarantee of Tax Consequences. BWL makes no commitment or guarantee that any amounts paid on behalf of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax or Federal Social Security Tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for such tax purposes, and to notify BWL if the Participant has reason to believe that any such payment is not so excludable.

10.7 Indemnification of BWL by Participants. If any Participant receives the benefit of one or more payments under this Plan that are not for Insurance Premium Expenses, such Participant shall indemnify and reimburse BWL for any liability BWL may incur for failure to withhold federal, or state and/or local income tax or FICA tax from such reimbursements.

10.9 Governing Law. The Plan will be construed, administered and enforced according to the laws of Michigan, to the extent not pre-empted by Federal law.

10.10 Gender. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Effective: January 1, 1991
Amended: January 1, 1995
Revised: March 1, 1999
Amended and Restated: May 23, 2006

Dox\word\FSA\FINAL PREMIUM ONLY PLAN

LANSING BOARD OF WATER AND LIGHT

MEDICAL REIMBURSEMENT PLAN

AMENDED AND RESTATED

Effective: May 23, 2006

LANSING BOARD OF WATER AND LIGHT

MEDICAL REIMBURSEMENT PLAN

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MEDICAL REIMBURSEMENT PLAN

ARTICLE I - INTRODUCTION

1.1 Purpose of Plan. The purpose of this Plan is to enable Participants to elect to receive reimbursement of Qualifying Medical Care Expenses that are excludable from the Participant's gross income under Section 105 of the Internal Revenue Code of 1986, as amended.

1.2 Medical Reimbursement Plan Status. This Plan is intended to qualify as a medical reimbursement plan under Section 105, and it is to be interpreted in a manner consistent with the requirements of Section 105 of the Code. This Plan is a governmental plan and is not subject to the Employee Retirement Income Security Act of 1974.

ARTICLE II - DEFINITIONS

Wherever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

2.1 "BWL" means Lansing Board of Water and Light, a municipal corporation organized under the laws of the State of Michigan.

2.2 "Cafeteria Plan" means the BWL Cafeteria Plan amended and restated effective May 23, 2006, as amended from time to time thereafter.

2.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.4 "Dependent" means any person who is a dependent of the Participant within the meaning of the Code without regard to Section 152(b)(1), (b)(2) and (d)(1)(B).

2.5 "Eligible Employee" means any person who meets the definition of Employee and the eligibility requirements of the Cafeteria Plan and this Plan.

2.6 "Employer" means the Lansing Board of Water and Light.

2.7 “Grace Period” means the period of two and a half months immediately following the end of a Plan Year and ending on November 15 of each year, during which period a Participant, under the terms of this Plan, may use for Qualifying Medical Care Expenses any balance remaining in his/her Medical Reimbursement Plan Balance at the end of the immediately preceding Plan Year.

2.8 "Highly Compensated Employee" means any person who is highly compensated employee as defined in Section 105(h) of the Code.

2.9 "Medical Care Expense" or "Medical Expense" means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Section 213 of the Code, and other expenses for medical care as permitted within a medical reimbursement plan by the Code, and by rulings, regulations and IRS published guidance thereunder, and not otherwise reimbursed or reimbursable to the Participant or used by the Participant as a deduction in determining his or her tax liability under the Code.

2.10 "Medical Reimbursement Plan Balance" means the Plan balance for a Participant described in Article V hereof.

2.11 "Participant" means any Eligible Employee who participates in the Plan in accordance with Article III.

2.12 "Plan" means the BWL Medical Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto.

2.13 "Plan Year" means the 12-consecutive-month period ending each August 31st.

2.14 "Qualifying Medical Care Expense" means a Medical Care Expense incurred by a Participant or the spouse or Dependent of a Participant during a Plan Year including its Grace

Period and governed by the terms of Article VI herein. Premiums paid for health coverage, or for long-term care coverage, are not Qualifying Medical Care Expenses.

ARTICLE III - ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. Each Employee who is eligible under the Cafeteria Plan will be an Eligible Employee for participation in this Plan.

3.2 Date of Participation. An Eligible Employee will become a Participant upon the effective date of his election under the Cafeteria Plan to participate in this Plan

3.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of (a) the date on which this Plan or the Cafeteria Plan terminates, or (b) the date on which his or her election to participate in this Plan expires or is terminated, or (c) the date of cessation of his participation in the Cafeteria Plan.

3.4 Reinstatement of Former Participant. If a former Participant again becomes eligible under Section 3.1, at that time, he may make an election again as provided in this Plan.

ARTICLE IV - ELECTION PARTICIPATE IN MEDICAL REIMBURSEMENTS PLAN

4.1 Election Procedure. An Eligible Employee may elect to participate in the Medical Reimbursement Plan by filing a benefit election and salary reduction agreement form in accordance with the procedures established under the Cafeteria Plan. An election to participate in the Medical Reimbursement Plan shall be irrevocable during the Plan Year, except as provided in the Cafeteria Plan.

4.2 Maximum Reimbursements. The maximum amount which the Participant may elect to receive under this Plan in the form of reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year shall be an amount established in the discretion of BWL, which amount may be changed from time to time, to be effective for the next Plan Year. Eligible Employees will be notified of such change during the election period for the next Plan Year. The maximum amount for the current Plan Year is stated in Appendix A which is attached and made a part of this Plan.

4.3 Family and Medical Leave Act ("FMLA"). Notwithstanding any other provision of this Plan, the Plan may (a) permit a Participant to revoke (and subsequently reinstate) his election under this Plan and (b) adjust the Participant's salary reduction amount as a result of such revocation and/or reinstatement to the extent BWL deems necessary or appropriate to assure the Plan's compliance with the provisions of FMLA. The Plan will allow a Participant taking FMLA leave to agree to pay in advance for pretax amounts the Participant would be required to pay while on leave, or continue to make contributions, after tax on the same schedule as while not on leave, or make all required catch-up contributions pretax or after tax upon return to work after FMLA leave.

ARTICLE V - MEDICAL REIMBURSEMENT PLAN BALANCES

5.1 Establishment of Plan Balances. BWL will establish and maintain a Medical Reimbursement Plan Balance for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year. In no event is this an account into which funds are deposited, maintained and/or reimbursed from.

5.2 Crediting of Plan Balance. There shall be credited to a Participant's Medical Reimbursement Plan Balance for each Plan Year, at the beginning of the Plan Year, an amount

equal to the amount elected by the Participant for that Plan Year. All amounts credited to each such Medical Reimbursement Plan Balance shall be the property of BWL until paid out pursuant to Article VI.

5.3 Debiting of Plan Balance. A Participant's Medical Reimbursement Plan Balance for each Plan Year shall be debited from time to time in the amount of any payment under Article VI to the Participant for Qualifying Medical Care Expenses incurred during such Plan Year including its Grace Period.

5.4 Forfeiture of Plan Balance. The amount credited to a Participant's Medical Reimbursement Plan Balance for any Plan Year shall be used only to calculate reimbursements to the Participant for Qualifying Medical Care Expenses incurred previously during such Plan Year including its Grace Period, and only if the Participant applies for reimbursement on or before the 120th day following the end of the Plan Year. If any elected amount remains in the Participant's Medical Reimbursement Plan Balance for a Plan Year including its Grace Period after all reimbursements hereunder, the balance shall not be carried over to the next Plan Year and the Participant shall forfeit all rights with respect to such balance. The remaining elected amount shall not be used to reimburse the Participant for Qualifying Medical Care Expenses incurred during any other Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of BWL, and the Participant shall forfeit all rights with respect to such balance.

5.5 No Transfer Among Cafeteria Plan Balances. The use of a Grace Period does not permit a Participant to transfer the Medical Reimbursement Plan Balance for the Participant among the Participant's other elected Cafeteria Plan benefits and does not provide an opportunity for new or revised elections to be made.

ARTICLE VI - PAYMENT OF MEDICAL CARE EXPENSE REIMBURSEMENTS

6.1 Claims for Reimbursement. To receive medical care reimbursements for a Plan Year including its Grace Period, a Participant shall apply to the Plan for reimbursement to the Participant of Qualifying Medical Care Expenses incurred by the Participant and/or his or her spouse or Dependents previously during the Plan Year including its Grace Period, by submitting an application in writing to the Plan, in such form as the Plan may prescribe, setting forth:

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

(b) the name of the person, organization or entity with which the expense was incurred;

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

(d) a written statement from the Participant that the medical expense has not been reimbursed and is not reimbursable under any other health plan coverage. Such application shall be accompanied by a written statement, which shall be from an independent third party, stating that the medical expense has been incurred and the amount of such expense, together with any additional documentation which the Plan may request. Such application shall be filed within a reasonable time of incurring the expense, but in no event later than the 120th day following the end of the Plan Year.

6.2 Reimbursement of Expenses. The Plan, within a reasonable period of time (generally once a month) of receiving the application in accordance with Section 6.1, shall make payment to the Participant debited to the Participant's Medical Reimbursement Plan Balance for Qualifying Medical Care Expenses incurred, that is, for services actually provided, during the Plan Year including its Grace Period. No reimbursement under this Section 6.2 of expenses incurred during

a Plan Year including its Grace Period shall at any time exceed the balance of the full annual contributions credited to the Participant's Medical Reimbursement Plan Balance for that Plan Year less reimbursements that have been made to the Participant, at the time of the requested reimbursement. Claims for Qualifying Medical Expenses incurred during a Grace Period will be reimbursed, when timely submitted, first from the preceding Plan Year balance and then from the current Plan Year balance, and reprocessing of claims will not be allowed.

6.3 Qualifying Medical Care Expenses. Examples of Medical Care Expenses that generally qualify are:

-Prescribed medicine and drugs.

-Medical doctors, dentists, orthodontists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists.

-Medical examination, X-ray and laboratory service.

-Hospital care (including meals and lodging), clinic costs, lab fees.

-Certain nonprescription over-the-counter medicine and drugs, such as antacids, allergy medicine, cold medicine, and pain relievers.

No reimbursement can be made for the following, among others:

-Expenses for which reimbursement is available under another health plan.

-Health insurance premiums paid to any other plan.

-Life insurance or income protection policies.

-Nursing care for a healthy baby.

-Illegal operations or drugs.

-Travel a doctor ordered for rest or change.

-Over-the-counter vitamins, toiletries and cosmetics.

ARTICLE VII - TERMINATION OF PARTICIPATION. If a Participant leaves BWL's employment, any Employer contribution and any salary reduction the Participant elected will end for this Plan, and he will have the opportunity to elect to end participation in this Plan. If the Participant elects to end participation, he will not have to make after-tax contributions to finish out the Plan Year, and will still be able to submit claims for reimbursement of Qualifying Medical Care Expenses incurred before termination, against the amounts that had been credited to the Participant's Medical Reimbursement Plan Balance but not used at time of termination. However, if after the Participant leaves BWL's employment, he continues to participate in the Plan, the Participant will have to continue to make contributions on an after-tax basis for the rest of the Plan Year, at the same time as when he was employed. Unless continuation of health coverage

(COBRA) applies and is elected, his participation in the Plan will end at the end of that Plan Year; if any elected amount remains in the Participant's Medical Reimbursement Plan Balance at the end of that Plan Year, the Grace Period for that Plan Year will apply. The Participant must submit claims for Qualifying Medical Care Expenses incurred during the Plan Year (including the Grace Period if applicable) on or before the 120th day following the end of the Plan Year in which the Participant left BWL's employ. Should the Participant be eligible for COBRA coverage under Federal law, he cannot make his COBRA contributions on a pre-tax basis. BWL will provide the Participant with information regarding continuation health care coverage at the time of termination.

ARTICLE VIII – ADMINISTRATION OF PLAN

8.1 Administration. It shall be a principal duty of BWL to see that the Plan is carried out, in accordance with its terms, without discrimination among those eligible to participate in the Plan. BWL will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, BWL's powers will include, but will not be limited to, the following final authority and discretion, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of claims procedures;

(b) To interpret the Plan, its interpretation thereof in good faith to be final, conclusive and binding on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To compute the amount of benefits which will be payable to any Participant in accordance with the provisions of the Plan;

(e) To authorize the payment of benefits;

(f) To appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan; and

(g) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be by written instrument.

8.2 Examination of Records. BWL will make available to each Participant such of its records as pertain to the Participant, for examination at reasonable times during normal business hours.

8.3 Reliance on Tables, etc. In administering the Plan, BWL will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel or other expert who is employed or engaged by BWL.

8.4 Claims Procedures.

(a) Any claim for benefits under the Plan shall be filed in accordance with the provisions of this Plan and such other claim procedures as may be established for the Plan from time to time. Notice of decision on a claim, and if a claim is denied, notice of any appeal procedure established for the Plan, shall be provided to the Participant in writing.

(b) If a claim is denied in whole or in part, the Plan shall provide the Participant with written notification within ninety (90) days from the date the claim was submitted.

Any Participant may request review of the denial of any claim of that Participant by filing a written application with the Plan. A written request for review must be filed within sixty (60) days after

the denial is received. Upon receipt of the written request for review, the Plan will review the claim and furnish in writing the reasons and facts relating to the decision.

A decision shall be made by the Plan with respect to such appeal within sixty (60) days of receipt of the appeal, unless special circumstances require an extension of time. Such decision shall be in writing to the Participant. In the case of an extension, the Participant shall be notified in writing prior to the commencement of the extension.

A decision will be made as soon as possible, but not later than one hundred twenty (120) days after the receipt of the appeal. Such decision on the appeal will be delivered to the Participant in writing and will set forth the specific reasons for the decision.

8.5 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by BWL is required, BWL shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.6 Final Authority. BWL has final authority and discretion to determine eligibility and benefits and interpret the Plan. Decisions by BWL are final, conclusive and binding.

8.7 Meeting Nondiscrimination Rules. If BWL determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated Employees, BWL shall take such action as BWL deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees with or without the consent of such Employees. To the extent that the Plan and/or certain Participants meet the requirements of any Code section that excludes such plan or participants from nondiscrimination requirements, such nondiscrimination requirements of that Code section shall not be applied by BWL.

8.8 HIPAA Privacy Requirements.

(a) HIPAA Privacy Requirements. The following HIPAA Privacy Requirements are the policies adopted by BWL regarding disclosure to and use by BWL ("Plan Sponsor") of protected health information from the Plan. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and privacy regulations implementing HIPAA restrict the ability of Plan Sponsor to use and disclose Protected Health Information ("PHI"). The following HIPAA definition of PHI applies to this Plan:

> Protected Health Information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted in this Section or as otherwise required or permitted by HIPAA.

(b) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan.

(c) Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing coverage under the Plan; or (2) modifying, amending, or terminating the Plan. The following HIPAA definition of Summary Health Information applies to this Plan:

> Summary Health Information means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(d) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph (e) of this Section and obtaining written certification pursuant to paragraph (h) of this Section, the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI only for Plan Administration Purposes. The following HIPAA definition of Plan Administration Purposes applies to this Plan Amendment:

> Plan Administration Purposes means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

(e) Conditions of Disclosure for Plan Administration Purposes. Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, the Plan Sponsor shall comply with these conditions of disclosure for Plan Administration Purposes:

- not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

- not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;

- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

- report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for, of which it becomes aware;

- make PHI available to comply with HIPAA's right to access requirements in accordance with 45 CFR § 164.524;

- make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 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 for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such information, when no longer needed for the purpose for which disclosure was made (or 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 between Plan and Plan Sponsor, required in 45 CFR § 504(f)(2) (iii), is satisfied.

(f) Maintaining Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall limit access to PHI to only the HIPAA Privacy Officer and such Department of Human Resources staff as are designated by the HIPAA Privacy Officer. No other persons shall have access to PHI. These employees shall have access to and use PHI only to the extent necessary to perform the Plan Administration Functions that the Plan Sponsor performs for the Plan.

(g) Non-compliance Issues. In the event that any of the employees specified in paragraph (f) of this Section does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

(h) Certification by Plan Sponsor. The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in paragraph (e) of this Section. As of May 23, 2006, both of these requirements have been met.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

9.1 Amendment of Plan. BWL reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable, by duly authorized action of BWL; but to the extent an amendment affects Eligible Employees who are members of the Collective Bargaining Unit as defined in the Cafeteria Plan, it shall not be

inconsistent with any relevant terms and conditions of the Collective Bargaining Agreement as defined in the Cafeteria Plan.

9.2 Termination of Plan. BWL has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but BWL will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan in whole or in part at any time without liability, by duly authorized action of BWL, subject to any limitations of the Collective Bargaining Agreement as defined in the Cafeteria Plan for Eligible Employees who are members of the Collective Bargaining Unit as defined in the Cafeteria Plan. Upon termination or discontinuance of the Plan, all contributions, elections and reductions in compensation related to the Plan shall terminate, and reimbursement shall be made only in accordance with Article VII.

ARTICLE X - MISCELLANEOUS

10.1 Information to be Furnished. Participants shall provide BWL with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

10.2 Statement of Benefits. BWL shall provide to each Participant receiving reimbursement under the Plan during a Plan Year a statement of the amount of benefits received by such Participant during that Plan Year. Such statement shall be furnished to the Participant by the January 31st following the end of such Plan Year.

10.3 Plan is Not a Contract. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer, or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

10.4 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against BWL, except as expressly provided herein.

10.5 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of BWL. Nothing herein will be construed to require BWL to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of BWL from which any payment under the Plan may be made.

10.6 Nonassignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.7 No Guarantee of Tax Consequences. BWL makes no commitment or guarantee that any amounts paid to a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax or federal Social Security Tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for such tax purposes, and to notify BWL if the Participant has reason to believe that any such payment is not so excludable.

10.8 Indemnification of BWL by Participants. If any Participant receives one or more reimbursements under this Plan that are not for Qualifying Medical Care Expenses, such

Participant shall indemnify and reimburse BWL for any liability BWL may incur for failure to withhold federal, state and/or local income tax or FICA tax from such reimbursements.

10.9 Governing Law. The Plan will be construed, administered and enforced according to the laws of Michigan, to the extent not pre-empted by Federal law.

10.10 Gender. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Effective: August 1, 1987
Amended: September 1, 1999
Restated and Amended: May 23, 2006

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Appendix A

Maximum Annual Medical Reimbursement Amount

For the 2005-2006 Plan Year, and until such time as this amount is revised by BWL, the annual maximum amount which may be elected under this Plan is $7,500.00.

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LANSING BOARD OF WATER AND LIGHT

DEPENDENT CARE REIMBURSEMENT PLAN

AMENDED AND RESTATED

Effective: May 23, 2006

LANSING BOARD OF WATER AND LIGHT

DEPENDENT CARE REIMBURSEMENT PLAN

TABLE OF CONTENTS

ARTICLE I - INTRODUCTION

1.1 The purpose of this Plan is to enable Participants to elect to receive reimbursement for the costs of dependent care that are excludable under Section 129 of the Internal Revenue Code of 1986, as amended. It is the intention of Lansing Board of Water and Light ("BWL") that the Plan qualify as a dependent care reimbursement plan under Section 129, and it is to be interpreted in a manner consistent with the requirements of Section 129. This is a governmental plan that is not subject to the Employee Retirement Income Security Act of 1974.

ARTICLE II - DEFINITIONS

2.1 "BWL" means Lansing Board of Water and Light, a municipal corporation organized under the laws of the State of Michigan.

2.2 "Cafeteria Plan" means the BWL Cafeteria Plan amended and restated effective May 23, 2006, as amended from time to time thereafter.

2.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.4 "Dependent" means any individual who is (a) a dependent of the Participant (as defined in section 152[a][1]) who has not attained the age of 13, or (b) a dependent of the Participant (within the meaning of Section 152 of the Code), or the spouse of the Participant, if the spouse is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the Plan Year; any required limitations of the Code also shall apply.

2.5 "Earned Income" means all earned income as defined in Code Section 32(c)(2).

2.6 "Educational Institution" means any college or university, the primary function of which is the presentation of formal instruction and which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

2.7 "Eligible Employee" means any person who meets the definition of Employee and the eligibility requirements of the Cafeteria Plan and this Plan.

2.8 "Eligible Employment Related Expenses" means all Employment Related Expenses incurred during the Plan Year by a Participant which are paid to a person who is not: (i) a Dependent of a Participant or (ii) a child of the Participant under the age of 19.

2.9 "Employer" means the Lansing Board of Water and Light.

2.10 "Employment Related Expenses" means expenses incurred for Qualifying Services or for the cost of sending a child of the Participant to a Qualifying Day Care Center.

2.11 "Highly Compensated Employee" means any person who is a highly compensated employee according to Code Section 414(q).

2.12 "Participant" means any Eligible Employee who participates in the Plan in accordance with Article III.

2.13 "Plan" means the BWL Dependent Care Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto.

2.14 "Plan Year" means the 12-consecutive-month period ending each August 31st.

2.15 "Qualifying Day Care Center" means (i) a day care center which complies with all applicable laws and regulations of the State and town, city or village in which it is located, (ii) provides care for more than six individuals (other than individuals who reside at the day care

center) and (iii) receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for a profit).

2.16 "Qualifying Individuals" means: (i) a Dependent of a Participant who is under the age of 13; (ii) a Dependent of a Participant who is physically or mentally incapable of caring for himself or herself; or (iii) the spouse of a Participant, if he or she is physically or mentally incapable of taking care of himself or herself.

2.17 "Qualifying Expenses" means Eligible Employment Related Expenses.

2.18 "Qualifying Services" means Services performed: (i) in the home of the Participant; or (ii) outside the home of the Participant for (a) the care of a Dependent of the Participant under the age of 13 or (b) the care of any other Qualifying Individual, who spends at least eight hours a day in the Participant's home; Qualifying Services shall not include expenses for a camp where the Dependent stays overnight.

2.19 "Services" means the services performed to enable a Participant and his spouse to be gainfully employed and which are related to the care of a Qualifying Individual or Individuals.

2.20 "Student" means an individual who during each of five calendar months during a Plan Year is a full-time student at an Educational Institution.

ARTICLE III - ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. Each Employee who is eligible under the Cafeteria Plan and further, whose spouse if any is employed or a full-time student at an Educational Institution or physically or mentally incapable of caring for himself, will be an Eligible Employee for participation in this Plan.

3.2 Date of Participation. An Eligible Employee will become a Participant upon the effective date of his election under the Cafeteria Plan to participate in this Plan.

3.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of (a) the date on which this Plan or the Cafeteria Plan terminates, (b) the date on which his or her election to participate in this Plan expires or is terminated under the Cafeteria Plan, or (c) the date of cessation of participation in the Cafeteria Plan.

3.4 Reinstatement of Former Participation. If a former Participant again becomes eligible under Section 3.1, at that time, he may make an election again as provided in this Plan.

ARTICLE IV - ELECTION PARTICIPANTE IN DEPENDENT CARE REIMBURSEMENT PLAN

4.1 Election Procedure. An Eligible Employee may elect to participate in Dependent care reimbursement Plan by filing an election and salary reduction agreement form in accordance with the procedures established under the Cafeteria Plan. An election to receive participate in dependent care reimbursement Plan shall be irrevocable during the Plan Year, except as provided in the Cafeteria Plan.

4.2 Maximum Dependent Care Reimbursement. The maximum amount which the Participant may receive in any Plan Year in the form of dependent care reimbursement under this Plan shall be the least of:

(a) The Participant's earned income for the Plan Year (after all reductions in compensation including the reduction related to dependent care reimbursement);

(b) The actual or deemed earned income of the Participant's spouse for the Plan Year; in the case of a spouse who is a full-time student at an Educational Institution or is physically or mentally incapable of caring for himself, such spouse shall be deemed to have earned income of

not less than $250 per month if the Participant has one Dependent and $500 per month if the Participant has two or more Dependents; or

(c) $5,000 ($2,500 if married and filing separately).

(d) If the amounts cited 4.2(b) & (c) are changed in the Code, this plan will automatically change to reflect what the code provides.

ARTICLE V - DEPENDENT CARE REIMBURSEMENT PLAN BALANCES

5.1 Establishment of Plan Balances. BWL will establish and maintain a Dependent Care Reimbursement Plan Balance for each Plan Year with respect to each Participant who has elected to receive dependent care reimbursement for the Plan Year. In no event is this an account into which funds are deposited, maintained and/or reimbursed from.

5.2 Crediting of Plan Balance. There shall be credited to a Participant's Dependent Care Reimbursement Plan Balance for a Plan Year, as of each date compensation is paid to the Participant in such Plan Year, a pro rata amount equal to the Dependent Care contribution to be made in accordance with the Participant's election under the Cafeteria Plan. All amounts credited to each such Dependent Care Reimbursement Plan Balance shall be the property of BWL until reimbursed to the Participant pursuant to Article VI.

5.3 Debiting of Plan Balance. A Participant's Dependent Care Reimbursement Plan Balance for each Plan Year shall be debited from time to time in the amount of any reimbursement of the Participant under Article VI for Eligible Employment Related Expenses incurred during such Plan Year.

5.4 Forfeiture of Plan Balance. The amount credited to a Participant's Dependent Care Reimbursement Plan Balance for any Plan Year shall be used only to calculate reimbursements to the Participant for Eligible Employment Related Expenses incurred during such Plan Year, and only if the Participant applies for reimbursement on or before the 90th day following the close of the Plan Year. If any elected amount remains in the Participant's Dependent Care Reimbursement Plan Balance for any Plan Year after all reimbursements hereunder, the balance shall not be carried over to the next Plan Year and the Participant shall forfeit all rights with respect to such balance. The remaining elected amount shall not be used to reimburse the Participant for Eligible Employment Related Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of BWL.

ARTICLE VI - PAYMENT OF DEPENDENT CARE REIMBURSEMENT

6.1 Eligible Expenses. Every Participant in the Plan shall be eligible to receive reimbursement under the Plan for Eligible Employment Related Expenses during the Plan Year and after he became a Participant in this Plan.

6.2 Required Information. Each Participant who desires to receive reimbursement under the Plan for Eligible Employment Related Expenses incurred by the Participant shall submit to the Plan in such form as the Plan may prescribe, a written statement containing the following information:

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

(b) the name of the person or entity to which the expense was or is to be paid by the Participant;

(c) a statement that the expense (or portion thereof) for which reimbursement is sought under the Plan has not been reimbursed and is not reimbursable under any other dependent care plan coverage; and

(d) such other information as may be required.

6.3 Claims. The Participant shall submit a statement to the Plan within a reasonable time of incurring the expense, but in no event later than 90 days following the close of the Plan Year within which the expense was incurred.

6.4 Reimbursement of Expenses. Within a reasonable time of receiving a claim statement (at least once a month), the Plan shall make payment to the Participant debited to the Participant's Dependent Care Reimbursement Plan Balance for Eligible Employment Related Expenses incurred, that is, for services actually provided, during the Plan Year. In no event shall any such reimbursement exceed the balance then remaining for that Participant.

6.5 Termination. If a Participant leaves BWL's employment, any Employer contribution and any salary reduction the Participant elected will end for this Plan, and he will have the opportunity to elect to end participation in this Plan. If the Participant elects to end participation, he will not have to make after-tax contributions to complete the Plan Year, and will still be able to submit claims for reimbursement of expenses incurred before termination, against the amounts that had been credited to the Participant's Dependent Care Reimbursement Plan Balance but not used at time of termination. These claims must be submitted within 90 days of the end of the Plan Year in which the Participant left BWL's employ. If, after the Participant leaves BWL's employment, he continues to participate in the Plan, the Participant will have to continue to make contributions on an after-tax basis for the rest of the Plan Year, at the same time as when he was employed. Then the Participant's participation in the Plan ends, although he can submit claims for expenses incurred during the Plan Year within 90 days of the end of the Plan Year.

ARTICLE VII - ADMINISTRATION OF PLAN

7.1 Administration. It shall be a principal duty of BWL to see that the Plan is carried out, in accordance with its terms, without discrimination among those eligible to participate in the Plan. BWL will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the powers of BWL will include, but will not be limited to, the following final authority and discretion, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of claims procedures;

(b) To interpret the Plan, its interpretation thereof in good faith to be final, conclusive and binding on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To compute the amount of benefits which will be payable to any Participant in accordance with the provisions of the Plan;

(e) To authorize the payment of benefits;

(f) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan; and

(g) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be by written instrument.

7.2 Examination of Records. BWL will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

7.3 Reliance on Tables, etc. In administering the Plan, BWL will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by BWL.

7.4 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by BWL is required, BWL shall exercise its authority in a non-discriminatory manner so that all persons similarly situated will receive substantially the same treatment.

7.5 Claims Procedures.

(a) Any claim for benefits under the Plan shall be filed in accordance with the provisions of this Plan and such other claim procedures as may be established for the Plan from time to time. Notice of decision on a claim, and if a claim is denied, notice of any appeal procedure established for the Plan, shall be provided to the Participant in writing.

(b) If a claim is denied in whole or in part, the Plan shall provide the Participant with written notification within ninety (90) days from the date the claim was submitted.

Any Participant may request review of the denial of any claim of that Participant by filing a written application with the Plan. A written request for review must be filed within sixty (60) days after the denial is received. Upon receipt of the written request for review, the Plan will review the claim and furnish in writing the reasons and facts relating to the decision.

A decision shall be made by the Plan with respect to such appeal within sixty (60) days of receipt of the appeal, unless special circumstances require an extension of time. Such decision shall be in writing to the Participant. In the case of an extension, the Participant shall be notified in writing prior to the commencement of the extension.

A decision will be made as soon as possible, but not later than one hundred twenty (120) days after the receipt of the appeal. Such decision on the appeal will be delivered to the Participant in writing and will set forth the specific reasons for the decision.

7.6 Final Authority. BWL has final authority and discretion to determine eligibility and benefits and interpret the Plan. Decisions by BWL are final, conclusive and binding.

7.7 Meeting Nondiscrimination Rules. If BWL determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirements imposed by the Code or any limitation on benefits provided to Highly Compensated Employees, BWL shall take such action as BWL deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees with or without the consent of such Employees. To the extent that the Plan and/or certain Participants meet the requirements of any Code section that excludes such plan or participants from nondiscrimination requirements, such nondiscrimination requirements of that Code section shall not be applied by BWL.

ARTICLE VIII - AMENDMENT OR TERMINATION OF PLAN

8.1 Amendment of Plan. BWL reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable, by duly authorized action of BWL; but to the extent an amendment affects Eligible Employees who are members of the Collective Bargaining Unit as defined in the Cafeteria Plan, it shall not be inconsistent with any relevant terms and conditions of the Collective Bargaining Agreement, as defined in the Cafeteria Plan.

8.2 Termination of Plan. BWL has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but BWL will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan in whole or in part at any time without liability, by duly authorized action of BWL, subject to any limitations of the Collective Bargaining Agreement as defined in the Cafeteria Plan for Eligible Employees who are members of the Collective Bargaining Unit as defined in the Cafeteria Plan. Upon termination or discontinuance of the Plan, all contributions, elections and reductions in compensation relating to the Plan shall terminate, and reimbursements shall be made only in accordance with Article VI.

ARTICLE IX - MISCELLANEOUS

9.1 Information to be Furnished. Participants shall provide BWL with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

9.2 Statement of Benefits. BWL shall provide to each Participant receiving reimbursement under the Plan during a Plan Year a statement of the amount of benefits received by such Participant during that Plan Year. Such statement shall be furnished to the Participant by the January 31st following the end of the plan year.

9.3 Plan is Not a Contract. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer, or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

9.4 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against BWL, except as expressly provided herein.

9.5 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of BWL. Nothing herein will be construed to require BWL to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of BWL from which any payment under the Plan may be made.

9.6 Nonassignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

9.7 No Guarantee of Tax Consequences. BWL makes no commitment or guarantee that any amounts paid to a Participant under this Plan will be excludable from the Participant's gross income for federal, state and/or local income tax purposes or Federal FICA tax purposes, or that any other federal, state or local tax treatment will apply to or be available to any Participant. It

shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and/or local income tax or other tax purposes, and to notify BWL if the Participant has reason to believe that any such payment is not so excludable.

9.8 Indemnification of BWL by Participants. If any Participant receives one or more reimbursements under this Plan that are not for Qualifying Expenses, such Participant shall indemnify and reimburse BWL for any liability BWL may incur for failure to withhold federal, state and/or local income tax or FICA tax from such payment of benefits.

9.9 Governing Law. The Plan will be construed, administered and enforced according to the laws of Michigan, to the extent not pre-empted by Federal law.

9.10 Gender. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Effective: August 1, 1987
Amended: September 1, 1999
Restated and Amended: May 23, 2006.

DOX\word\fsa\FINAL DEPENDENT CARE PLAN RE

LANSING BOARD OF WATER AND LIGHT

CASH OPTION PLAN (COP)

CAFETERIA PLAN (B)

AMENDED AND RESTATED

Effective: March 27, 2007

LANSING BOARD OF WATER AND LIGHT

Cafeteria Plan B: Cash or Health/Prescription Drug Election

TABLE OF CONTENTS

ARTICLE I – INTRODUCTION

1.1 Purpose of Plan. The purpose of this Plan is to make a limited choice of benefits available to Eligible Employees and Eligible Retirees of the Lansing Board of Water and Light (BWL).

1.2 Cafeteria Plan Status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. This Plan is a governmental plan and is not subject to the Employee Retirement Income Security Act of 1974.

ARTICLE II – DEFINITIONS

2.1 "BWL" means Lansing Board of Water and Light, a municipal corporation organized under the laws of the State of Michigan.

2.2 "Cash Compensation" means payment for work performed, but does not include other benefits.

2.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.4 "Collective Bargaining Agreement" means the current Collective Bargaining Agreement between BWL and a collective bargaining representative for a specified class of Participants, which requires any provisions of the Plan to be maintained for the benefit of that class of Participants covered by that agreement. Collective Bargaining Agreement also means any renewal, modification, amendment or successor agreement to the current agreement.

2.5 "Collective Bargaining Unit" means a specified class or classes of employees whose compensation and fringe benefits are described in a Collective Bargaining Agreement between BWL and a collective bargaining representative for the specified class or classes of employees.

2.6 "Eligible Employee" means an Employee of BWL who meets the eligibility requirements specified in the Plan.

2.7 "Eligible Retiree" means a Retiree of BWL who meets the eligibility requirements specified in the Plan.

2.8 "Employee" means any person who is receiving remuneration from BWL for services rendered to BWL as a full-time regular employee as defined by BWL policy and stated in Appendix A which is attached and made a part of this Plan, or, for members of the Collective Bargaining Unit, as

defined in the Collective Bargaining Agreement if different, but Employee for the purposes of this Plan does not include retirees or beneficiaries. Appendix A shall be updated automatically as the definition of full-time regular employee is revised from time to time by BWL.

2.9 "Employer" means the Lansing Board of Water and Light.

2.10 "Highly Compensated Employee" means any person who is a highly compensated employee as defined in Section 125(e) of the Code.

2.11 "Key Employee" means any person who is a key employee as defined in Section 416 of the Code.

2.12 "Participant" means any Eligible Employee or Eligible Retiree who participates in the Plan in accordance with Article III.

2.13 "Plan" means the BWL Cafeteria Plan B as set forth herein, together with any and all amendments and supplements hereto.

2.14 "Plan Year" means the twelve-consecutive month period ending each August 31st.

2.15 "Retiree" means any former Employee who meets the definition of Retiree set forth in the BWL Post-Retirement Benefit Plan ("Retiree Benefit Plan"), but Retiree for the purposes of this Plan does not include beneficiaries.

ARTICLE III - ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. In order to be eligible to participate in this Plan, an Employee or Retiree must be eligible for health and prescription drug coverage under the terms of one of the following: the Collective Bargaining Agreement, the BWL health and prescription drug plans for active employees, or the BWL Post-Retirement Benefit Plan. Further, in order to be eligible to participate in this Plan, an Employee or Retiree must demonstrate by written proof that, to the satisfaction of BWL, that person currently is enrolled in health care coverage, from a source other than BWL, which coverage is similar to the coverage provided by the applicable BWL health plan for which the Employee or Retiree is eligible. For purposes of this Plan, Medicare Part A coverage alone, or Medicare Part A and Part B coverage alone, is not alternative coverage. Each person who meets the definition of Employee as stated herein and the other requirements stated in this Section shall be an Eligible Employee. Each person who meets the definition of Retiree as stated herein and the other requirements stated in this Section shall be an Eligible Retiree.

3.2 Participation. Each Eligible Employee shall be eligible to participate in the Plan on the first day of the month following his date of hire or, if the first date of employment is the first work day of the month, then on the first date of employment. Each Eligible Retiree shall be eligible to participate in the Plan immediately upon being determined eligible under this Plan. No spouse or dependent of an Employee or Retiree is eligible to become a Participant in this Plan. A Participant must continue to meet the eligibility requirements of this Plan throughout the Plan Year.

3.3 Election. All elections are prospective elections and do not apply retroactively to the date of election except as provided in Section 4.8 for certain changes in status of a Participant during a Plan Year. An Eligible Employee or Eligible Retiree shall become a Participant by executing the required benefit election form(s), following the election procedure set forth in this Plan.

3.4 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of (a) the date on which this Plan terminates or (b) the date on which the Participant ceases to be an Eligible Employee or Eligible Retiree eligible to participate under Section 3.1 or (c) the Participant elects to terminate his/her participation under the circumstances permitted by this Plan or (d) the Participant's election expires. Loss of eligibility for coverage of the Participant by the applicable BWL health and prescription drug plans and/or loss of enrollment of the Participant in alternative coverage shall cause a Participant to immediately cease to be eligible to participate in this Plan.

3.5 Reinstatement of Former Participant. A former Participant will become eligible to participate in this Plan again if and when he/she meets the eligibility requirements of Section 3.1, and at that time may become a Participant by executing the required benefit election form(s), following the election procedure set forth in this Plan.

3.6 Notice. It is the obligation of the Participant to promptly notify BWL of any loss of the alternative coverage which was a qualification for eligibility. Notice must be in writing given to BWL at least thirty (30) days prior to the date of the loss of coverage. If timely notice is not given BWL reserves the right to retroactively cancel coverage or recover payment of cash benefit made after the date of loss of the alternative coverage.

ARTICLE IV – BENEFITS, ELECTIONS AND TERMINATION

4.1 Benefit Options. Except to the extent that any Plan benefits for Participants are specified in the Collective Bargaining Agreement, BWL in its discretion will decide for each Plan Year which

benefits may be elected and the annual amount of any taxable cash benefit option. Election choice is subject to limits and requirements stated in this Plan document. This Plan currently provides that a Participant may elect only one benefit for each Plan Year, either (1) the taxable cash benefit or (2)(a) health coverage alone without prescription drug coverage, or (b) both health and prescription drug coverage, under the BWL health plan or health and prescription drug plans applicable to that Participant. The election of either (1) or (2) is exclusive and the benefits may not be combined.

4.2 Coverage Benefits . To the extent health coverage, or health and prescription drug coverage, ("Coverage Benefits") are benefit choices under this Plan, the choices that apply to a Participant shall be the coverage(s) for which that person is eligible at that time under the terms of one of the following: the Collective Bargaining Agreement, the BWL health and prescription drug plans for active employees, or the BWL Post-Retirement Benefit Plan. While the election to receive a Coverage Benefit may be made under this Plan, the coverage will be provided through the applicable health and prescription drug plans. The types and amounts of health and prescription drug benefits available, the requirements for participating in the health and prescription drug plans, and the other terms and conditions of coverage and benefits under such plans and as may be required by law such as under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") and the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") are as set forth from time to time in the applicable health and prescription drug plans.

4.3 Cash Benefit. In order to receive the taxable cash benefit, the Participant must waive both health and prescription drug coverage under the BWL plan(s) applicable to that Participant for the Plan Year period. Any elected taxable cash benefit will be paid pro rata over the year with each pay period for Eligible Employee Participants and at the end of each month for Eligible Retiree Participants.

4.4 Annual Election. Approximately 60 days prior to the commencement of each Plan Year, Eligible Employees, Eligible Retirees and Participants, will be informed about the benefits which may be elected for the upcoming Plan Year and will have the opportunity to make an election under this Plan as described in Section 4.5. A Participant annually must demonstrate enrollment in alternative coverage as required in Section 3.1.

4.5 Election Procedure.

(a) For Eligible Employees. Approximately 60 days prior to the commencement of each Plan Year, BWL shall make available the benefit election form(s) to each Eligible Employee who is not a Participant and who is eligible to become a Participant at the beginning of the next Plan Year. The election made shall be effective as of the first day of the next Plan Year. In order to participate, each Eligible Employee shall specify his election and shall agree to participate. The benefit election form(s) must be completed and returned to BWL on or before such date as BWL shall specify, which date shall be prior to the start of the next Plan Year. Participants who wish to change their election may do so during the 60 days prior to the commencement of the next Plan Year.

(b) For Eligible Retirees. Approximately 60 days prior to the commencement of each Plan Year, BWL shall make available the benefit election form(s) to each Eligible Retiree who is not a Participant and who is eligible to become a Participant at the beginning of the next Plan Year. The election(s) made shall be effective as of the first day of the next Plan Year. In order to participate, each Eligible Retiree shall specify his election and shall agree to participate. The benefit election form(s) must be completed and returned to BWL on or before such date as BWL shall specify, which date shall be prior to the start of the next Plan Year. Participants who wish to change their election may do so during the 60 days prior to the commencement of the next Plan Year.

4.6 New Eligible Employees and Eligible Retirees During the Plan Year. Any Employee or Retiree who is not an Eligible Employee or Eligible Retiree during the period of 60 days prior to the commencement of each Plan Year, but who becomes an Eligible Employee or Eligible Retiree at a later date, must execute the required benefit election form(s) in order to participate. BWL shall provide the benefit election form(s) described in Section 4.5 to a new Eligible Employee or new Eligible Retiree who becomes eligible during the Plan Year. In order to participate, the individual shall specify his election and shall agree to participate. The required form(s) must be completed and returned to BWL on or before such date as BWL shall specify, which date shall be no later than the beginning of the first pay period for which the Eligible Employee's election will apply, and for Eligible Retirees, the date shall be prior to the date the election takes effect.

4.7 Failure to Elect. If the completed form(s) is not returned to BWL on or before the specified due date for any Plan Year, a Participant shall be deemed to have elected for the new Plan Year the same

option as he had elected in the previous Plan Year, and a newly Eligible Employee or newly Eligible Retiree shall be deemed to have declined participation in this Plan.

4.8 Irrevocability of Election by the Participant during the Plan Year. Elections made under the Plan (or deemed to be made under Section 4.7) may not be amended or revoked by the Participant during the Plan Year, except for certain limited changes in status upon determination by BWL. Change in status events which may permit a change in election during the Plan Year are limited to (a) those which correspond with Code Sec. 9801(f) special enrollment rights under the BWL health and prescription drug plan(s) applicable to the Participant who seeks such a change in election, and (b) those election changes which are required by a court order, judgment or decree. The Participant must notify BWL in writing within thirty (30) days following such change of status occurring, and submit a notice of loss of alternative coverage as provided in Section 3.6, if such loss occurs as well. If eligibility in this Plan is not lost due to the change in status, the Participant may request to revoke or amend a benefit election for the balance of a Plan Year and to file a new or amended benefit election form(s) but only if both the amendment or revocation and the new or amended election are on account of and consistent with the change in status IRC Sec. 9801(f). Unless otherwise required by law, the election must apply prospectively and shall be effective at such time as BWL shall prescribe.

4.9 Termination.

(a) Employees. If an Eligible Employee Participant no longer is eligible for this Plan, the benefit the Participant elected under this Plan will stop as of the date of loss of eligibility and the BWL health and prescription drug plans will provide for the terms of eligibility, enrollment and coverages, and ability to waive coverages, applicable to the Employee under those plans.

(b) Retirees. If an Eligible Retiree Participant no longer is eligible for this Plan, the benefit the Participant elected under this Plan will stop as of the date of loss of eligibility and the Post-Retirement Benefit Plan will provide the terms of eligibility, enrollment and coverages, and ability to waive coverages, for any health and prescription drug coverage available under that plan. For the taxable cash benefit, there will be no monthly payment made for the month of the Retiree's death.

(c) COBRA Notice. If the Participant had elected coverage which provides for COBRA rights, the applicable health and prescription drug plans, and not this Plan, are responsible for providing notice of COBRA rights and all COBRA management.

ARTICLE V - ADMINISTRATION OF PLAN

5.1 Administration. It shall be a principal duty of BWL to see that the Plan is carried out, in accordance with its terms, without discrimination among those eligible to participate in the Plan. BWL will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the powers of BWL will include, but will not be limited to, the following final authority and discretion, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of claims procedures;

(b) To interpret the Plan, its interpretation thereof in good faith to be final, conclusive and binding on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants, and such other persons or entities as may be required to assist in administering and supervising the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

Notwithstanding the foregoing, any claim which arises under elected BWL health and prescription drug plans shall not be subject to review under this Plan, and the authority of BWL under this Section 5.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such other plan.

5.2 Examination of Records. BWL will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

5.3 Reliance on Tables, etc. In administering the Plan, BWL will be entitled to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel, or other expert who is employed or engaged by BWL.

5.4 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by BWL is required, BWL shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

5.5 Final Authority. BWL has final authority and discretion to determine eligibility and benefits and interpret the Plan. Decisions by BWL are final, conclusive and binding.

5.6 Meeting Nondiscrimination Rules. If BWL determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated or Key Employees, BWL shall take such action as BWL deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated or Key Employees with or without the consent of such Employees. To the extent that the Plan and/or certain Participants meet the requirements of any Code section that excludes such plan or participants from nondiscrimination requirements, such nondiscrimination requirements of that Code section shall not be applied by BWL.

ARTICLE VI - AMENDMENT AND TERMINATION OF PLAN

6.1 Amendment of Plan. BWL reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable, by duly authorized action of BWL, but to the extent an amendment affects Eligible Employees who are, or Eligible Retirees who were, members of the Collective Bargaining Unit, it shall not be inconsistent with any relevant terms and conditions of the Collective Bargaining Agreement.

6.2 Termination of Plan. BWL has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but BWL will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan in whole or in part at any time without liability, by duly authorized action of BWL, subject to any limitations of the Collective Bargaining Agreement for Eligible Employees who are, or Eligible Retirees who were, members of the Collective Bargaining Unit. Upon termination or discontinuance of the Plan, all contributions and elections related to the Plan shall terminate.

ARTICLE VII - MISCELLANEOUS

7.1 Information to be Furnished. Participants shall provide BWL with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2 Plan is not a Contract. Nothing contained in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan..

7.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against BWL, except as expressly provided herein.

7.4 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of BWL. Nothing herein will be construed to require BWL to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of BWL from which any payment under the Plan may be made.

7.5 Nonassignability of Rights. The right of any Participant to receive any benefit under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

7.6 No Guarantee of Tax Consequences. BWL makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state and/or local income tax purposes or federal FICA tax purposes, or that any other federal, state or local tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and/or local income tax or other tax purposes, and to notify BWL if the Participant has reason to believe that any such payment is not so excludable.

7.7 Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of Michigan, to the extent not pre-empted by Federal law.

7.8 Gender. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Effective: January 1, 1991

Amended January 1, 1995

Restated and Amended: March 27, 2007

Dox\word\fsa\cash option plan cop final

Appendix A

Definition of Full-Time Regular Employee

BWL policy as stated in the Employee Policies and Benefits Reference Handbook as of April 17, 2007 provides that a Full-Time Regular Employee is the following:

> A Full-Time Regular Employee is one who is hired on a full-time regular status and is receiving remuneration from the Employer for services rendered to the Employer or who would be remunerated except for an authorized leave of absence as a full-time employee under the Personnel Policy.
>
> Full-time means an active employee is regularly scheduled to work at least thirty (30) hours per week for the Employer. Full-time for work reduction and job sharing means an active employee is regularly scheduled to work at least twenty (20) hours per week.

This definition of Full-Time Regular Employee shall be updated automatically as the definition is revised from time to time by BWL and stated in the document named above.

Exhibit D
to
Executive Summary

Amendment to the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light (October 1, 2014)

[SEE ATTACHED]

AMENDMENT
TO THE
POST-RETIREMENT BENEFIT PLAN
FOR
ELIGIBLE EMPLOYEES OF LANSING BOARD OF WATER AND LIGHT

This Amendment is made this ____ day of _____, 2014, by the Lansing Board of Water and Light (the "BWL") to the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light (the "Plan").

WHEREAS, the BWL previously established the Plan to make certain health benefits available to qualifying retirees of the BWL; and

WHEREAS, the BWL desires to adopt an amendment to the Plan, effective as of October 1, 2014, except as otherwise provided.

NOW, THEREFORE, the BWL hereby adopts this amendment to the Plan, effective as of October 1, 2014, unless otherwise provided herein, as follows:

1. The Plan is amended by deleting the lead-in phrase of Section 1.h. and replacing it with the following:

"h. **'Early Retirement Date'** means the Employee's Normal Retirement Date as defined in subsection l. of this Section 1., below, but modified as follows:"

2. The Plan is amended by deleting Section 1.n. and replacing it with the following:

"n. **'Participant'** means an individual that qualifies and is eligible for benefits under this Plan, at the time of eligibility and qualification for benefits, pursuant to the remaining provisions of this Plan."

3. The Plan is amended by adding the following to the end of Section 2:

"Notwithstanding anything to the contrary contained herein, as a retiree health plan, no individuals shall be considered to be Participants in this Plan unless and until they qualify and are eligible for benefits pursuant to Sections 3, 5, or 6 of this Plan. Provisions of this Plan referencing employees, Employees, eligible employees shall be read in a consistent manner."

4. The Plan is amended by deleting Section 3.a.(1) and by replacing it with the following:

"(1) Coverage. Each eligible Participant will receive the health coverage as provided on the documentation attached hereto, and shall be responsible for all applicable deductibles, co-pays, and premium sharing amounts."

5. The Plan is amended by deleting the first two paragraphs of Section 3.a.(2) and by replacing them with the following:

"(2) Waiving Coverage. Any eligible Participant that produces written proof of alternative health and prescription drug coverage may elect to receive cash in lieu of participating in the employer sponsored health and prescription drug coverage. Such individuals shall be paid a monthly amount to be determined by the employer. Eligible individuals may waive health and prescription drug coverage separately; however, individuals are eligible to receive cash provided they waive both health and prescription drug coverage. Only Retirees are eligible for the cash in lieu benefit and no Spouses, Dependents or other beneficiaries shall be entitled to a cash in lieu benefit."

6. The Plan is amended by deleting the first sentence of Section 3.a.(3) only and replacing it with the following:

"(3) Duplicate Coverage. No Retiree shall be eligible to receive any health coverage under this Plan (or to elect any cash payment in lieu of health and prescription drug coverage under the Cash or HPD Cafeteria Plan) during any time when the Retiree's Spouse is eligible as a primary participant under the Employer-sponsored health and prescription drug plan."

7. The Plan is amended by deleting the second sentence of Section 3.b.(1) and adding the following to the end of that Section:

"The Retiree (and, as applicable, the Retiree's Spouse and Dependents) shall be responsible for all applicable deductibles, co-pays, and premium sharing amounts. This Plan may provide for a separate prescription drug benefit for individuals that qualify for such benefits under this Plan as Medicare-eligible from the benefit for those individuals that qualify for such benefits under this Plan that are not Medicare-eligible."

8. The Plan is amended by deleting the first sentence of Section 3.d. only and replacing it with the following:

"In general, each Retiree shall receive coverage under the Retiree Group Term Life Insurance Plan sponsored by the Employer and shall be responsible for all corresponding and applicable deductibles, copays and premium sharing amounts; additionally, (1) any individuals qualifying for life insurance benefits under this Plan will continue to be eligible for, and receive, such benefits only to the extent that they timely remit any applicable premium amounts, and (2) life insurance payouts shall be paid to the applicable beneficiary(ies) as soon as administratively feasible after the Retiree's death."

9. The Plan is amended by deleting the second and third paragraphs of Section 6 and replacing them with the following:

"Notwithstanding the preceding provisions of this Section 6, on and after January 1, 1997, a surviving Spouse need not be eligible for surviving spouse benefits under a pension plan sponsored by the Employer to be eligible for benefits under this Section 6."

10. The Plan is amended by adding the following provision to the end of Section 15:

"The benefits and coverages provided by this Plan are not vested and any termination of the Plan shall in no way cause any benefits to become vested."

11. The Plan is amended by adding a new Section 18 to the end thereof as follows:

"**Benefit Costs and Coverages**. Notwithstanding anything to the contrary contained herein, and subject to any applicable collective bargaining agreement, any individuals receiving benefits under this Plan will be subject to the cost structures, including premium contributions and sharing, that apply to active employees, and the Employer continues to reserve the right, in its sole discretion, and from time to time, to modify the cost structures of the Plan, as applicable to individuals receiving benefits under this Plan. This Plan does not guarantee any particular level of benefits or cost sharing amounts. Additionally, the Employer continues to reserve the right to change the underlying coverages provided by this or any other Plan, including the use of PPO, HMO, POS, or other coverages or networks. This Plan shall continue to be deemed a separate plan (including with this separate Plan document) from any health plan provided by the Employer to its active employees, notwithstanding that this Plan may track benefits from one or more other plans or arrangements sponsored by the Employer."

Except as altered and amended by this Amendment, the provisions of the Plan, as currently existing, are hereby ratified and confirmed.

IN WITNESS WHEREOF, the BWL has caused its name to be signed by its proper officer duly authorized to evidence the adoption of this Amendment on the date first set forth above.

Lansing Board of Water and Light

By:_____

Its:_____

Exhibit E
to
Executive Summary

Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light
(As Restated March 27, 2007)

[SEE ATTACHED]

POST-RETIREMENT BENEFIT PLAN
FOR ELIGIBLE EMPLOYEES OF
LANSING BOARD OF WATER AND LIGHT

March 27, 2007

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POST-RETIREMENT BENEFIT PLAN
FOR ELIGIBLE EMPLOYEES OF
LANSING BOARD OF WATER AND LIGHT

Lansing Board of Water and Light established the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light effective July 1, 1999. The Retiree Benefit Plan is hereby restated effective March 27, 2007, as set forth herein, for the benefit of eligible employees and former employees of the Employer. It is intended that this Plan meet the requirements of Code Sections 79, 105 and 106 so that the Employer's contributions on behalf of participating employees and former employees will be excluded from gross income for federal income tax purposes and so that noncash benefits paid under the Plan will be excluded from gross income.

1. Definitions.

a. **"Benefit Commencement Date"** means the first day of the calendar month on or after the Original Effective Date which follows any of (1), (2), (3) or (4) below:

(1) the date on which the Employee reaches his or her Normal Retirement Date;

(2) the date on which the Employee reaches his or her Early Retirement Date;

(3) the date on which the Employee reaches his or her Disability Retirement Date; or

(4) the date of the Employee's death.

b. **"Benefit Service Credit"** means:

(1) An Employee will receive Benefit Service Credit for any period during which the Employee performs the duties of his or her position for the Board.

(2) An Employee will receive Benefit Service Credit for any period of Disability for which the employee receives any sick leave or paid time off payments, or for which he or she is on an approved workers' compensation leave of absence.

(3) This subsection (3) applies to any individual who takes a leave of absence from active employment with the Board for the purpose of completing service in the Uniformed Services of the United States of America. It only applies to an individual who (i) meets the requirements described below for providing advance notice of the impending leave; (ii) is on said leave for not more than five (5) years; (iii) is discharged or terminates his or her Uniformed Service under honorable conditions; (iv) reapplies for reemployment with the Board within the time frame described below; and (v) is reemployed by the Board. Any individual who meets these requirements will receive Benefit Service Credit for his or her period of Uniformed Service in accordance with this Plan and relevant law.

(a) Uniformed Services. The Uniformed Services include the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training, or full-time National Guard duty), and the commissioned corps of the Public Health Service. Other categories of covered service may be added by the President in limited circumstances.

(b) Advance Notice of Impending Leave. The Board must receive written or verbal advance notice of the impending Uniformed Service from the employee or the appropriate officer of the Uniformed Service in which the service is to occur. This notice requirement is waived where required by applicable law.

(c) Applying for Reemployment. In general, the individual must report back to the Board for work or apply for reemployment in a manner consistent with this subsection (c).

(i) Uniformed Service of less than 31 days. Notice must be given of the individual's readiness to return to work not later than the beginning of the first full regular scheduled work period of service that starts at least eight hours after the person has been safely transported home from the place of Uniformed Service, or as soon as possible after the eight hour period if reporting by that time is impossible or unreasonable through no fault of the individual.

(ii) Uniformed Service of more than 31 days but less than 181 days. Any individual in this category must submit an application for reemployment or present himself or herself for work not later than 14 days after completing their Uniformed Service or, if meeting this deadline is impossible or unreasonable through no fault of the individual, then on the next calendar day when submission becomes possible.

(iii) Uniformed Service of more than 180 days. The individual must submit the application for reemployment or present himself or herself for work not later than 90 days after completion of the Uniformed Service.

The foregoing provisions shall be interpreted in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and Code Section 414(u), and any amendments thereto.

(4) An Employee who is hired prior to January 1, 1997, will receive Benefit Service Credit for any period of active military duty prior to employment for which the Employee is not otherwise entitled to such credit under subsection (3) above, but only to the extent of 50%

of the period of active military duty. A "period of active duty" for this purpose means active duty with any of the armed forces of the United States, under honorable conditions. Periods of active duty of less than thirty (30) days and periods of active duty for training regardless of length are not "periods of active duty" for this purpose. With proper documentation, one-half (50%) of such service is Benefit Service Credit up to a maximum of two (2) years. This provision shall be applied in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and Internal Revenue Code Section 414(u).

(5) An Employee hired prior to July 1, 1997 will receive Benefit Service Credit for any period during which the Employee works full-time for any department of the City of Lansing.

(6) When determining an Employee's Benefit Service Credit, lost time due to leave of absence, sickness or accident is not included in the determination of whether a break in service has occurred. However, Benefit Service Credit will not accrue for any leave of absence (whether or not approved), subject to Board leave of absence policy. Benefit Service Credit also does not accrue for unpaid absences of any kind over 80 hours per year. If an Employee terminates employment during a leave of absence, or other absence due to sickness or accident, the applicable provisions of this Plan will apply to such termination.

(7) In addition to the foregoing, an Employee will have previously earned Benefit Service Credit reinstated as described below.

(a) If the Participant was an Employee of the Employer on June 30, 1987 and lost Benefit Service Credit prior to June 30, 1987 as a result of a prior termination of employment, the Benefit Service Credit that was lost under those circumstances will be reinstated as of July 1, 1987;

(b) Under certain circumstances, an Employee who received a lump sum distribution from the Pension Plan on termination of employment may be entitled to repay that lump sum to the Pension Plan on reemployment. If the Employee is eligible to make such a repayment and elects to repay the lump sum on reemployment, the Employee will have his or her prior Benefit Service Credit reinstated.

(c) All years of Benefit Service Credit earned prior to employment termination with the Employer will be reinstated upon reparticipation in this Plan if the individual is reemployed by the Employer within 365 days following said termination of employment; and

(d) In the case of a Participant who is reemployed by the Employer more than 365 days after employment termination with the Employer, all years of Benefit Service Credit which the Participant had earned prior to said employment termination will be reinstated upon reparticipation in this Plan if:

(i) the individual had at least three (3) years of Benefit Service Credit on said employment termination; or

(ii) the Break in Service was shorter than the individual's years of Benefit Service Credit which accumulated prior to the Break in Service.

c. **"Break in Service"** means the Participant terminated employment with the Employer on or after the Original Effective Date and is subsequently reemployed by the Employer.

d. **"Code" or "Internal Revenue Code"** means the Internal Revenue Code of 1986, as amended from time to time.

e. **"Dependent"** means any individual who satisfies the definition of "dependent" under the Employer's group health plan and who is:

(1) a dependent as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and

(2) any child to whom Code Section 152(e) applies (regarding, for example, a child of divorced parents, where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents.

f. **"Disability"** means a physical or mental impairment resulting from a bodily injury, disease or mental disorder which substantially limits an Employee's ability to perform the essential functions of a job. This limitation must be certified by a physician or vocational expert of the Employer's choice.

g. **"Disability Retirement Date"** means the date the Employee is determined to be Disabled, provided the Employee has completed at least ten (10) Years of Service as of the Disability determination date.

h. **"Early Retirement Date"** means the Employee's Normal Retirement Date defined in Section 1.h. below, modified as follows:

(1) The date that is ten (10) consecutive years immediately preceding his or her Normal Retirement Date, provided the Employee has completed at least twenty-five (25) Years of Benefit Service Credit as of the date of his or her Separation From Service; or

(2) The date that is five (5) consecutive years immediately preceding his or her Normal Retirement Date, provided the Employee has completed at least fifteen (15) Years of Benefit Service Credit as of the date of his or her Separation From Service.

i. **"Effective Date"** means March 27, 2007, the effective date of this restated Plan.

j. **"Employee"** means an individual who is classified by the Employer as a regular full-time employee.

k. **"Employer"** or **"Board"** means the Lansing Board of Water and Light.

l. **"Normal Retirement Date"** means the later of the date on which the individual has incurred a Separation From Service and all of the following of subsection (1) or (2) below are true as to the individual:

(1) the individual was most recently hired by the Employer after June 30, 1990 and has attained age sixty-five (65) and completed at least ten (10) years of Benefit Service Credit.

(2) the individual was most recently hired by the Employer before July 1, 1990, and has satisfied the earliest of the following:

(a) has attained age sixty (60) and completed at least ten (10) Years of Benefit Service Credit;

(b) has attained age fifty-five (55) and completed at least thirty (30) years of Benefit Service Credit, or

(c) in the case of any individual who has incurred a Separation From Service after attaining age forty-five (45) and completing at least twenty-five (25) years of Benefit Service Credit, on or after the date on which the individual has attained age fifty-five (55) and would have completed at least thirty (30) years of Benefit Service Credit if he or she had remained continuously employed by the Employer as a regular full-time employee after his or her most recent Separation From Service with the Employer.

m. **Original Effective Date** means July 1, 1999.

n. **"Participant"** means an Employee who participates in the Plan in accordance with Section 2.

o. **"Pension Plan"** means the Lansing Board of Water and Light Defined Benefit Plan for Employees' Pensions.

p. **"Plan"** or **"Retiree Benefit Plan"** means the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light.

q. **"Plan Administrator"** means the Board of Water and Light.

r. **"Plan Year"** means the consecutive 12-month period beginning on July 1 and ending on June 30.

s. **"Retiree"** means a former Employee of the Employer who (1) has reached his or her Normal Retirement Date or Early Retirement Date or is determined to be Disabled and (2) is eligible for a benefit under this Retiree Benefit Plan.

t. **"Separation From Service"** means Employee's complete severance of employment with the Employer, whether on account of the Employee's death, Disability or termination of employment and whether voluntary or involuntary.

u. **"Service"** means:

(1) Service includes any period an Employee performs the duties of his or her position for the Board and any period of Disability for which an employee receives any pay from the Board or is on an approved workers' compensation leave of absence.

(2) This subsection (2) applies to any individual who takes a leave of absence from active employment with the Board for the purpose of completing service in the Uniformed Services of the United States of America. It only applies to an individual who (i) meets the requirements described below for providing advance notice of the impending leave; (ii) is on said

leave for not more than five (5) years; (iii) is discharged or terminates his or her Uniformed Service under honorable conditions; (iv) reapplies for reemployment with the Board within the time frame described below; and (v) is reemployed by the Board. (In the case of any individual who meets these requirements, Service includes his or her period of Uniformed Service in accordance with this Plan and relevant law.)

(a) Uniformed Services. The Uniformed Services include the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training, or full-time National Guard duty), and the commissioned corps of the Public Health Service. Other categories of covered service may be added by the President in limited circumstances.

(b) Advance Notice of Impending Leave. The Board must receive written or verbal advance notice of the impending Uniformed Service from the individual or the appropriate officer of the Uniformed Service in which the service is to occur. This notice requirements is waived where required by applicable law.

(c) Applying for Reemployment. In general, the individual must report back to the Board for work or apply for reemployment in a manner consistent with this subsection (c).

(i) Uniformed Service of less than 31 days. Notice must be given of the individual's readiness to return to work not later than the beginning of the first full regular scheduled work period of service that starts at least eight hours after the person has been safely transported home from the place of Uniformed Service, or as soon as possible after the eight hour period if reporting by that time is impossible or unreasonable through no fault of the individual.

(ii) Uniformed Service of more than 31 days but less than 181 days. Any individual in this category must submit an application for reemployment or present himself or herself for work not later than 14 days after completing his or her Uniformed Service or, if meeting this deadline is impossible or unreasonable through no fault of the individual, then on the next calendar day when submission becomes possible.

(iii) Uniformed Service of more than 180 days. The individual must submit the application for reemployment or present himself or herself for work not later than 90 days after completion of the Uniformed Service.

The foregoing provisions shall be interpreted in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and Code Section 414(u), and any amendments thereto.

v. **"Spouse"** means the person who is legally married to the Retiree, or if applicable, the Employee (as determined under state law) on and/or after the Retiree's or Employee's Benefit Commencement Date and who is treated as a spouse under the Code; provided, however, the term "spouse" shall not include a person legally separated from the Retiree or Employee under a divorce or separate maintenance decree.

w. **"Trust Agreement"** means the Lansing Board of Water and Light Retiree Benefit Plan and Trust Agreement.

x. **"Trust"** means the trust created by the Board of Water and Light pursuant to the terms of the Trust Agreement. The Trust shall be operated so as to be exempt from tax under Internal Revenue Code Section 501(c)(9).

y. **"Union Employee"** means the terms of the individual's employment are governed by a collective bargaining agreement between the Employer and union representatives.

z. **"Years of Service"** means the Service calculated and based on each 12-month anniversary of the Employee's most recent date of hire by the Employer. Any Employee who performs Service for the Employer as a full-time regular employee (as defined in the Employer's personnel policies) throughout any such consecutive 12-month period is credited with one Year of Service. Any Employee who performs Service for the Employer as a full-time regular employee (as determined under the Employer's personnel policies) for only a portion of any such consecutive 12-month period will be credited with a ratable portion of one Year of Service calculated in accordance with administrative procedures adopted and uniformly applied by the Plan. Years of Service are earned for all periods of employment with the Employer in accordance with administrative procedures adopted and uniformly applied by the Plan.

2. Eligibility to Participate. Each individual who is a Participant in the Plan on the Effective Date of this restated Plan shall continue to participate in the restated Plan. Any other individual who becomes an Employee of the Employer on or after the Effective Date shall participate in the Plan as of his or her date of hire. No other individual is eligible to participate in the Plan.

Subject to the applicable law, participation in the Plan shall terminate on the first to occur of:

(1) the date of the Participant's Separation From Service before becoming eligible for benefits payable under the Plan;

(2) the date on which the individual is no longer eligible to participate in the Plan in accordance with Article 2; and

(3) the date on which the Plan is terminated.

3. **Eligibility for Benefits**. Each Retiree (and as applicable, the Retiree's Spouse and Dependents) shall be eligible to receive the benefits described in this Section 3 beginning on and after the Retiree's Benefit Commencement Date.

a. Health Coverage. The health coverage provided under this Plan shall, in the discretion of the Employer, be substantially the same coverage (based on the cost per Retiree to the Employer for providing said health coverage) made available to active Employees.

(1) Coverage. Each Retiree (and, as applicable, the Retiree's Spouse and Dependents) shall receive health coverage under the Employer's health plan, a copy of which is available upon request. The Retiree (and, as applicable, the Retiree's Spouse and Dependents) shall be responsible for applicable deductibles and co-pays, but shall not participate in premium sharing.

(2) Waiving Health and Prescription Drug Coverage. A Retiree may elect to make separate waivers under this Plan of health and/or prescription drug coverage and receive any such coverage not waived.

Any Retiree who (i) is eligible for Employer provided health coverage and prescription drug coverage and (ii) provides written proof, to the satisfaction of the Employer, that the Retiree is currently enrolled in alternative health coverage which is similar to the Employer provided health coverage, from a source other than the Employer will be eligible to participate in the Employer's Code Section 125 Cafeteria Plan B: Cash or Health/Prescription Drug Election (the "Cash or HPD Cafeteria Plan"). Said Retiree may annually receive a cash benefit under the Cash or HPD Cafeteria Plan (and not under this Plan) in lieu of the Employer sponsored health coverage plan and the Employer sponsored prescription drug coverage plan described in this subsection a. and subsection b. below. A Retiree must waive both the health

coverage and the prescription drug coverage to elect the cash benefit under the Cash or HPD Cafeteria Plan.

Notwithstanding the foregoing, on the day following the date the Retiree loses alternative health coverage or otherwise becomes ineligible to participate in the Cash or HPD Cafeteria Plan, the Retiree (and if applicable, the Retiree's Spouse and Dependents) shall resume participation in the health and prescription drug coverage described in this subsection a. and subsection b. below, provided the Retiree is otherwise eligible for said coverage under this Retiree Benefit Plan.

(3) Duplicate Coverage. No Retiree shall be eligible to receive any health coverage under this Plan (or to elect any cash payment in lieu of health and prescription drug coverage under the Cash or HPD Cafeteria Plan) during any time when the Retiree's Spouse is eligible as a primary participant under the Employer sponsored health plan for active employees. Health coverage offered under this Retiree Benefit Plan shall commence (or if applicable, recommence) on the day following the date the Spouse is no longer eligible as a primary participant under the Employer sponsored health plan for active employees.

(4) Each Retiree and his or her Spouse (or surviving Spouse as the case may be) must sign up for Medicare Parts A, B and, pursuant to the Employer's administrative policy, Part D at the earlier of attainment of age sixty-five (65) or the earliest date the individual becomes eligible for Medicare Parts A, B and, if applicable, Part D to remain eligible for health and prescription drug coverage under this Plan. As soon as administratively possible following the date the Employer receives documentation evidencing that the Retiree or Spouse or both, or the surviving Spouse (as the case may be) have enrolled in Medicare Parts A, B and, if applicable, Part D, the Employer shall substitute health and prescription drug coverage for the

Retiree or Spouse or both, or the surviving Spouse (as the case may be) under a complementary health and prescription drug program that supplements Medicare. Such complementary coverage shall not be available if the Retiree (i) is not eligible for health coverage under this Plan or (ii) has waived health and prescription drug coverage as described in Section 3.a.(2) above and elected a cash benefit under the Cash or HPD Cafeteria Plan.

The Employer shall also make reimbursement to the Retiree and/or the Retiree's Spouse or, if applicable, to the surviving Spouse toward the cost of Medicare Part B coverage. Such reimbursement shall equal 90% of the cost of the applicable Medicare coverage.

b. Prescription Drug Coverage. The prescription drug coverage provided under this Plan shall, in the discretion of the Employer, be substantially the same coverage (based on the cost per Retiree to the Employer for providing said prescription drug coverage) made available to active Employees.

(1) Coverage. Each Retiree (and, as applicable, the Retiree's Spouse and Dependents) shall receive prescription drug coverage under the Employer's prescription drug plan, a copy of which is attached hereto. The Retiree (and, as applicable, the Retiree's Spouse and Dependents) shall be responsible for applicable deductibles and co-pays, but shall not participate in premium sharing.

(2) Duplicate Coverage. No Retiree shall receive any prescription drug coverage benefit under this Plan during any time when the Retiree's Spouse is eligible as a primary participant under the Employer sponsored prescription drug plan for active employees. Prescription drug benefits offered under the Retiree Benefit Plan shall commence (or, if applicable, recommence) on the day following the date the Spouse is no longer eligible as a primary participant under the Employer sponsored prescription drug plan for active employees.

c. Dental Coverage.

(1) Coverage. Each Retiree (and, as applicable, the Retiree's Spouse and Dependents) shall receive dental coverage under the Employer's dental plan, a copy of which is attached hereto. The Retiree (and, as applicable, the Retiree's Spouse and Dependents) shall be responsible for applicable deductibles and co-pays, but shall not participate in premium sharing.

(2) Duplicate Coverage. No Retiree shall receive any dental coverage benefit under this Plan during any time when the Retiree's Spouse is eligible as a primary participant under the Employer sponsored dental plan for active employees. Dental benefits offered under the Retiree Benefit plan shall commence (or if applicable, recommence) on the day following the date the Spouse is no longer eligible as a primary participant under the Employer sponsored dental Plan for active employees.

d. Life Insurance.

In general, each Retiree shall receive coverage under the Retiree Group Term Life Insurance Plan, a copy of which is attached hereto. No Spouse or Dependent of any Retiree shall receive coverage under the Retiree Group Term Life Insurance Plan. Notwithstanding the foregoing, no Retiree Group Term Life Insurance Plan coverage shall be extended to any Retiree who was receiving $10,000 coverage under that Life Insurance Plan on the day before his or her Separation From Service which caused him or her to be eligible for benefits hereunder pursuant to Section 2 above.

Any Employee who carried life insurance coverage through the Lansing Board of Water and Light equal to 1½ times his or her salary rounded up to the next highest $1,000 immediately prior to retirement may continue such coverage following retirement at one-third (⅓) of that pre-retirement amount rounded to the next higher $500. Each Retiree who is a former

Union Employee and who receives coverage under this Section 3.d. shall pay fifty percent (50%) of the premium cost for that life insurance coverage and shall continue to receive benefits so long as the Retiree continues to pay the applicable premiums.

4. **Funding Benefits** Benefits provided pursuant to this Retiree Benefit Plan may, in the Employer's discretion, be funded through any or all of the Trust Agreement, the Pension Plan and the general assets of the Employer; provided, however, with regard to any Plan Year in which a qualified transfer is made under Code Section 420 to a Code Section 401(h) account under the Pension Plan, health benefits shall be paid from said Pension Plan before any payments for health coverage are made by the Trust.

5. **Disability Benefits** Any Employee who has been credited with at least ten (10) Years of Service under the Plan and is determined to be Disabled shall be eligible for the benefits described in Section 3 above beginning on and after the Employee's Benefit Commencement Date.

6. **Death Benefits** In general, no death benefit shall be paid from the Plan for any person based on the Employee's participation in the Plan. However, following the demise of a Retiree or an Employee who has completed at least ten (10) Years of Service with the Employer as of the date of death, the Retiree's, or if applicable, the Employee's surviving Spouse and Dependents shall be eligible for health, prescription drug and dental coverage as described in Section 3 above; provided, however, the surviving Spouse will be eligible for said benefits only if the surviving Spouse is eligible for surviving spouse benefits under any pension plan sponsored by the Employer. Said coverage shall commence on the Retiree's, or if applicable, Employee's Benefit Commencement Date and shall continue for the life of the surviving Spouse and, in the

case of the Dependent, for as long as the individual remains an eligible Dependent under the Plan.

If the surviving Spouse is not eligible for surviving spouse coverage under any pension plan maintained by the Employer, subject to applicable law, coverage for the surviving Spouse under this Plan shall cease on the last day of the month following the date of the Retiree's death.

In addition to the foregoing, if an eligible surviving Spouse remarries, the subsequent spouse of the surviving Spouse shall be eligible for Spouse benefits under this Plan.

7. **Vesting** No benefit provided under this Plan is wholly or partially vested under any circumstance, either before or after commencement of any benefit payable under the Retiree Benefit Plan. Subject to the requirements of any collective bargaining agreement, the Employer reserves the right, in its sole discretion, to reduce or eliminate any or all Plan benefits at any time as to any or all Plan Participants, Retirees and/or their eligible Spouses, surviving Spouses and/or Dependents.

8. **Claims**. Claims for benefits under the Plan must be made to the Plan Administrator in writing by the claimant or the claimant's authorized representative on forms supplied by the Plan Administrator (or other designated claims representative). Claims must be submitted to the Plan Administrator in the manner described in the Plan's Summary Plan Description. Benefits under the Plan will be paid only if the Plan Administrator in its sole discretion determines that the claimant is entitled to them. The Plan Administrator has sole and exclusive discretionary authority to construe and interpret the provisions of the Plan, make factual determinations and will decide all questions of eligibility and the amount, manner and time of any benefit payment as described in the Plan.

9. **HIPAA Privacy Compliance**. This Section 9 is added to comply with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and its corresponding regulations related to the privacy of protected health information as applied to the health, dental and prescription drug benefits offered under the Plan and the related security requirements.

a. Definitions.

(1) Health Care Operations include activities undertaken by the Plan related to treatment and payment including, but not limited to, the following activities: quality assessment, activities relating to improving health or reducing health care costs, case management and care coordination, contacting health care providers, and resolution of internal grievances.

(2) Payment includes activities undertaken by the Plan to fulfill its responsibility for coverage and provision of Plan benefits that relate to a Participant to whom health care is provided.

(3) Plan Administration means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing and monitoring. Plan Administration does not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and it does not include any employment-related functions.

(4) Plan Sponsor means the Lansing Board of Water and Light.

(5) Protected Health Information ("PHI") means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant,

or there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of Participants either living or deceased.

b. Disclosure of PHI for Plan Administration Purposes. Unless otherwise permitted or required by law, and subject to the conditions of disclosure in paragraph c., below, the Plan may disclose PHI to the Plan Sponsor provided that the Plan Sponsor uses or discloses such PHI only for Plan Administration purposes.

c. Disclosure to Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor only upon certification by the Plan Sponsor that the Plan documents have been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and only after the Plan Sponsor has agreed to:

(1) not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

(2) ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI and agree to implement reasonable and appropriate security measures to protect the information;

(3) not use or disclose PHI for employment-related actions and decisions unless authorized by a Participant;

(4) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by a Participant;

(5) report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware and any security incident of which it becomes aware;

(6) make PHI available to an individual in accordance with HIPAA's access requirements;

(7) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(8) make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(9) make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;

(10) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);

(11) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the group health plan; and

(12) Ensure that the adequate separation required by the provisions of 45 CFR § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

d. Adequate Separation Between the Plan and the Plan Sponsor. To ensure adequate separation between the Plan and the Plan Sponsor, the Plan Sponsor shall allow only the following individuals access to PHI:

(1) HIPAA Compliance Officer; and

(2) staff designated by the HIPAA Compliance Officer.

No other individuals shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan Administration functions that the Plan Sponsor performs for the Plan.

e. Noncompliance Issues. If the employees described in paragraph (d), above, do not comply with the provisions of this HIPAA Privacy Compliance Section of the Plan, those employees shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

10. Payment of Administrative Expenses. All reasonable Plan and Trust administration expenses including, but not limited to, administrative fees and expenses owing to any third party administrative service provider, consultant, accountant, attorney, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration of the Plan and Trust, shall be paid by the Trustees from the Trust assets.

11. Right of Reimbursement The Retiree, Spouse (including a surviving Spouse) and/or Dependents (as applicable) must reimburse the Plan for overpayments by the Plan or payments made by the Plan that are also covered by another group health plan, a government program that is not secondary to the Plan under state or federal law, or a statutory plan such as workers compensation.

If the Plan pays benefits to the Retiree, Spouse or Dependents for covered Plan services, the Plan will have an equitable lien on the amounts it has paid and the Retiree, or any person or organization that received payment for services to the Retiree, Spouse or Dependent, must reimburse the Plan for those benefits. Such lien will apply and reimbursement will be required where any of these conditions exist:

- The Retiree did not pay for the services;
- The services did not legally have to be paid;
- The Plan's payments exceeded the Plan's benefit limits;

In the case of (i) an overpayment by the Plan, or (ii) payment of benefits for which the Retiree did not pay, or (iii) payment of benefits for services for which the Retiree was not legally obligated to pay or (iv) payment of benefits in excess of the Plan's benefits limits, the amount of the Retiree's reimbursement obligation will be the amount the Plan paid less what the Plan should have paid.

If the refund is due from another person or entity (e.g., a hospital), the Retiree, Spouse and/or Dependents must assist the Plan in obtaining the refund.

If the Plan does not promptly receive the full refund due it, the Plan Administrator may, in the Administrator's discretion, withhold payment of future benefits until the refund has been made, or take other actions necessary to recover the refund.

12. **Right of Subrogation and Equitable Lien** If the Retiree, Spouse (including a surviving Spouse) or Dependent suffers an injury or illness caused by the negligence or wrongdoing of a third party, the Plan shall have the right of subrogation and shall have an equitable lien on the recovery for that injury or sickness. That means that the Plan may recover from the Retiree, Spouse or Dependents any recovery the Retiree, Spouse or Dependents may receive from that

third party through judgment, settlement or otherwise (however it is characterized) and may recover that amount from the Retiree or dependents, up to the amount that the Plan pays the Retiree, Spouse or Dependents for covered services. The Plan's recovery from the Retiree, Spouse or Dependents will not be reduced to reflect any of the Retiree's, Spouse's or Dependent's litigation costs or attorney fees, unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion.

Additionally, the Plan shall have an equitable lien on any recovery the Retiree or dependent may receive from any third party for any sickness or injury for which the Plan pays benefits. The equitable lien applies also to workers compensation payments where the Plan has paid otherwise eligible benefits prior to a determination that such benefits are due. Payment by a workers compensation carrier or the Employer will mean that such determination has been made. The Plan's equitable lien will attach to the first right of recovery to any money or property that is obtained by anyone (including, but not limited to the Retiree, Retiree's beneficiary, legal counsel and/or a trust) as a result of an exercise of the Retiree's, Spouse's or Dependent's rights of recovery against any third party. The Plan will be entitled to seek any other equitable remedy against any party possessing or controlling such funds or properties. At the sole discretion of the Plan Administrator, the Plan may reduce any future benefits for covered services otherwise available to the covered person under the Plan by an amount up to the total reimbursable amount that is subject to enforcement under the equitable lien.

13. **No Employment Contract**. This Plan shall not be deemed to constitute a contract between the Employer and any Employee or to be a consideration or an inducement for the employment of any Employee. Nothing contained in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of

the Employer to discharge any Employee at any time regardless of the effect which such discharge shall have upon him or her as a participant in this Plan.

14. **Exclusive Benefit**. The rights of Employees and Retirees under the Plan are hereby acknowledged to be legally enforceable. Except as may be permitted under applicable law, the Plan is maintained for the exclusive benefit of Employees and Retirees.

15. **Plan Amendment and Termination**. Subject to the terms of any collective bargaining agreement, the Employer reserves the right, in its sole discretion, to make from time to time any amendment or amendments to this Plan by action of its governing Board. Subject to the requirements of any collective bargaining agreement, the Employer may, in its sole discretion, terminate the Plan at any time. Plan termination shall not cause nonvested benefits to become vested.

16. **Successor Employer, Merger or Consolidation** In the event of the dissolution, merger, consolidation or reorganization of the Employer, provision may be made by which this Plan will be continued by the successor; and, in that event, such successor shall be substituted for the Employer under the Plan. The substitution of the successor shall constitute an assumption of all obligations under the Plan by the successor, and the successor shall have all the powers, duties and responsibilities of the Employer under the Plan.

17. **Application of State Law** Subject to applicable law, this Plan, as amended from time to time, shall be administered, construed and enforced according to the laws of the State of Michigan and in courts situated in that State.

LANSING BOARD OF WATER AND LIGHT

Date: June 5, 2007 By: _____
Chair, Board of Commissioners

Date: June 5, 2007 By: _____
Corporate Secretary

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Proposed Resolution
To Amend Employer Contribution to
Medical Benefit Plans

WHEREAS, Governor Rick Snyder, on September 27, 2011, signed legislation known as the "Public Funded Health Insurance Contribution Act", Public Act 152 of 2011 limiting the amount public employers may pay for government employee medical benefits, and;

WHEREAS, Public Act 152 of 2011 took effect January 1, 2012 and applies to all public employers including the Lansing Board of Water & Light, and;

WHEREAS, Public Act 152 of 2011 created a "hard cap" for medical benefit plan coverage year beginning January 1, 2012, so that a public employer may not pay more of the annual costs for medical benefit plans than a total equal to $5,857.58 for single person coverage, $12,250 for individual and spouse coverage, and $15,975.23 for family coverage adjusted October 1, 2014. These caps are to be adjusted by October 1 each year to apply to the following calendar year, based on the change in the medical care component of the United States consumer price index (CPI), and;

WHEREAS, by a majority vote of its governing body, a public employer may opt-out of the hard cap and into an 80% cap option where the public employer may not pay more than 80% of the total annual costs of all the medical benefit plans for its employees, and;
Whereas, by a 2/3 vote of its governing body each year, a local unit of government may exempt itself from the requirements of Public Act 152 of 2011 for the next year, and;

WHEREAS, the Board of Commissioners met on July 24th 2012 and passed a resolution (#2012-07-01) to exempt itself from the requirements of Public Act 152 of 2011 and implemented a 10% premium sharing, and;

WHEREAS, the Board of Commissioners met on July 23rd 2013 and passed a resolution (#2013-07-02) to exempt itself from the requirements of Public Act 152 of 2011 and implemented a 12% premium sharing, and;

RESOLVE that the Board by at least 2/3 vote desires to exempt itself from the requirements of Public Act of 2011 for the upcoming benefit plan year, effective January 1, 2015.

FURTHER RESOVE that the Board desires to implement a 12 % premium sharing for all active employees for medical benefits effective January 1, 2015.

Public Employer Contributions to Medical Benefit Plans

HR Committee Meeting
September 2014

LANSING BWL
Hometown People. Hometown Power.

Public Act 152 – Publicly Funded Health Insurance Contribution Act

- Adopted by the Legislature and signed into law by the Governor as Act 152 of 2011
- The Act caps the amount a public employer, including municipal utility systems, may pay for employee health care insurance.
- Required BWL employees to be responsible for a larger portion of their health care cost after September 1, 2012

Public Act 152, 2011

- The BWL has three options:
  - Comply with PA 152 and limit expenditures on health care cost based on a schedule of dollars provided in the Act; or
  - Limit expenditures on health care cost based on a 80/20 percentage split, requiring a majority vote; or
  - Exempt itself entirely from the Act, requiring a 2/3 vote

Board Resolution #2012-07-01

- The Board approved to exempt itself from the requirements of Public Act 152 of 2011 for the next year and implemented a 10% premium sharing
- Required a 2/3 vote to pass

Board Resolution #2013-7-02

- The Board approved to exempt itself from the requirements of Public Act 152 of 2011 for the next year and implemented a 12% premium sharing
- Required a 2/3 vote to pass

Increase Employee Cost Per Pay Period if Hard Cap Requirement of Act 152 is Implemented.

Act 152 - Hard Cap Requirement

Benefit Plan	Current Annual Benefit Cost	Act 152 Required Cap	Difference	Per Pay Period Required Payments Current 12%	Hard Cap	Increase
Single	$ 7,887.84	$ 5,857.58	$ 2,030.26	$ 36.40	$ 78.09	$ 41.69
Empl +1	$ 17,747.64	$ 12,250.00	$ 5,497.64	$ 81.92	$ 211.45	$ 129.53
Family	$ 22,086.00	$ 15,975.23	$ 6,110.77	$ 101.94	$ 235.03	$ 133.09

Increase Employee Cost Per Pay Period if 80/20 Cap is Implemented

Benefit Plan	Annual Benefit Cost	Employee Share 20%	Per Pay Period Required Payments Current 12%	80/20 Cap	Increase
Single	$ 7,887.84	$ 1,577.57	$ 36.40	$ 60.68	$ 24.28
Empl +1	$ 17,747.64	$ 3,549.53	$ 81.92	$ 136.52	$ 54.60
Family	$ 22,086.00	$ 4,417.20	$ 101.94	$ 169.89	$ 67.95

Alternatives Utilizing Option 3 to Opt-Out of Act 152, 2011 – Various Premium Sharing Options

Benefit Plan	Annual Benefit Cost	Per Pay Period* Current 12%	15%	18%	20%
Single	$ 7,887.84	$ 36.40	$ 45.51	$ 54.61	$ 60.68
Empl +1	$ 17,747.64	$ 81.92	$ 102.39	$ 122.87	$ 136.52
Family	$ 22,086.00	$ 101.94	$ 127.42	$ 152.90	$ 169.89

* For every 1% increase in the premium sharing percentage the per pay amount is increased by $3.04 for Single Coverage, $6.82 for Empl +1 and $8.49 for Family Coverage