HUMAN RESOURCES COMMITTEE MEETING
AGENDA

January 19, 2016

5:30 P.M. – 1201 S. Washington Ave.
Lansing, MI - REO Town Depot
Board of Water & Light Headquarters

Call to Order

Roll Call

Public Comments on Agenda Items

1. Human Resources Committee Meeting Minutes of 11/10/15……**TAB 1**

2. Pension Plan Compliance Updates (Executive Summary): ……..**TAB 2**

   a) Cafeteria Plan
   b) Post-Retirement Benefit Plan

3. Amendments to the Cafeteria Plan and Post-Retirement Benefit Plan Resolution……**TAB 3**

4. Other

Adjourn

HUMAN RESOURCESS COMMITTEE

November 10, 2015

The Human Resources Committee of the Lansing Board of Water and Light (BWL) met at the BWL Headquarters-REO Town Depot located at 1201 S. Washington Ave., Lansing, MI, at 5:30 p.m. on Tuesday, November 10, 2015.

Human Resources (HR) Committee Chairperson Tony Mullen called the meeting to order and asked the Corporate Secretary to call the roll. The following members were present: Commissioners Tony Mullen, Mark Alley, Sandra Zerkle, and Alternate Member Dennis M. Louney. Also present: Commissioners David Price, Ken Ross, Non-Voting Commissioners Mike Froh (Meridian Township), Bill Long (Delta Township) and Robert Nelson (E. Lansing).

Absent: Commissioner Anthony McCloud.

Public Comments

None

Approval of Minutes

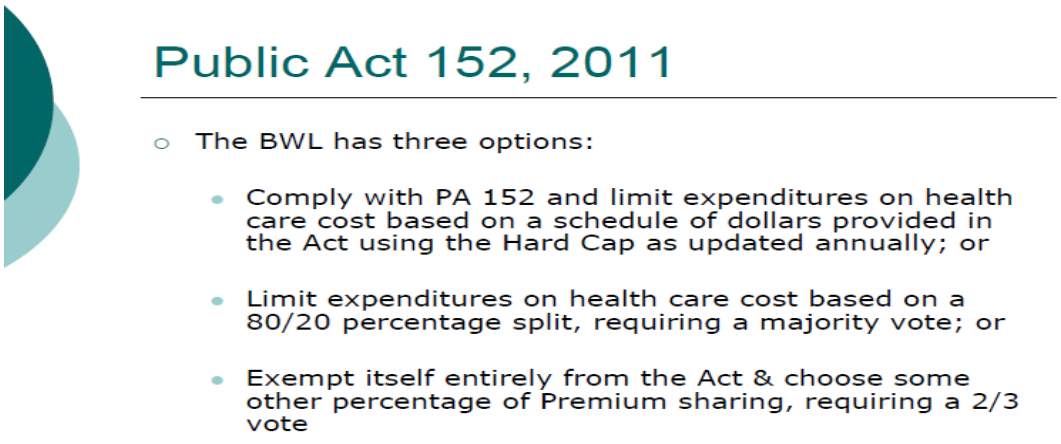
Motion by Commissioner Zerkle, Seconded by Commissioner Alley, to approve the Human Resources Committee meeting minutes of September 15, 2015.

Action: Motion Carried.

PA 152/Employee Contribution to Medical Benefit Plan Resolution

HR Committee Chairperson Tony Mullen introduced Michael Flowers, Executive Director of Human Resources and Heather Shawa-DeCook, Chief Financial Officer, who gave a presentation on the Employee Contribution to Medical Benefit Plan.

Mr. Flowers discussed three options for the BWL to remain compliant under PA 152, 2011.



There was an extensive discussion regarding the Employee Contribution to a Medical Benefit Plan. The Administration presented a proposed Resolution and asked that the Committee forward the Resolution to the full Board for consideration.

Proposed Resolution
To Amend Employee 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 years beginning January 1, 2012, such that a public employer may not pay more than the statutory caps for medical benefit plans, 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 24, 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 23, 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;

WHEREAS, the Board of Commissioners met on September 23, 2014 and passed a resolution (#2014-09-03) to exempt itself from the requirements of Public Act 152 of 2011 and kept the 12% premium sharing, and;

WHEREAS, the Board of Commissioners met on July 28, 2015 and passed a resolution (#2015-07-12) to exempt itself from the requirements of Public Act 152 of 2011 and kept the 12% premium sharing through December 31, 2015, and;

Resolved that the Board by at least 2/3 vote exempts itself from the requirements of Public Act 152 of 2011 for the 2016 health benefit plan year, which is effective January 1, 2016 through December 31, 2016, and;

Further resolved that effective January 1, 2016 the premium sharing for the 2016 health benefit plan year remains at 12% until June 30, 2016 for all active employees.

Be it further resolved that, effective July 1, 2016, for the remaining 2016 health benefit plan year the premium sharing shall increase from 12% to 14% for all non-bargaining employees. Premium sharing for all bargaining employees will remain at 12%, and will then be subjected to the Collective Bargaining Unit Agreement effective November 1, 2016.

Motion by Commissioner Zerkle, Seconded by Commissioner Alley, to forward the proposed resolution for PA 152/Employee Contribution to Medical Benefit Plan to full Board for consideration.

Action: Motion Carried.

Excused Absence

Motion by Commissioner Zerkle, Seconded by Commissioner Alley, to excuse Commissioner McCloud from tonight's meeting.

Action: Motion Carried

Public Comments

None

Adjourn

Motion by Commissioner Zerkle, Seconded by Commissioner Alley, the meeting adjourned at 6:24 p.m.

Action: Motion Carried

Respectfully Submitted
Tony Mullen, Chair
Human Resources 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 proposed resolutions 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 updates. 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 $2,550 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 been administered. For example, it is now clear that it is a retiree only benefit plan. Additionally, throughout the proposed document there are corresponding comments which describe the nature of the adjustments.

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.

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: **February 1, 2016**; 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, $2,550).

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 _____, 2016.

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

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

Lansing Board of Water and Light (the "Employer") established the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light effective July 1, 1999. ~~The~~This Retiree Benefit Plan ~~is hereby~~was restated effective March —,27, 2007~~, as set forth herein~~, for the benefit of eligible employees and former employees of the Employer. This Retiree Benefit Plan has been amended from time to time, and the Lansing Board of Water and Light desires to amend and restate this Retiree Benefit Plan. 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. Effective as of _____ 2015, this Retiree Benefit Plan is hereby amended and restated as follows:

Comment [A1]: Changes summarizing process.

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~~Employer.

Comment [A2]: Throughout document "Board" is changed to Employer to be uniform. Previously it was used interchangeably.

(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~~Employer 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~~Employer within the time frame described below; and (v) is reemployed by the ~~Board~~Employer. 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~~Employer 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).~~

(c) Re-Employment. A Retiree who would otherwise be eligible to participate in this Plan (along with his or her Spouse, and Dependent(s), where applicable) who is re-employed as an active employee with the Employer will not be eligible to receive covered benefits under this Plan during such active service. A rehired individual (and his or her Spouse and/or Dependent(s)) may qualify for coverage under the health plan sponsored by the Employer for active employees if he, she and/or they qualify for such coverage.

Comment [A3]: Goal was to eliminate potential ambiguity as to whether this is a retiree only plan. Active employee have been presumed to be in active plan and not retiree plan. This language makes clear what happens upon re-employment.

(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~~Employer 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~~individual 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~~an individual 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~~he or she 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.

Comment [A4]: This section is factored into whether or not an "individual" is eligible to participate. Therefore, it is more appropriate to denote as "individual". Similar adjustments have been made throughout document where appropriate.

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

Comment [A5]: This section relates to an "Employee" condition of employment.

Comment [A6]: To direct where in the document this is outlined. Allow ease of review/read.

(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 __, 2007~~ _____, 2015, 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~~individual, including a Retiree, who ~~participates in~~qualifies and is eligible for benefits under this Plan, at the ~~Plan in accordance with Section 2~~time of eligibility and qualification for benefits, pursuant to the remaining provisions of this Plan.

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~~this Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light.

q. **"Plan Administrator"** means the Lansing 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.~~, and who is not an active employee. A Retiree may lose his or her "Retiree" status upon rehire, and may re-gain that "Retiree" status upon a subsequent separation from service with the Employer.

Comment [A7]: Previous language just denoted that participate was employee that participates. Needed to remove "employee" reference to make certain active employees are not part of plan and thus retiree plan. Revised language is also a more accurate definition of what it means to be a "participant".

Comment [A8]: Language intended to make certain this is a retiree only 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~~Employer and any period of Disability for which an employee receives any pay from the ~~Board~~Employer 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~~Employer 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~~Employer within the time frame described below; and (v) is reemployed by the ~~Board~~Employer. (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~~Employer 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~~requirement is waived where required by applicable law.

(c) Applying for Reemployment. In general, the individual must report back to the ~~Board~~Employer 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~~ pursuant to a valid 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~~ marriage license; provided, however, the term "spouse" shall not include a person legally separated from the Retiree or Employee under a divorce or separate maintenance decree. The following rules shall apply to Spouses under this Plan:

(1) An individual must be the Retiree's Spouse at the time benefits are provided by this Plan.

(2) An individual becoming a Retiree's Spouse prior to the Retiree's retirement will be eligible for coverage under this Plan after the Retiree's death.

(3) An individual becoming a Retiree's Spouse after the Retiree's retirement will be eligible for coverage under this Plan (along with any applicable Dependents that otherwise qualify for coverage) but such coverage will terminate after the Retiree's death.

Comment [A9]: Allows the plan to be in line with state law in determining benefits. Language was also contemplated in light same sex benefits may become legal. As written, language would potentially be of issue and concern given current law which permits same sex benefits.

Comment [A10]: Additional clarification and distinction between spouse as dependent vs spouse rights at commencement.

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 Lansing 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~~.~~ as long as he or she continues to meet the eligibility requirements. Any other individual who becomes ~~an Employee~~eligible for benefits pursuant to Section 3 of ~~the Employer on or after the Effective Date~~ this Plan shall ~~participate~~become a Participant as provided in ~~the Plan as of his or her date of hire.~~Section 3. No other individual is eligible to participate in the Plan. Participation by Spouses and Dependents is derivative and depends on the coverages and rights of the applicable Retiree.

~~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;~~

~~(1)~~ the date that a Participant (including a Spouse or Dependent) resumes or begins active employment with the Employer (in which case participation in this Plan will terminate

for that person resuming or beginning employment and for any Spouse or Dependent whose coverage would otherwise be derivative through that person);

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

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

Comment [A11]: Language better clarifies spousal participation and dependent participation.

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~~ Participant shall receive health coverage under the ~~Employer's health~~ terms of the plan~~, a copy of which is available upon request. The Retiree~~ attached as Exhibit A. The Participant shall be responsible for applicable deductibles, and co-pays, but shall not participate in premium sharing.

Comment [A12]: Language makes coverage applicable to participants generally. Also will have copy of health plan attached as exhibit A, which is updated from time to time.

~~————————~~(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~~eligible Participant that produces written proof~~, to the satisfaction of the Employer, that the Retiree is currently enrolled in~~ of alternative health ~~coverage~~

~~which is similar to the Employer provided health coverage, from a source other than the Employer will be eligible to participate~~and prescription drug coverage may elect to receive cash in lieu of participating 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~~employer sponsored health ~~coverage plan and the Employer sponsored~~ and prescription drug coverage and thus participate in Employer's Cafeteria Plan B: "Cash in Lieu" plan. Such individuals shall be paid a monthly amount to be determined by the employer. Eligible individuals may waive health and prescription drug coverage ~~plan described in this subsection a. and subsection b. below. A Retiree must~~separately; however, individuals are eligible to receive cash provided they waive both ~~the~~ health ~~coverage~~ and ~~the~~ prescription drug coverage ~~to elect~~. 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 ~~under the Cash or HPD Cafeteria Plan~~.

Comment [A13]: Language condensed to effectively same cash in lieu of benefits is available under this 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.~~

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~~Health~~(3) Duplicate Coverage. If a re-hired Retiree has a subsequent separation from service, health coverage offered under this Retiree Benefit Plan shall commence (or if applicable, recommence) on the day following the date ~~the Spouse~~he or she 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

Comment [A14]: Language no longer needed as active employees are not eligible to receive benefits in retiree plan. Original language address what happens if spouse is active and receives active benefits or cash in lieu of benefits. With clear separation, language not needed.

Comment [A15]: This language allows retiree that go into active service and thus participates in active plan because they are active employee, to come back onto the retiree plan once they cease participating in the active plan as an active employee.

Comment [A16]: Edits in this section is same as health coverage section.

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cost per Retiree to the Employer for providing said prescription drug coverage) made available to active Employees.

~~————————~~(1) Coverage. ~~Each Retiree and, if applicable, the Retiree's Spouse and Dependents~~Each Participant ~~-~~shall receive prescription drug coverage under the ~~Employer's~~ prescription drug plan~~, a copy of which is~~ attached hereto~~. The Retiree~~ as Exhibit B. The Participant shall be responsible for applicable deductibles, and co-pays, but shall not participate in premium sharing.~~————————~~(2) Duplicate Coverage. ~~No~~If a re-hired Retiree ~~shall receive any prescription drug~~has a subsequent separation from service, health 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~~this Retiree Benefit Plan shall commence (or~~,~~ if applicable, recommence) on the day following the date ~~the Spouse~~he or she is no longer eligible as a primary participant under the Employer~~-~~sponsored ~~prescription drug~~health plan for active employees.

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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.

Comment [A17]: Addresses individual that may or may not be eligible to receive prescription benefits under Medicare.

c. Dental Coverage.

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

(2) Duplicate Coverage. If a re-hired Retiree has a subsequent separation from service, dental coverage offered under this Retiree Benefit Plan shall commence (or if applicable, recommence) on the day following the date he or she is no longer eligible as a primary participant under the Employer-sponsored dental plan for active employees. ~~Duplicate Coverage. No Retiree~~ Participant shall receive any dental coverage benefit under this Plan during any time when the ~~Retiree's~~ Participant'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~~ he or she is no longer eligible as a primary participant under the Employer sponsored dental Plan for active employees.

d. Life Insurance.

~~In general, each~~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~~

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~~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.~~available upon request, as follows:

~~———~~(1) Any Employee who ~~carried~~was participating in life insurance coverage ~~through~~provided by the ~~Lansing Board of Water and Light~~Employer with a coverage amount equal to ~~1½~~one and one-half (1½) times his or her salary, rounded up to the next highest $1,000 increment, 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~~ increment.

(2) No Retiree Group Term Life Insurance Plan coverage shall be extended to any Retiree who elected to be covered at the $10,000 level of coverage under the Group Life Insurance Plan provided by the Employer on the day before his or her Separation From Service from active employment.

(3) No Spouse or Dependent of any Retiree shall receive coverage under the Retiree Group Term Life Insurance Plan, and 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 under the Retiree Group Term Life Insurance Plan and shall continue to receive benefits ~~so~~for as long as the Retiree continues to pay the applicable premiums.

Comment [A18]: Language tightened up to read easier. This section is slightly different than the rest as it specifies "retiree" and "employee" because it specifically ties to elections during employment.

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.

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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~~death 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 he or she was married to the ~~surviving Spouse is~~Retiree on the date of the Retiree's retirement. If eligible for ~~surviving spouse benefits under any pension plan sponsored by the Employer. Said~~this coverage, this coverage shall commence on the Retiree's, or if applicable, the 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~~.~~ or before or after any termination of the Plan. Subject to the requirements of any collective bargaining agreement, the Employer reserves the right, in its sole discretion, to reduce

Comment [A19]: This language adjusted to make certain it is a standalone document and not tied to the Defined Benefit Plan, which was how language was previously written. Benefit elections under Defined Benefit Plan may be made for spousal benefits. However, that should not impact this section.

Comment [A20]: Language goes without saying. However, necessary during recent court developments, benefits don't vest after plan has been terminated.

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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.

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(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;

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(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

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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

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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; or
- 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.

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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

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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.

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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.

18. Separate Plan. 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 provide ~~track~~ benefits similar ~~from~~ to one or more other plans or arrangements sponsored by the Employer.

Comment [A21]: Statement to make clear separate plan.

LANSING BOARD OF WATER AND LIGHT

Date: _____ By: _____
Chair, Board of Commissioners

Date: _____ By: _____
Corporate Secretary

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

Updated 1/__/2016

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

Lansing Board of Water and Light (the "Employer") established the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light effective July 1, 1999. This Retiree Benefit Plan was restated effective March 27, 2007, for the benefit of eligible employees and former employees of the Employer. This Retiree Benefit Plan has been amended from time to time, and the Lansing Board of Water and Light desires to amend and restate this Retiree Benefit Plan. 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. Effective as of _____ 2015, this Retiree Benefit Plan is hereby amended and restated as follows:

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 Employer.

(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 Employer 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 Employer within the time frame described below; and (v) is reemployed by the Employer. 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 Employer 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) Re-Employment. A Retiree who would otherwise be eligible to participate in this Plan (along with his or her Spouse, and Dependent(s), where applicable) who is re-

employed as an active employee with the Employer will not be eligible to receive covered benefits under this Plan during such active service. A rehired individual (and his or her Spouse and/or Dependent(s)) may qualify for coverage under the health plan sponsored by the Employer for active employees if he, she and/or they qualify for such coverage.

(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 Employer 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 individual 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 an individual who is reemployed by the Employer more than 365 days after employment termination with the Employer, all years of Benefit Service Credit which he or she 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 Employee 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 as defined in subsection l. of this Section 1, below, but 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 _____, 2015, 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"** 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 individual, including a Retiree, who 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.

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

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

q. **"Plan Administrator"** means the Lansing 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 has reached his or her Normal Retirement Date or Early Retirement Date or is determined to be Disabled, and who is not an active employee. A Retiree may lose his or her "Retiree" status upon rehire, and may re-gain that "Retiree" status upon a subsequent separation from service with the Employer.

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 Employer and any period of Disability for which an employee receives any pay from the Employer 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 Employer 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 Employer within the time frame described below; and (v) is reemployed by the Employer. (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 Employer 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 requirement is waived where required by applicable law.

(c) Applying for Reemployment. In general, the individual must report back to the Employer 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 pursuant to a valid state law marriage license; provided, however, the term "spouse" shall not include a person legally separated from the Retiree or Employee under a divorce or separate maintenance decree. The following rules shall apply to Spouses under this Plan:

(1) An individual must be the Retiree's Spouse at the time benefits are provided by this Plan.

(2) An individual becoming a Retiree's Spouse prior to the Retiree's retirement will be eligible for coverage under this Plan after the Retiree's death.

(3) An individual becoming a Retiree's Spouse after the Retiree's retirement will be eligible for coverage under this Plan (along with any applicable Dependents that otherwise qualify for coverage) but such coverage will terminate after the Retiree's death.

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 Lansing 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 as long as he or she continues to meet the eligibility requirements. Any other individual who becomes eligible for

benefits pursuant to Section 3 of this Plan shall become a Participant as provided in Section 3. No other individual is eligible to participate in the Plan. Participation by Spouses and Dependents is derivative and depends on the coverages and rights of the applicable Retiree.

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

(1) the date that a Participant (including a Spouse or Dependent) resumes or begins active employment with the Employer (in which case participation in this Plan will terminate for that person resuming or beginning employment and for any Spouse or Dependent whose coverage would otherwise be derivative through that person);

(2) the date on which the individual is no longer eligible to participate in the Plan in accordance with the provisions of this Plan; 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 Participant shall receive health coverage under the terms of the plan attached as Exhibit A. The Participant shall be responsible for applicable deductibles, and co-pays, but shall not participate in premium sharing.

(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 and thus participate in Employer's Cafeteria

Plan B: “Cash in Lieu” plan. 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.

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. If a re-hired Retiree has a subsequent separation from service, health coverage offered under this Retiree Benefit Plan shall commence (or if applicable, recommence) on the day following the date he or she 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 Participant shall receive prescription drug coverage under the prescription drug plan attached hereto as Exhibit B. The Participant shall be responsible for applicable deductibles, and co-pays, but shall not participate in premium sharing.(2) Duplicate Coverage. If a re-hired Retiree has a subsequent separation from service, health coverage offered under this Retiree Benefit Plan shall commence (or if applicable, recommence) on the day following the date he or she is no longer eligible as a primary participant under the Employer-sponsored health plan for active employees.

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.

c. Dental Coverage.

(1) Coverage. Each Participant shall receive dental coverage under the Employer's dental plan, a copy of which is attached hereto. The Participant shall be responsible for applicable deductibles, and co-pays, but shall not participate in premium sharing.(2) Duplicate Coverage. If a re-hired Retiree has a subsequent separation from service, dental coverage offered under this Retiree Benefit Plan shall commence (or if applicable, recommence) on the day following the date he or she is no longer 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 he or she is no longer eligible as a primary participant under the Employer sponsored dental Plan for active employees.

d. Life Insurance.

Each Retiree shall receive coverage under the Retiree Group Term Life Insurance Plan, a copy of which is available upon request, as follows:

(1) Any Employee who was participating in life insurance coverage provided by the Employer with a coverage amount equal to one and one-half (1½) times his or her salary, rounded up to the next highest $1,000 increment, 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 increment.

(2) No Retiree Group Term Life Insurance Plan coverage shall be extended to any Retiree who elected to be covered at the $10,000 level of coverage under the Group Life Insurance Plan provided by the Employer on the day before his or her Separation From Service from active employment.

(3) No Spouse or Dependent of any Retiree shall receive coverage under the Retiree Group Term Life Insurance Plan, and 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 under the Retiree Group Term Life Insurance Plan and shall continue to receive benefits for as 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 death 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 he or she was married to the Retiree on the date of the Retiree's retirement. If eligible for this coverage, this coverage shall commence on the Retiree's, or if applicable, the 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.

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 or before or after any termination of the 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; or

- 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.

18. Separate Plan. 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 provide benefits similarto one or more other plans or arrangements sponsored by the Employer.

LANSING BOARD OF WATER AND LIGHT

Date: _____ By: _____
Chair, Board of Commissioners

Date: _____ By: _____
Corporate Secretary

Proposed Resolution

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 February 1, 2016, in the form attached hereto) is hereby adopted and approved; and

BE IT FURTHER RESOLVED, that the Amendment and Restatement of the Post-Retirement Benefit Plan (as of February 1, 2016, 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.