City of Plainwell

Rick Brooks, Mayor
Lori Steele, Mayor Pro-Tem
Brad Keeler, Council Member
Todd Overhuel, Council Member
Roger Keeney, Council Member

Department of Administration Services
211 N. Main Street
Plainwell, Michigan 49080
Phone: 269-685-6821 Fax: 269-685-7282
Web Page Address: www.plainwell.org

"The Island City"

AGENDA
Plainwell City Council
Monday, July 23, 2018
7:00PM

1. **Call to Order**
2. **Invocation**
3. **Pledge of Allegiance**
4. **Roll Call**
5. **Approval of Minutes/Summary** – 07/09/2018 Regular Meeting
6. **General Public Comments**
7. **County Commissioner Report**
8. **Presentations** – *Judge William A. Baillargeon – State of Allegan County Courts*
9. **Agenda Amendments**
10. **Mayor's Report**
11. **Recommendations and Reports:**

    A. WR – Installation of SCADA Radio Antennas and Coaxial
    Council will consider a contract with Perceptive Controls for installation of the SCADA antennas and coaxial related to the hardware replacement at a cost of $8,272.00.

    B. Resolution 18-20 – Section 125 Plan Document Amendment
    Council will consider changes to the plan document for employee benefits.

    C. 2018/2019 Budget Amendment - Encumbrance Rollover
    Council will consider a budget amendment for the 2017/2018 purchases rolled over into the 2018/2019 budget.

12. **Communications:** The April and May 2018 Public Safety Reports, the June 2018 Water Renewal Report and the DRAFT Planning Commission Minutes from July 18, 2018.
13. **Accounts Payable - $130,552.35**
14. **Public Comments**
15. **Staff Comments**
16. **Council Comments**
17. **Adjournment**

Note: All public comment limited to two minutes, when recognized please rise and give your name and address

MINUTES
Plainwell City Council
July 9, 2018

1. Mayor Brooks called the regular meeting to order at 7:00 PM in City Hall Council Chambers.

2. Scott Fenner of Lighthouse Baptist Church gave the invocation.

3. Pledge of Allegiance was given by all present.

4. Roll Call: Present: Mayor Brooks, Mayor Pro-tem Steele, and Councilman Keeney. Absent: Councilman Keeler and Councilman Overhuel.

5. Approval of Minutes/Summary:
A motion by Steele, seconded by Keeney, to accept and place on file the Council Minutes and Summary of the 06/25/2018 regular meeting and the Council Minutes. On voice vote, all voted in favor. Motion passed.

6. General Public Comments: None

7. Presentations:
Director Bomar celebrated David Kuitert and his 25 years of service in various roles in the Department of Public Safety. Dave is currently an on-scene safety officer and does most of the testing on the equipment, and he offers AED and CPR training for the city and in the community. He has been and continues to be a valuable asset.

   Superintendent Nieuwenhuis and Personnel Manager Lamorandier celebrated Kim Brown's 10 years of service and how she has helped transform the flower program into one of the best in the area. Kim is very caring and takes pride in her work, which is noticed by staff and many visitors. Kim helps throughout the department, but her passion is the Parks and particularly the flowers.

8. County Commissioner Report: None

9. Agenda Amendments: None.

10. Mayor's Report: None

11. Recommendations and Reports:

   A. City Manager Wilson introduced Jeff Wingard from Fleis & Vandenbrink who briefed Council on a tentative timeline for the Sherwood Avenue Improvement starting with design work through the construction phases in the summer/fall of 2019. He noted that some of this work will be in conjunction with the ongoing SAW Grant and that surveying is already underway. The Council questioned coordination with the Plainwell Days Festival and school bus routes, which Mr. Wingard noted could be coordinated in the design phases.
   A motion by Steele, seconded by Keeney, to accept the proposal from Fleis & Vandenbrink for the Sherwood Avenue design and construction engineering services in the amount of $125,400.00 and authorizing the City Manager to execute all related documents. On a roll-call vote, all in favor. Motion passed.

   B. Clerk/Treasurer Kelley reminded Council about an emergency purchase of two (2) SCADA radios approved at the June 25 meeting. While Superintendent Pond was working to get the radios back online, Perceptive Controls reached out and offered a system-wide replacement of all the SCADA radios with a lower per-unit cost and better technology. The approved radios are being returned and Superintendent Pond recommends purchasing the replacement hardware as presented.

A motion by Keeney, seconded by Steele, to approve the system-wide replacement of nine (9) SCADA radios from Perceptive Controls at a cost of $13,176.47. On a roll-call vote, all in favor. Motion passed.

C. Superintendent Nieuwenhuis reported the process of adding ferric chloride at the beginning of the wastewater treatment process and that only one firm bid on the services for a two-year period.
A motion by Steele, seconded by Keeney, to approved a two-year contact with Webb Chemical for ferric chloride at $471 per dry ton (estimated annual cost of $16,824.12). On a roll-call vote, all in favor. Motion passed.

D. Superintendent Nieuwenhuis reported the process of adding chlorine and sulfur dioxide near the end of the wastewater treatment process and that Alexander Chemical is the only regional vendor offering those chemicals.
A motion by Keeney, seconded by Steele, to approve the purchase of plant chemicals from Alexander Chemical with an estimated annual cost of $7,063.84. On a roll-call vote, all in favor. Motion passed.

12. Communications:
    A. **A motion by Steele, seconded by Keeney, to accept and place on file the June 2018 Investment and Fund Balance reports and the DRAFT 04/24/2018 Minutes for the M-40/M-89 Corridor Committee. On a voice vote, all in favor. Motion passed.**

13. Accounts Payable:
    A motion by Keeney, seconded by Steele, that the bills be allowed and orders drawn in the amount of $220,682.65 for payment of same. On a roll call vote, all in favor. Motion passed.

14. Public Comments None.

15. Staff Comments

    Personnel Manager reported new employee health insurance as of August 1, 2018 and that this may be an annual process as the health insurance industry is rapidly changing.

    Superintendent Nieuwenhuis reported a new water testing process started this week at the Kenyon Park Water Tower.

    Community Development Manager Siegel reported installation, vandalism and re-installation of the Dog Park sign and provided an update on the Sherwood Park restrooms. She noted donations received and recent community events.

    Director Bomar reported on recent training attended.

    Clerk/Treasurer Kelley reported continued work on the upcoming election and year-end accounting.

16. Council Comments: None.

17. Adjournment:
    A motion by Steele, seconded by Keelney, to adjourn the meeting at 7:29 PM. On voice vote, all voted in favor. Motion passed.

Minutes respectfully
Submitted by,
Brian Kelley
City Clerk/Treasurer

SUMMARY
Plainwell City Council
July 9, 2018

1. Mayor Brooks called the regular meeting to order at 7:00 PM in Council Chambers at City Hall.

2. Invocation was given by Scott Fenner of Lighthouse Baptist Church.

3. Pledge of Allegiance was given by all present.

4. Roll Call: Present: Brooks, Steele, and Keeney. Absent: Keeler and Overhuel.

5. Approved Minutes/Summary of the 06/25/2018 regular meeting.

6. Recognized two employees for years of service.

7. Approved contract with Fleis & Vandenbrink for design and construction engineering services for the Sherwood Avenue Improvement Project in the amount of $125,400.00.

8. Approved purchase of nine (9) replacement SCADA radios from Perceptive Controls for a hardware cost of $13,176.16.

9. Approved purchase of ferric chloride from Webb Chemical at an estimated annual cost of $16,824.12.

10. Approved purchase of chlorine and sulfur dioxide from Alexander Chemical at an estimated annual cost of $7,063.84.

11. Accepted and placed on file the June 2018 Investment and Fund Balance Reports and the DRAFT 04/24/2018 Minutes of the M-40/M-89 Corridor Committee.

12. Approved Accounts Payable for $220,682.65.

13. Adjourned the meeting at 7:29 pm.

Submitted by,
Brian Kelley
City Clerk/Treasurer

Allegan County Board of Commissioners

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269-686-5331 Main Fax
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BOARD OF COMMISSIONERS MEETING – AGENDA

Board Room – County Services Building
9:AM

DISCUSSION ITEMS:

1. Annual Wellness Report ***(313 employees participate in the program and through the processes, indicates evidence of physical and emotional healthy trends.)***
2. 2019 Budget ***(effective date.; passed unanimously)***
   a. Gabridge & Company—Auditor ***(Allegan County received an unmodified opinion which is the highest achievement possible)***
   b. **CLOSED SESSION:** Collective Bargaining
3. Board Planning ***(effective date.; passed unanimously)***
4. Administrative Update ***(Discussed specific subject within "Administrator's Report", that I emailed to all municipalities)***

1PM **CALL TO ORDER:**
OPENING PRAYER: Commissioner Tom Jessup
PLEDGE OF ALLEGIANCE:
ROLL CALL:
PUBLIC HEARING: Animal Control Ordinance Amendment
(Amended to align with current practices.; passed unanimously)
PRESENTATIONS:
Special Recognitions—Sheriff Frank Baker ***(Noting MADD arrests about 600 arrests, and 3 officers noticed for saving lives.)***
PROCLAMATIONS:
INFORMATIONAL SESSION:
Community Mental Health—Director Mark Witte ***(107 employees have not received raises in pay for 4 years. All counties in the region ran financially negative last year. Working hard to rebuild the strong team. Committed to living within their budget and initially not met warmly.)***

CONSENT ITEMS:

1. Motion to approve of claims paid and to incorporate into proceedings of the Board (7/6/18 & 7/13/18) ***($681,874.63, $340,024.81; passed unanimously)***

ACTION ITEMS:

1. Resolution to congratulate retiring James Hettinger of Allegan County Economic Development for contributions and job creation.
2. Board of Commissioners—adopt Animal Control Ordinance Amendment ***(.; passed 6-1 Thiele)***

Mission Statement
"The Allegan County Board of Commissioners shall plan, develop, and evaluate the necessary policies and resources to ensure our county continues to progress and prosper"

3. Administration—authorize building lease (169-858) ***(Secretary of State rent the building for about a month during remodeling current building; passed unanimously)***
4. Sheriff's Department—approve position reclassification (166-948) ***(; passed unanimously)***
5. Area Agency on Aging of Western Michigan (AAAWM)—approve Annual Implementation Plan (AIP) FY2019 ***(Annual funding; passed unanimously)***
6. Send Chairman to Tenessee a third place award ***(Pay per diem, accomadations and traveling; passed 5-2; Black, Thiele)***

DISCUSSION ITEMS:

1. Board of Commissioners—discuss Lake Michigan Water Supply System TABLED 5/10/18 ***(Little interest, but municipalities near the lake may.; passed unanimously)***

ROUND TABLE:

- District-1-Dean Kapenga-***(Nothing)***
- District-2-Jim Storey-***(Nothing)***
- District-3-Max R. Thiele-***(1-Drain Commission wants to abandon 2 drains in Ganges Township.2-Question 2% casino money, revenue sharing board and casino is shorting entities by not following rules. This body has the responsibility to study the facts. Request future 2018 agenda for discussion about casino and revenue sharing board actions.)***
- District-4-Mark DeYoung-***(Attended MSU conference)***
- District-5-Tom Jessup-***(In Elpaso TX. Visiting son. There a lot of young people serving in military and they need our prayers.)***
- District-6-Gale Dugan-***(Nothing)***
- District-7-Don Black-***(MTA assessing reform expected inpact on municipalities? Consider sending AEDC member to national conference like Jim Hettinger as member who attended and sent presentation for me to read each year I chaired the body.)***

District #7 Commissioner (616) 920-2875 Don Black Synopsis-July 12, 2018

(Comments in italics are my opinions and interpretation of the Commission meeting and actions)

Arrogance

"The truest characters of ignorance are vanity and pride and arrogance."

– Samuel Butler (British writer, 1835-1902)

ADJOURNMENT: Next Meeting – Thursday, July 26, 2018, 1PM **@ BOARD ROOM – COUNTY SERVICES BUILDING, COUNTY SERVICES COMPLEX**.MTA

Bryan D. Pond, Superintendent
129 Fairlane Street
Plainwell, Michigan 49080
Phone: 269-685-5153
Fax: 269-685-1994
Email: BPond@plainwell.org

7/19/2018

To: Erik Wilson, City Administrator
From: Bryan Pond, Superintendent WR
Cc: Brian Kelly City Treasurer
RE: Installation of SCADA radios antennas and coaxial

We have referred the installation of the antennas coaxial and radios to Perceptive Controls. The work will be done by Roe Comm Communications, and Perceptive Controls will work with them to obtain a licensed radio frequency and program the PLC's and radios

The installation and programming quote attached, is for $8,272 and I am requesting council's approval of the expenditure from line item 590-540-930, as Perceptive Controls is our named SCADA programmer.

July 18, 2018

Company: City of Plainwell
Contact Name: Bryan Pond
Phone Number: 269-685-5153
Job Name Radio Upgrade

Dear Mr. Pond

Perceptive Controls is please to submit our quote to subcontract the Roe-Comm radio antenna installation.

Roe-Comm Pricing:

APPENDIX
EQUIPMENT DESCRIPTION AND PRICES

Plainwell Waste Water

Qty.	Item Description	Unit Price	Extended Price
	Lift Station & Master Antenna System Upgrade:		
7	9 dB UHF Yagi Antenna with Clamp and N-Female Connector 30' LMR400 Cable with N-Male Connectors Polyphaser Bulkhead or Flange Lightning Arrester 3' Jumper from Arrester to Radio	$306.00	$2,142.00
7	Travel and Labor to Install Lift Station Antenna and Feedline and Jumpers and Arrester	$285.00	$1,995.00
	DPW Main Site Antenna System Upgrade:		
1	Omni-Directional 8 dB Gain 450/460 or 460/470 MHz Antenna to Mast Mounting Bracket Included, 16LBS (1) Polyphaser Lightning Arrester N-Female (1) Jumper Cable Radio to Arrester	$1,046.00	$1,046.00
1	Labor to Remove Existing 902-928 MHz Antenna and Install New 6 dB Gain Omni Antenna and Interface Test for Proper Operation	$1,867.00	$1,867.00
	Licensing:		
1	Coordinate New FB and Mobiles for Additional Channel, Processing, 10 Year License	$395.00	$395.00
	System Investment		$ 7,445.00

IMPLEMENTATION:

Delivery of equipment will take place approximately four to six weeks after order is completed. Roe-Comm, Inc will be available after installation to answer any questions regarding use of system.

Perceptive Supply Price : $7445/0.9 = $8,272.00

Payment Terms: 50% upon order 50% upon completion, Net 30 Days.
Delivery: 5-7 weeks after receiving P.O.

If you have any questions, please feel free to contact me anytime at 269.685.3040 x102.

Best Regards,

Ryan Fisher
Perceptive Controls

140 East Bridge Street – Plainwell, MI 49080 – 269.685.3040

Resolution 18-20

TO AMEND AND RESTATE THE CITY OF PLAINWELL FLEXIBLE BENEFITS PLAN 501

The undersigned, City Council (the "Employer"), hereby adopt the following Resolution and direct that this Consent Resolution be entered in the minute books of the Employer.

WHEREAS, the Employer previously adopted a Code Section 125 Cafeteria Plan of the Internal Revenue Code of 1986, referred to as the Flexible Benefits Plan (Plan 501) , and;

WHEREAS, Article XI of the Plan allows the Employer to amend the Plan, and;

WHEREAS, the City's Medical coverage runs on an August thru July plan year, and;

WHEREAS, to be in compliance the a change in our Section 125 Flexible Benefit Plan 501 plan year we will run on a short plan year from July 1, 2018 thru July 31, 2018, and;

WHEREAS, this amendment and restatement shall be effective as of July 1, 2018 for the short plan year, and;

WHEREAS, our new plan year will begin August 1, 2018 thru July 31, 2019 with each subsequent plan year being August 1st and end on July 31st, and;

WHEREAS, this amendment and restatement shall be effective as of August 1, 2018 for the full plan year, and;

WHEREAS, this amendment will update eligibility requirements, clarify city contributions as well as updates to the Summary Plan Description.

NOW, THEREFORE, BE IT RESOLVED that the Plainwell City Council has hereby reviewed the attached amendment and does hereby approves the restatement and adoption of the amendment to the Plan Document and the Summary Plan Description as set forth therein;

BE IT FURTHER RESOLVED, that the officers of the Employer are authorized and directed to take any and all action as may be necessary to effectuate this Resolution.

Yeas:
Nays:
Absent:

RESOLUTION DECLARED ADOPTED:

CERTIFICATION

As its Clerk/Treasurer, I Brian Kelley certify that this is a true and complete copy of a resolution adopted by the City Council of the City of Plainwell, Allegan County, Michigan, at a regular meeting held on Monday, July 23, 2018.

Date:

_____
Brian Kelley, Clerk/Treasurer

For the
Employees of

City of Plainwell

Effective August 1, 2018

SECTION 125 FLEXIBLE BENEFIT

SUMMARY PLAN DESCRIPTION

City of Plainwell Plan #501

Employer's Address: **211 N Main St,**
Plainwell, MI 49080
(269) 685-6821
www.plainwell.org

Plan Year: **08/01 - 07/31**

Employer's Identification Number:
38-6004724

INTRODUCTION

The purpose of this Summary Plan Description ("SPD") is to provide you with a brief description of the Section 125 Flexible Benefit Plan for the employees of City of Plainwell (the "125 Plan") and the benefits offered through the Section 125 Plan and available to you under the 125 Plan. Should you have any questions concerning the benefits described in this SPD, you should consult the plan documents, insurance certificates, policies, or other benefit brochures or material provided to you. Further questions concerning benefits or policy statements contained in this handbook should be referred to the person indicated below:

Name: SANDRA LAMORANDIER

Title: PERSONNEL MANAGER

Address: 211 N Main St, Plainwell, MI 49080

Phone: (269) 685-6821

The City of Plainwell (the "Employer") currently intends to continue all of the benefits described in this SPD, however, the Employer reserves the right to amend, reduce, or terminate any of these benefits at any time.

Neither this SPD nor the official plan documents confer any contractual right to any person to either become or remain an employee of the Employer.

This SPD summarizes the principal features of the 125 Plan and benefits provided through the 125 Plan. The terms and conditions of the 125 Plan and other benefits provided through are contained in the 125 plan document or other general benefits specific plan document, as applicable adopted by the Employer. If the provisions of this SPD conflict with those of the 125 plan document or any other applicable plan document, the provisions of the applicable plan document will control.

TYPE OF PLAN AND CONTRIBUTIONS

What is a Section 125 Flexible Benefit Plan?

It is a benefit plan, sometimes called a "cafeteria plan," that allows you, the employee, to pay for the benefits you choose with the benefit dollars available for your use from your Employer ("Flex Credits") or through a Salary Reduction Agreement with your Employer. Salary reduction means that you are able to use "pre-tax" dollars to pay for certain benefits. The 125 Flexible Benefit Plan for the Employees of the City of Plainwell will be referred to as the "125 Plan" throughout this SPD.

What benefits are available under the Plan?

The 125 Plan gives you a selection of benefits from which to choose those which most fit the needs of you and your family. Benefits offered under the 125 Plan are as follows:

- Dependent Day Care Flexible Spending Account (Dependent Day Care FSA)
- Health Flexible Spending Account (Health FSA)
- HSA/Limited Flex
- Cancer
- Health Event
- Group Health Insurance
- Group Dental
- Group Vision
- Group Life
- Accident

While you pay for these benefits through the 125 Plan, details about eligibility, benefits, claims, and other administrative items for those benefits may not be discussed in this SPD. Please refer to the insurance documents, Summary Plan Descriptions, or other material about the specific type of coverage for information about those benefits. This SPD only discusses eligibility, benefits, claims, and other administrative information for the 125 Plan, the Health Flexible Spending Account ("Health FSA), and the Dependent Day Care Flexible Spending Account ("Dependent Day Care FSA").

Health Savings Account (HSA) Benefits

The Plan lets you elect to make contributions on a pre-tax basis, from your regular pay, to an HSA for payment of certain medical expenses. Your Health Savings Account, if you elect to have one established, it is maintained by a American Fidelity Health Services Administration. The Employer's involvement will be limited to transmitting your contributions.

You are permitted to change your election for HSA Benefits at any time for any reason as long as the change is made prospectively and takes effect no sooner than the beginning of the month following the elections change. Any change that meets these requirements can be made including increasing, decreasing, beginning or eliminating contributions.

The Employer contributes' it's contribution into your HSA account in August of each year. The amount is based on your insurance plan 2400single 4800/family.. If there is a need for additional funds the city will reimburse up to a maximum allowable, whichever is lesser.

For HSA-ineligible active employees enrolled in employer medical coverage AND a Medical FSA account, the Employer agrees to contribute to the FSA an amount equal to the amount contributed by the employee (subject to the maximum of the amount contributed to HSA-eligible employees with similar coverage), or the IRS maximum allowable, whichever is lesser.

For active employees with adult children on the employer medical plan, the Employer agrees to give the employee the option to elect a portion of the Employer-provided HSA contribution to be taken as taxable income to cover the adult child's out-of-pocket expenses.

How is Health Insurance Premiums Paid?

Your share of any employer-sponsored health (which includes dental and vision) insurance premium that is deducted from your paycheck will automatically be deducted and paid on a pre-tax basis after the Plan Year begins based on 24 pays. The Employer shall inform the Participant of the applicable Compensation Reductions required to pay a Participant's cost of coverage. The cost of coverage may depend on certain factors such as whether coverage is elected for the Participant only or for the Participant and one or more of his Dependents. In the unlikely event you don't want this part of the benefit; you must submit an Election to Waive form for this benefit.

Cash in Lieu of Benefits

A Participant may elect to waive coverage under an Employer-sponsored Benefit Plan. If permitted by the Employer, you may waive any such coverage. However, in order to waive medical coverage, the Participant is required to have alternate medical coverage and provide sufficient evidence of that coverage to the City.

If a Participant elects to waive medical coverage, the Participant's Compensation may be increased by an amount determined by Employer for each Plan Year. The Participant may use/receive the additional Compensation as follows:

a. The Participant may choose to apply all or part of the additional Compensation to obtain Qualified Benefits, including any FSAs available under the Plan.

b. The Participant may choose to receive all or part of the additional Compensation through Employer's payroll system during the Plan Year to which the election relates. However, a Participant shall not receive any additional Compensation on account of this election for any time period after he terminates employment with Employer.

What is the maximum dollar amount available for the purchase of benefits under the 125 Plan?

If you are eligible to participate in the 125 Plan, you may authorize your Employer to reduce your compensation by the amount needed to purchase the benefits you elected. You make your election for salary reduction on the benefit election form.

The maximum amount you may choose to pay for the purchase of benefits through salary reduction is $25,000.00 per plan year. Throughout this SPD the term "Plan Year" means the 12 month period (or shorter under special circumstances) beginning August 1.

ELIBILITY AND PARTICIPATION

When do employees become eligible to participate in the Section 125 Plan?

All employees who work and are regularly scheduled to work 20 hours per week or more excluding Seasonal and Temporary employees, are eligible for Section 125 Plan participation on the first day of the month following 30 days of service.

Are employees automatically covered under the 125 Plan?

If you do not submit an enrollment form when you become eligible to participate or during Open Enrollment for each Plan Year, you will be automatically enrolled in the Employer's default benefits package, if applicable. You must submit an enrollment form to waive the default benefits, if applicable, or to be covered under any coverage different than the default benefits at the time you are eligible to participate and at each Open Enrollment. If you made an election of benefits for the prior Plan Year, your benefit elections will remain the same for all benefits other than the Health FSA and the Dependent Day Care FSA. You must submit an enrollment form to elect to participate in the Health FSA and the Dependent Day Care FSA at the time you become eligible to participate and during each Open Enrollment thereafter.

Throughout this SPD, the term "Open Enrollment" means a period of 4 weeks immediately before the beginning of each Plan Year during which you will have the opportunity to make elections for benefits offered under the 125 Plan for the next Plan Year. July 1st thru July 31.

When may eligible employees enroll in the 125 Plan?

Generally, you must enroll during Open Enrollment for each Plan Year. You will receive specific information about Open Enrollment each year before Open Enrollment starts.

New employees or employees becoming eligible for plan participation after the Plan Year's Open Enrollment must enroll prior to end of the first 30 days of employment. If you do not enroll during this period you must wait until the next Open Enrollment prior to the next Plan Year to enroll in benefits offered through the 125 Plan.

If you are on FMLA leave during Open Enrollment, your Employer will provide you with Open Enrollment information and you may make changes to your coverage during Open Enrollment. The same rules regarding benefit elections that apply to other participants in the 125 plan will also apply to you during Open Enrollment.

PLAN ELECTIONS AND ELECTION CHANGES

How do eligible employees enroll in the 125 Plan?

You must complete an election form to participate. If your Employer offers a default benefits package you must complete an election form to waive coverage under the 125 Plan. This form must be completed before the beginning of the Plan Year, or by the date you become eligible to participate in the 125 Plan, if later.

May benefit elections be changed during the year?

You may not change your benefit elections during a Plan Year, unless that change is the result of one of the qualified events described below and the change is on account of and corresponds with the qualified event. All changes (except for changes made due to certain special enrollment rights) will be effective the first of the month following the completion of the forms required to make the election change and will remain in effect for the remainder of the Plan Year.

Usually if an event allows a change in your Health FSA election, you may only revoke the Health FSA election; you may not just reduce the amount.

If all requirements are met, the following are circumstances under which election changes may be made:

Certain changes in status.

You may change your election if one of the following events occurs:

- A change in your legal status, such as marriage, death of spouse, divorce, legal separation or annulment;
- A change in the number of your dependents, such as birth, death, adoption or placement for adoption;
- A change in employment, including any employment status change affecting benefit eligibility of you, your spouse or your dependent, such as termination or commencement of employment, a change in hours, a strike or lockout, a commencement or return from an unpaid leave of absence, switching from salaried to non-salaried, union to non-union, full-time to part-time (or vice versa) and a change in worksite;
- Dependent satisfies or ceases to satisfy dependent eligibility requirement, including attainment of age, student status, etc.; or
- Residence change of you, your spouse or your dependent affecting the employee's eligibility for coverage.

Change in Cost of Coverage (does not apply to Health FSA).

If the cost you must pay for health coverage or dependent care significantly increases during the Plan Year, you may choose to change your election to increase your contributions to pay for the increased cost; choose another benefit package that offers similar coverage; or drop coverage (but only if there is no other similar benefit package offered). If the cost for health coverage or dependent care significantly decreases during the Plan Year, you may

choose to change your election to decrease your contributions to pay only for the decreased cost or choose the benefit package if you are not enrolled in that package that experienced the decreased cost (and drop alternate coverage if you are already enrolled in other coverage).

Change in Coverage (does not apply to Health FSA).
You may change your election if one of the following events occurs:

- There is a significant curtailment of coverage;
- There is an addition or significant improvement of benefit options offered under the 125 Plan;
- You, your spouse, or dependent loses coverage under another Employer plan;
- There is a change of election under another Employer plan; or
- Coverage with your dependent care provider changes.

Medicare or Medicaid (does not apply to Dependent Day Care FSA).
If you, your spouse, or your dependent becomes entitled to or loses entitlement to Medicare or Medicaid, you may change your election for that person accordingly.

Certain Judgment, Decrees, and Orders (does not apply to Dependent Day Care FSA).
A judgment, decree, or order relating to divorce, separation, annulment, or custody requires you to change coverage under your benefits; you may make a corresponding change in your election.

Once the election form is completed, are employees automatically covered under the insurance benefits elected?

Yes. You are not required to complete an application in order to participate; however, some benefits may require that you and/or your dependents meet underwriting requirements. Please refer to the documents and other material about a specific benefit to find out about any coverage requirements that may apply to you.

May I stay in the 125 Plan if I am absent on a Family and Medical Leave?

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act (FMLA) for periods totaling 12 weeks during the Plan Year, you are entitled to maintain the coverage you have under the Plan during your absence. Of course, you must pay the premiums for the coverage during your absence using one of the following methods:

Prepayment. Under the prepayment option, you may increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave.

Pay-as-you-go. With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while you are gone, the premiums will be paid through salary reduction as if you had not taken the leave. If at any point your FMLA leave

is unpaid and you choose this option, you will have to reimburse the Plan at regular intervals from your after-tax funds for the premiums that come due during the leave.

Catch up: The employee and Employer agree before the FMLA leave begins that the Employer will advance payment of the employee's share of the cost of coverage during the leave. The employee must agree to pay the Employer back for the amounts when he returns from leave. Upon return from leave, the employee makes catch-up salary reduction contributions to cover his share of the cost of coverage during the leave. In addition, the pre-leave salary reduction election resumes for the duration of the Plan Year unless the employee makes a change in election as allowed under the permitted election change regulations (i.e., for change in status) upon return from leave.

HEALTH FSA

Who can participate in the Health FSA?

If you are eligible to participate in the 125 Plan and participate in the employer offered medical plan then you are eligible to participate in the Health FSA at the same time you become eligible to participate in the 125 Plan.

How do I become a Participant?

You become a Participant in the Health FSA by electing Health FSA benefits during your initial enrollment or during Open Enrollment. At Open Enrollment each year, you must make an election, even if you do not change your current election. You may also become a Participant if you experience a change in status event that permits you to enroll mid-year.

When you complete the Salary Reduction Agreement, you specify the amount you wish to contribute with pre-tax contributions and/or Flex Credits, to the extent available. Your enrollment material will indicate if Flex Credits are available for Health FSA coverage. Thereafter, each paycheck (24 pays) will be reduced by an amount equal to a prorated share of the annual contribution, reduced by any Flex Credits allocated to your Health FSA.

Once you become a Participant, your eligible dependents also become covered. For purposes of the Health FSA, eligible dependents are the following:

- Your legal spouse (as determined by state and federal law) and
- Any other individuals who would qualify as a tax dependent under Code Section i105(b).

May anyone other than my spouse and tax dependents receive benefits under my Health FSA?

If the Plan Administrator receives a Qualified Medical Child Support Order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the Participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree, or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health FSA, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing QMCSOs. A QMCSO may permit reimbursement of eligible expenses for the alternate recipients named in the order from your Health FSA, but this does not necessarily

mean you will be entitled to a mid-year change in election to increase your Health FSA election.

What is the maximum annual amount that I may elect under the Health FSA?

You may elect any annual reimbursement amount subject to a maximum of $2650.00 (this amount is subject to change by the IRS). You will be required to pay the annual contribution equal to the annual reimbursement amount you have elected reduced by any Flex Credits allocated to your Health FSA. Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election.

How do I get reimbursed from the Health FSA?

If your claim for reimbursement is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways:

- A check made payable to you;
- Electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the Participant);
- If an electronic payment card is used, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's debit card rules).

What amounts will be available for reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full annual amount of Health FSA reimbursement you have elected, reduced by the amount of previous reimbursements received during the Plan Year, will be available at any time during the Plan Year, without regard to how much you have contributed.

How do I receive reimbursement under the Health FSA?

Under the Health FSA, you have two reimbursement options. You may complete and submit a claim form for reimbursement either by mail, through online submission, or by using the American Fidelity mobile app. Alternatively, if applicable you can use your Health FSA debit card to pay the expense. The following is a summary of how both options work.

Traditional Claims: When you incur an Eligible Medical Expense (described below), you file a claim with American Fidelity by completing and submitting an Expense Reimbursement Voucher or completing the required information online at www.americanfidelity.com or through the mobile app. You may obtain an Expense Reimbursement Voucher from your Employer or American Fidelity. You must include with a reimbursement submission, a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

- Name of person receiving service;
- Name and address of service provider;
- Nature of service or supplies (drug name if a prescription or over-the-counter medication;
- Amount of reimbursable expense under the Plan; and
- Date(s) of service.

American Fidelity Assurance will process the claim once it receives the Expense Reimbursement Voucher or online or mobile app submission from you. Reimbursement for expenses that are determined to be eligible will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Expense you will receive notification of this determination. You must submit all claims for reimbursement during the Plan Year in which they were incurred or before the end of the 90 day period following the end of the Plan Year.

Debit Card. Alternatively, you may be able to use, if enabled as a 125 Plan option, a debit card to pay the expense. In order to be eligible for the debit card you must agree to abide by the terms and conditions of the debit card program including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. Even if you use the debit card to pay an expense, you may still need to submit a written statement from an independent third party as described under Traditional Claims above.

What expenses are eligible for reimbursement from my Health FSA?

Only "Eligible Medical Expenses" are eligible for reimbursement (for rules applicable to the Limited Purpose Health FSA, see below). An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Internal Revenue Code ("Code") Section 213(d); and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source

The Code generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over-the-counter drugs (and over-the-counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

"Stockpiling" of over-the-counter items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such items could be used during the Plan Year (as determined by the Employer or its delegate).

In addition, in accordance with IRS regulations, certain expenses are not reimbursable under any Health FSA:

- Health insurance premiums;
- Expenses incurred for qualified long-term care services;
- Over-the counter medications unless prescribed by a physician; and
- Any other expenses that are specifically excluded by the Employer.

When must the expenses be incurred in order to receive reimbursement?

Expenses must be incurred ***during*** the Plan Year and while you are a Participant in the 125 Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Salary Reduction Agreement or election form becomes effective, or for any expenses incurred after the close of the Plan Year or after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

What if the Eligible Expenses I incur during the Plan Year are less than the annual amount I have elected for my Health FSA?

You will forfeit any amount you elected to have contributed to your Health FSA if it has not been applied to provide reimbursement for Eligible Expenses incurred during the Plan Year that are submitted for reimbursement within the 90 day runoff period after the end of the Plan Year. Your plan contains a Carryover Provision which allows you to carryover up to $500.00 of unused election amounts from one year to the next. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

What happens if a claim for benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedure in this SPD for a detailed summary of the claims procedures that applies to this Plan.

What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been

properly substantiated during the Plan Year as set forth in this SPD, or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a Qualifying Individual), your Employer may recoup the excess reimbursements in one or more of the following ways:

- Your Employer (or its delegate) will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification;
- Your Employer may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or
- Your Employer may withhold such amounts from your pay (to the extent permitted under applicable law).

If your Employer is unable to recoup the excess reimbursement by the means set forth above, the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

What happens to my Health FSA if I take an approved leave of absence?

If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at the same coverage level in effect before the FMLA leave. Expenses incurred during the period you did not participant in the Health FSA are not eligible for reimbursement under the Health FSA after your return and reinstatement.

If you are on FMLA leave at the end of a Plan Year, you will need to elect Health FSA coverage during Open Enrollment to have coverage in effect after the end of the 125 Plan Year.

How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

How does my Limited Purpose Health FSA differ from a Health FSA?

If you participate in the Health FSA, you will be ineligible to participate in a Health Savings Account (HSA) unless you only participate in the Limited Purpose Health FSA. The Limited Purpose Health FSA only allows reimbursement for:

- Services or treatments for dental care (excluding premiums), and/or
- Services or treatments for vision care (excluding premiums).

Your participation in the Health FSA could also disqualify your spouse from establishing and making or receiving tax favored contributions to an HSA as defined in Code Section 223 unless you have elected the Limited Purpose Health FSA.

DEPENDENT DAY CARE FSA

Who can participate in the Dependent Day Care Flexible Spending Account (Dependent Day Care FSA)?

If you are eligible to participate in the 125 Plan, then you are eligible to participate in the Dependent Day Care FSA at the same time you become eligible to participate in the 125 Plan.

How do I become a Participant?

You become a Participant in the Dependent Day Care FSA by electing day care benefits during your initial enrollment period or Open Enrollment period. At Open Enrollment each year, you must make an election to participate in the Dependent Day Care FSA, even if you do not change your current election amount.

You may also become a Participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year. See the section in this SPD about Change in Elections for more details regarding mid-year election changes and the effective date of those changes.

When you complete the Salary Reduction Agreement, you specify the amount you wish to contribute with pre-tax contributions and/or Flex Credits, to the extent available. Your enrollment material will indicate if Flex Credits are available for day care coverage. Thereafter, each paycheck will be reduced by an amount equal to a prorata share of the annual contribution, reduced by any Flex Credits allocated to your Dependent Day Care FSA.

What is my "Dependent Day Care Account"?

If you elect to participate in the Dependent Day Care FSA, your Employer or its delegate will establish a "Dependent Day Care Account" to keep a record of the reimbursements to which you are entitled, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account.

When does my coverage under the Dependent Day Care FSA end?

Your coverage under the Dependent Day Care FSA ends on the earlier of the following to occur:

- The date that you elect not to participate in accordance with the election rules of the 125 Plan;
- The last day of the Plan Year unless you make an election during Open Enrollment for the following year;

- The date that you no longer satisfy the Dependent Day Care FSA eligibility requirements;
- The date that you terminate employment; or
- The date that the Plan is terminated or you, or the class of eligible employees of which you are a member, are specifically excluded from the Plan.

If you terminate employment or you cease to be eligible during the Plan Year, you may submit for reimbursement Eligible Day Care Expenses (described below) incurred for services provided prior to the date of separation, but during the Plan Year, up to the amount of your Dependent Day Care Account.

What is the maximum annual amount I may elect under the Dependent Day Care FSA?

The maximum annual amount is currently $5,000 per Plan Year if you:

- Are married and file a joint return;
- Are married but your spouse maintained a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Day Care FSA; or
- Are single.

If you are married and reside together, but file a separate federal income tax return, the maximum that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your spouse's earned income. Special rules apply if your spouse is:

- Physically or mentally incapable of caring for himself or herself, or
- A full-time student (as defined by Code Section 21).

Ask your American Fidelity representative for more information if you think these rules may apply to you.

What is an "Eligible Day Care Expense" for which I can claim a reimbursement?

Generally, an expense must meet all of the following conditions for it to be an "Eligible Day Care Expense":

- The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after the effective date of your election to participate in the Dependent Day Care FSA and during the Plan year to which it applies;
- Each individual for whom you incur the expense is a "Qualifying Individual". A "Qualifying Individual" is:
    - An individual under age 13 who is your "qualifying child" as defined in Code Section 152(a) (1). Generally, a "qualifying child" is your child (including a brother, sister, step sibling) or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of

abode with you for more than half the year and does not provide over half of his/her support. There is a special rule for children of divorced parents. The child is a Qualifying Individual of the "custodial parent", as defined in Code Section 152(e).; or

- A spouse or other tax dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

- The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp and for kindergarten (or above) do not qualify;
- If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, and such dependent regularly spends at least 8 hours per day in your home;
- If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), and the center complies with all applicable state and local laws and regulations;
- The expense is not paid or payable to a child of yours who is under age 19 by the end of the calendar year in which the expense is incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent; and
- You supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not a reimbursable expense if you have any doubts.

When must the expenses be incurred in order to receive reimbursement?

Eligible day care expenses must be incurred ***during*** the Plan Year. You may not be reimbursed for any expenses arising before the Dependent Day Care FSA becomes effective, before your Salary Reduction Agreement or election form becomes effective, or for any expenses incurred after the close of the Plan Year and after your participation in the Dependent Day Care FSA ends.

How do I receive reimbursement under the Dependent Day Care FSA?

When you incur eligible day care expenses, you submit a written or electronic claim for reimbursement to American Fidelity You may obtain an Expense Reimbursement Voucher from American Fidelity. You must include this form or provide all information requested for online submission or through the mobile app with your request for reimbursement. If there are enough funds in your Dependent Day Care FSA, you will be reimbursed for your Eligible Expenses as soon as possible after receiving the claim and processing it. If your claim was for an amount that was more than your current Dependent Day Care FSA

balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, you may not be reimbursed for any total expenses above your annual election amount. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for DCAP benefits?

You will forfeit any amount you elected to have contributed to your Dependent Day Care FSA if it has not been applied to provide reimbursement for Eligible Expenses incurred during the Plan Year that are submitted for reimbursement within the 90 day run-out period after the end of the Plan Year. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

Will I be taxed on the reimbursements I receive from my Dependent Day Care FSA?

You will not normally be taxed on your dependent care expense reimbursements so long as your family's aggregate dependent care reimbursements (under this Dependent Day Care FSA and/or another employer's Dependent Day Care FSA) do not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

If I participate in the Dependent Day Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under the Dependent Day Care FSA, although the amount of dependent care expenses you incur in excess of the amounts reimbursed from your Dependent Day Care FSA may be eligible for the dependent care credit. You should check with your tax advisor for advice about your situation.

What happens if my claim for reimbursement under the Dependent Day Care FSA is denied?

You will have the right to a full and fair review process. You should refer to the Claims For Benefits section in this SPD for additional information.

What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Dependent Day Care FSA that exceed the amount of Eligible Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a Qualifying Individual), the Employer or its delegate may recoup the excess reimbursements in one or more of the following ways:

- The Employer will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of such notification;
- The Employer may offset the excess reimbursement against any other Eligible Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or
- The Employer may withhold such amounts from your pay (to the extent permitted under applicable law).

If the Employer is unable to recoup the excess reimbursements by the means set forth above, the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse tax consequences to you.

How long will the Dependent Day Care FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

CLAIMS FOR BENEFITS

How does an employee file for benefits under the coverage elected?

To obtain benefit payments under the Plan you must comply with the rules and procedures of the particular benefit you elected. For claims procedures for the Health FSA and Dependent Day Care FSA, see the applicable question in this SPD for those benefits. If you have questions concerning insured benefit payments, you should contact the insurance carrier or the party listed at the beginning of this handbook.

What is the procedure to follow if benefits are denied?

Should you disagree with the benefit amount or if your claim is denied, you may request an additional review by filing a written request in care of the Employer. You must file this written request within 60 days after receiving payment or denial.

You will be notified in writing of the final decision within 60 days of receipt of your request for review. A thorough explanation as to the reason for denial will be furnished.

Some special rules apply to claims appeals under the Health FSA benefits, if offered under the Plan. The Employer is responsible for evaluating all claims for reimbursement under the Health FSA. The Employer will decide your claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Employer, including in cases where a claim is incomplete. You will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Employer is expected to be made. You will be given 45 days in which to complete an incomplete claim. The Employer may require such other evidence as it deems necessary to decide your claim.

If the Employer denies your initial appeal, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

- The specific reason or reasons for the denial,
- Reference to the specific plan provision on which the denial is based,
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken if you wish to appeal the Employer's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

If your initial appeal is denied in whole or in part, you may appeal to Employer for a review of the denied appeal. Your appeal must be made in writing within 180 days of the Employer's initial notice of adverse benefit determination, or else you will lose the right to appeal your denial.

Your written appeal should state the reasons that you feel your claim appeal should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) documents and other information relevant to your appeal. The Employer will review all written comments you submit with your appeal.

The Employer will review and decide your appeal within a reasonable time not longer than 60 days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial appeal denial and will not be that individual's subordinate. The Employer may require such other evidence as it deems necessary to decide your appeal. If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- The specific reason(s) for the denial,
- The specific Plan provision(s) on which the decision is based,
- A statement of your right to review (on request and at no charge) relevant documents and other information,
- If the Employer relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol,or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request," and
- A statement of your right to bring suit under ERISA § 502(a) if applicable.

You may only bring suit whether under ERISA or otherwise within 1 year of the date on the final determination of your appeal.

TERMINATION OF BENEFITS

When will my benefits under the 125 Plan terminate?

Benefits under the 125 Plan that are described in this handbook can terminate (unless the Plan provides otherwise) if:

- Your employment terminates;
- The policy terminates;
- The provider goes out of business;
- You discontinue any required contributions; or
- The Employer amends or terminates the Plan.

In any case of reduction of benefits by Plan amendment or termination, you must understand that although the Employer intends to continue these Plans indefinitely, for business reasons it must reserve the right to change or discontinue the Plan at any time. If the Employer terminates any benefit or the 125 Plan for any reason and does not replace the coverage with comparable benefits, you will receive ample notice.

What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your spouse's and dependent's right, to continue the same coverage under a component medical benefit plan that was in place the day before a Qualifying Event if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of such Qualifying Event. Continuation Coverage under federal law is provided under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).

A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- Your death;

Certain Participants with the Health FSA benefits will be eligible for COBRA Continuation Coverage if they have positive Health FSA balances at the time of a Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event). You will be notified if you are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA coverage for the Health FSA will cease at the end of the Plan Year and may not be continued for the next Plan Year. You may pay premiums for such coverage on an after-tax basis, but not beyond the current Plan Year.

Your ERISA Rights

The 125 Plan, HSA and Dependent Day Care FSA Components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and other benefit plans you pay for through the 125

Plan are governed by ERISA. This SPD does not describe the other benefit plans you pay for through the 125 Plan. Consult the benefit plan specific document and the separate SPDs for those benefits.

If you participate in the Health FSA you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- Receive Information About Your Plan and Benefits;
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the City of Plainwell, as Plan Administrator, is required by law to furnish each Participant with a copy of this summary annual report. The City of Plainwell currently is not required to submit a 5500.

COBRA and HIPAA Rights

You may continue any medical and dental coverage (and, in some cases, your Health FSA coverage) for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Note: This does not apply to the Dental Insurance Plan or Health FSA, which are “excepted benefits” under HIPAA.)

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest

of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the City of Plainwell, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL INFORMATION

A. PLAN NAME AND NUMBER

Plan Name – **City of Plainwell Flexible Benefit Plan** (the "Plan")

Plan Number - **501**

B. NAME, ADDRESS, TELEPHONE NUMBER AND TAX IDENTIFICATION NUMBER OF PLAN SPONSOR AND PLAN ADMINISTRATOR

City of Plainwell
211 N Main St,
Plainwell, MI 49080
(269) 685-6821
38-6004724

C. PARTICIPATING EMPLOYERS

The Employer whose employees are covered by the Plan is the **City of Plainwell.**

A complete updated list of the Employers participating in the Plan may be obtained upon written request to the Plan Administrator and is also available at the office of the Plan Administrator for examination by Participants and beneficiaries.

D. NAME AND ADDRESS OF THE AGENT FOR SERVICE OF LEGAL PROCESS

City of Plainwell
211 N Main St,
Plainwell, MI 49080
(269) 685-6821

E. PLAN YEAR

The Plan Year for purposes of maintaining the Plan's records is the annual period **August 1, 2018 thru July 31, 2019. Each subsequent plan year will begin on August 1 and end on July 31.**

F. TYPE OF ADMINISTRATION

The Plan is self-administered by the Employer. However, the Employer has by contract obtained the performance of certain administrative functions such as the review, processing, and payment of claims from a Claims Recordkeeper ("Recordkeeper"). The name, address, and telephone number of the Recordkeeper is:

American Fidelity Assurance Company
2000 N Classen Blvd
Oklahoma City, OK 73106
(800) 654-8489

G. FUNDING MEDIUM

The Health FSA Component is a group health plan. The Health FSA is self-funded by the Employer. It is a contract administration plan. A third-party Recordkeeper processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

H. QUALIFIED MEDICAL SUPPORT ORDERS

The Medical and Dental Insurance Plans and the Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Employer.

G. INSURERS

Insurance contracts have been purchased from insurers to fund certain benefits available under the 125 Plan. The insurers are as follows:

Type of Benefits	Insurer
Flexible Spending Accounts	American Fidelity Assurance Company
Health Savings Accounts	American Fidelity Assurance Company
Cancer	American Fidelity Assurance Company
Accident	American Fidelity Assurance Company
Accident	AFLAC
Cancer	AFLAC
Group Life	Madison National Life
Group Medical	Priority Health
Group Dental	Delta Dental
Group Vision	VSP

City of Plainwell Section 125 Flexible Benefit Plan

Plan Year
July 1, 2018 thru
July 31, 2018

Effective July 1, 2018

ADOPTED JULY 23, 2018

As its Clerk/Treasurer, I Brian Kelley certify that this is a true and complete copy adopted by the City Council of the City of Plainwell, Allegan County, Michigan, at a regular meeting held on July 23, 2018

_____ _____

Brian Kelley Clerk/Treasurer Date

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

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

A. EMPLOYER INFORMATION

Name of Employer:	CITY OF PLAINWELL
Address:	211 N MAIN ST PLAINWELL, MI 49080
Employer Identification Number:	38-6004724
Nature of Business:	GOVERNMENT
Name of Plan:	CITY OF PLAINWELL FLEXIBLE BENEFIT PLAN
Plan Number:	501

B. EFFECTIVE DATE

Original effective date of the Plan:	September 1, 1996
If Amendment to existing plan, effective date of amendment:	July 1, 2018

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

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

Length of Service:	First day of the month following 30 days of service.
Minimum Hours:	All employees with 20 hours of service or more each week excluding seasonal and temporary. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 18 years.

D. PLAN YEAR

The current plan year will begin on July 1, 2018 and end on July 31, 2018. Each subsequent plan year will begin on August 1 and end on July 31.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

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

Employer may furnish a Non-Elective Contribution as shown in the Enrollment Material. If an employee opts out of coverage, he/she may receive $2700 per year as taxable cash.

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will not be paid to the Participant as taxable cash.

For HSA ineligible active employees enrolled in the employer medical coverage AND a Medical FSA account, the Employer agrees to contributed to the FSA an amount equal to the amount contributed by the employee (subject to the maximum of the amount contributed to HSA eligible employee with similar coverage), or the IRS maximum allowable, whichever is lesser.

For HSA eligible active employees enrolled in the employer medical coverage, the city will contribute $2400 for a single and $4800 for a family in August of each year, if there is need for additional funds the city will reimburse up to a maximum amount allowed by the IRS.

For active employees with adult children on the employer medical plan, the Employer agrees to give the employee the option to elect a portion of the City-provided HSA contribution to be taken as taxable income to cover the adult child's out-of-pocket expenses.

Elective Contributions (Salary Reduction):

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

$25000.00 per plan year.

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

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

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

Priority Health
American Fidelity Assurance Company Accident Only Plan
Aflac Accident, Hospital Indemnity, Personal Sickness & Specified Health Event

Eligibility Requirements for Participation, if different than Item C.

Priority Health: All employees at hire with 40 hours of service or more each week, excluding seasonal & temporary employees.

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

N/A

Eligibility Requirements for Participation, if different than Item C.

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

American Fidelity Assurance Company
Aflac

Eligibility Requirements for Participation, if different than Item C.

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

Delta Dental
VSP

Eligibility Requirements for Participation, if different than Item C.

Delta Dental and VSP Vision: All employees with 40 hours of service or more each week, excluding seasonal & temporary employees.

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

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

Madison National Life
American Fidelity Assurance Company

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, **may not** exceed $50,000.

Eligibility Requirements for Participation, if different than Item C.

Madison National Life: All employees with 40 hours of service or more each week, excluding seasonal & temporary employees.

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

Minimum Contribution - $ **0.00** per Plan Year Maximum

Contribution - $ **5000.00** per Plan Year

Recordkeeper: **American Fidelity Assurance Company**

Eligibility Requirements for Participation, if different than Item C.

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

Minimum Coverage - $ **0.00** per Plan Year

Maximum Coverage - $ **2650.00** per Plan Year or a Prorated Amount for a Short Plan Year. In no event, may the maximum exceed the limit as indicated by the IRS in accordance with the law.

Recordkeeper: **American Fidelity Assurance Company**

Restrictions: **N/A**

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

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

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

Eligibility Requirements for Participation, if different than Item C.

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

HSA Trustee – **As designated by the employee and mutually agreed upon by the employer.**

Maximum Contribution – As indexed annually by the IRS.

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

Vision and Dental

If the Plan includes the limitation on expenses, a Participant's carryover amounts (when applicable) will be treated as an election for a limited Medical Reimbursement Plan for the carryover amounts for any plan year for which the participant has elected a Health Savings Account for that plan year.

Eligibility Requirements for Participation, if different than Item C.

a. An Employee must complete a Certification of Health Savings Account Eligibility which confirms that the Participant is an eligible individual who is entitled to establish a Health Savings Account in accordance with Code Section 223(c)(1).
b. Eligibility for the Health Savings Account shall begin on the later of (i) first day of the month coinciding with or next following the Employee's

commencement of coverage under the High Deductible Health Plan, or (ii) the first day following the end of a Grace Period available to the Employee with respect to the Medical Reimbursement Accounts that are not limited to vision and dental expenses (unless the participant has a $0.00 balance on the last day of the plan year).

c. An Employee's eligibility for the Health Savings Account shall be determined monthly.

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

This Plan is hereby adopted _____.

CITY OF PLAINWELL
(Name of Employer)

By:_____

Title:_____

APPENDIX A

Related Employers that have adopted this Plan

Name(s):
N/A

THIS DOCUMENT IS NOT COMPLETE WITHOUT SECTIONS I THROUGH XIII
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SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

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

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

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

SECTION II

DEFINITIONS

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

2.01 **Administrator** — The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).

2.02 **Beneficiary** — Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.02A **Carryover** — The amount equal to the lesser of (a) any unused amounts from the immediately preceding Plan Year or (b) five hundred dollars ($500), except that in no event may the Carryover be less than five dollars ($5).

2.03 **Code** — Internal Revenue Code of 1986, as amended.

2.04 **Dependent** — Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom

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

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

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

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

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

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

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

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

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

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

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

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

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

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

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

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f) or Section 2701(f) of the Public Health Service Act, then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that

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

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

(g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

(h) Cancellation due to reduction in hours of service. A Participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the cancellation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is cancelled.

(i) Cancellation due to enrollment in a Qualified Health Plan. A participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant is eligible for a Special Enrollment Period (as defined in Code Section 9801(f)) to enroll in a Qualified Health Plan(as described in section 1311 of the Patient Protection and Affordable Care Act (PPACA)) through a competitive marketplace established under section 1311(c) of PPACA (Marketplace), pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is cancelled.

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

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

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering

similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

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

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.

6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

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

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated

for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

(a) Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

(b) Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

(c) Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

(d) Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

(e) Forfeiture. Subject to Section 8.06 and 8.07, any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

(f) COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in

which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

(g) Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

(h) Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan (increased by any Carryover to the Plan Year), shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

(i) Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

(j) Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

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

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

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

8.04 ELIGIBLE MEDICAL EXPENSES:

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

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

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

(c) Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and (b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 8.04(b)).

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

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

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

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.

(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

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

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

(i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

(d) Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of such cards set forth in

Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

8.06 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

8.07 Carryover: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Carryover with respect to the Medical Reimbursement Plan, the provisions of this Section 8.07 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2013-71, the Carryover for a Participant who has an amount remaining unused as of the end of the run-off period for the Plan Year, may be used to pay or reimburse Eligible Medical Expenses during the following entire Plan Year. The Carryover does not count against or otherwise affect the Maximum benefit set forth in Section 8.03 (b). Eligible Medical Expenses incurred during a Plan Year shall be reimbursed first from unused contributions for the current Plan Year, and then from any Carryover carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run-off period, (b) must be counted against any Carryover amount from the prior Plan Year, and (c) cannot exceed the maximum Carryover from the prior Plan Year. If the Employer elects to apply Section 8.06 in Section F.7 of the Adoption Agreement, this Section 8.07 shall not apply.

8.08 QUALIFIED RESERVIST DISTRIBUTIONS: Notwithstanding anything in the Plan to the contrary, an individual who, by reason of being a member of a reserve component (as defined in 37 U.S.C. § 101), is ordered or called to active duty for a period in excess of 179 days or for an indefinite period may elect to receive a distribution of all or a portion of the unused Elective Contributions in his or her Account relating to the Medical Expense Reimbursement Plan if the distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year that includes the date of such order or call. If the distribution is for the entire amount of unused Elective Contributions available in the Medical Expense Reimbursement Plan, then no additional reimbursement requests will be processed for the remainder of the Plan Year.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

(a) Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

(b) Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.

(c) For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

(d) Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

(e) Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

(f) Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.

(g) Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more

than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

(a) "Dependent" (for purposes of this Section IX) means any individual who is:

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

(b) "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:

(i) provides care for more than six individuals (other than individuals who reside at the facility);

(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and

(iii) satisfies all applicable laws and regulations of a state or unit of local government.

(c) "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;

(ii) paid or payable to a Dependent Care Service Provider; and

(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

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

(i) a Dependent Care Center, or

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

SECTION X

HEALTH SAVINGS ACCOUNTS

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

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

10.03 TERMS, CONDITIONS AND LIMITATION:

(a) Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.

(b) Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

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

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

SECTION XI

AMENDMENT AND TERMINATION

11.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

(a) General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

(b) Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

(c) Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

(a) Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

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

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

(b) Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

(c) Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

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

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

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

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

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

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

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

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

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

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

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

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

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

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

SECTION XIII

MISCELLANEOUS PROVISIONS

13.01 INABILITY TO LOCATE PAYEE: If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

13.02 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant or Dependent.

13.04 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

13.05 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.06 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

13.07 CONSTRUCTION:

(a) Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

(b) Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

13.08 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.09 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.

PD 0217sw

City of Plainwell Section 125 Flexible Benefit Plan

Plan Year
August thru July

Effective August 1, 2018

ADOPTED JULY 23, 2018

As its Clerk/Treasurer, I Brian Kelley certify that this is a true and complete copy adopted by the City Council of the City of Plainwell, Allegan County, Michigan, at a regular meeting held on July 23, 2018

_____ _____

Brian Kelley Clerk/Treasurer Date

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

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

A. EMPLOYER INFORMATION

Name of Employer:	CITY OF PLAINWELL
Address:	211 N MAIN ST PLAINWELL, MI 49080
Employer Identification Number:	38-6004724
Nature of Business:	GOVERNMENT
Name of Plan:	CITY OF PLAINWELL FLEXIBLE BENEFIT PLAN
Plan Number:	501

B. EFFECTIVE DATE

Original effective date of the Plan:	September 1, 1996
If Amendment to existing plan, effective date of amendment:	August 1, 2018

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

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

Length of Service:	First day of the month following 30 days of service.
Minimum Hours:	All employees with 20 hours of service or more each week excluding seasonal and temporary. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 18 years.

D. PLAN YEAR

The current plan year will begin on August 1, 2018 and end on July 31, 2019. Each subsequent plan year will begin on August 1 and end on July 31.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

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

Employer may furnish a Non-Elective Contribution as shown in the Enrollment Material. If an employee opts out of coverage, he/she may receive $2700 per year as taxable cash.

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will not be paid to the Participant as taxable cash.

For HSA ineligible active employees enrolled in the employer medical coverage AND a Medical FSA account, the Employer agrees to contributed to the FSA an amount equal to the amount contributed by the employee (subject to the maximum of the amount contributed to HSA eligible employee with similar coverage), or the IRS maximum allowable, whichever is lesser.

For HSA eligible active employees enrolled in the employer medical coverage, the city will contribute $2400 for a single and $4800 for a family in August of each year, if there is need for additional funds the city will reimburse up to a maximum amount allowed by the IRS.

For active employees with adult children on the employer medical plan, the Employer agrees to give the employee the option to elect a portion of the City-provided HSA contribution to be taken as taxable income to cover the adult child's out-of-pocket expenses.

Elective Contributions (Salary Reduction):

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

$25000.00 per plan year.

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

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

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

Priority Health
American Fidelity Assurance Company Accident Only Plan
Aflac Accident, Hospital Indemnity, Personal Sickness & Specified Health Event

Eligibility Requirements for Participation, if different than Item C.

Priority Health: All employees at hire with 40 hours of service or more each week, excluding seasonal & temporary employees.

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

N/A

Eligibility Requirements for Participation, if different than Item C.

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

American Fidelity Assurance Company
Aflac

Eligibility Requirements for Participation, if different than Item C.

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

Delta Dental
VSP

Eligibility Requirements for Participation, if different than Item C.

Delta Dental and VSP Vision: All employees with 40 hours of service or more each week, excluding seasonal & temporary employees.

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

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

Madison National Life
American Fidelity Assurance Company

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, **may not** exceed $50,000.

Eligibility Requirements for Participation, if different than Item C.

Madison National Life: All employees with 40 hours of service or more each week, excluding seasonal & temporary employees.

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

Minimum Contribution - $ **0.00** per Plan Year Maximum

Contribution - $ **5000.00** per Plan Year

Recordkeeper: **American Fidelity Assurance Company**

Eligibility Requirements for Participation, if different than Item C.

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

Minimum Coverage - $ **0.00** per Plan Year

Maximum Coverage - $ **2650.00** per Plan Year or a Prorated Amount for a Short Plan Year. In no event, may the maximum exceed the limit as indicated by the IRS in accordance with the law.

Recordkeeper: **American Fidelity Assurance Company**

Restrictions: **N/A**

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

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

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

Eligibility Requirements for Participation, if different than Item C.

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

HSA Trustee – **As designated by the employee and mutually agreed upon by the employer.**

Maximum Contribution – As indexed annually by the IRS.

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

Vision and Dental

If the Plan includes the limitation on expenses, a Participant's carryover amounts (when applicable) will be treated as an election for a limited Medical Reimbursement Plan for the carryover amounts for any plan year for which the participant has elected a Health Savings Account for that plan year.

Eligibility Requirements for Participation, if different than Item C.

a. An Employee must complete a Certification of Health Savings Account Eligibility which confirms that the Participant is an eligible individual who is entitled to establish a Health Savings Account in accordance with Code Section 223(c)(1).
b. Eligibility for the Health Savings Account shall begin on the later of (i) first day of the month coinciding with or next following the Employee's

commencement of coverage under the High Deductible Health Plan, or (ii) the first day following the end of a Grace Period available to the Employee with respect to the Medical Reimbursement Accounts that are not limited to vision and dental expenses (unless the participant has a $0.00 balance on the last day of the plan year).

c. An Employee's eligibility for the Health Savings Account shall be determined monthly.

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

This Plan is hereby adopted _____.

CITY OF PLAINWELL
(Name of Employer)

By:_____

Title:_____

APPENDIX A

Related Employers that have adopted this Plan

Name(s):
N/A

THIS DOCUMENT IS NOT COMPLETE WITHOUT SECTIONS I THROUGH XIII
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SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

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

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

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

SECTION II

DEFINITIONS

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

2.01 **Administrator** — The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).

2.02 **Beneficiary** — Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.02A **Carryover** — The amount equal to the lesser of (a) any unused amounts from the immediately preceding Plan Year or (b) five hundred dollars ($500), except that in no event may the Carryover be less than five dollars ($5).

2.03 **Code** — Internal Revenue Code of 1986, as amended.

2.04 **Dependent** — Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom

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

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

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

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

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

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

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

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

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

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

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

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

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

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

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

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f) or Section 2701(f) of the Public Health Service Act, then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that

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

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

(g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

(h) Cancellation due to reduction in hours of service. A Participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the cancellation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is cancelled.

(i) Cancellation due to enrollment in a Qualified Health Plan. A participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant is eligible for a Special Enrollment Period (as defined in Code Section 9801(f)) to enroll in a Qualified Health Plan(as described in section 1311 of the Patient Protection and Affordable Care Act (PPACA)) through a competitive marketplace established under section 1311(c) of PPACA (Marketplace), pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is cancelled.

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

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

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering

similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

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

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.

6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

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

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated

for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

(a) Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

(b) Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

(c) Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

(d) Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

(e) Forfeiture. Subject to Section 8.06 and 8.07, any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

(f) COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in

which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

(g) Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

(h) Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan (increased by any Carryover to the Plan Year), shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

(i) Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

(j) Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

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

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

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

8.04 ELIGIBLE MEDICAL EXPENSES:

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

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

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

(c) Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and (b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 8.04(b)).

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

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

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

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.

(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

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

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

(i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

(d) Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of such cards set forth in

Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

8.06 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

8.07 Carryover: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Carryover with respect to the Medical Reimbursement Plan, the provisions of this Section 8.07 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2013-71, the Carryover for a Participant who has an amount remaining unused as of the end of the run-off period for the Plan Year, may be used to pay or reimburse Eligible Medical Expenses during the following entire Plan Year. The Carryover does not count against or otherwise affect the Maximum benefit set forth in Section 8.03 (b). Eligible Medical Expenses incurred during a Plan Year shall be reimbursed first from unused contributions for the current Plan Year, and then from any Carryover carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run-off period, (b) must be counted against any Carryover amount from the prior Plan Year, and (c) cannot exceed the maximum Carryover from the prior Plan Year. If the Employer elects to apply Section 8.06 in Section F.7 of the Adoption Agreement, this Section 8.07 shall not apply.

8.08 QUALIFIED RESERVIST DISTRIBUTIONS: Notwithstanding anything in the Plan to the contrary, an individual who, by reason of being a member of a reserve component (as defined in 37 U.S.C. § 101), is ordered or called to active duty for a period in excess of 179 days or for an indefinite period may elect to receive a distribution of all or a portion of the unused Elective Contributions in his or her Account relating to the Medical Expense Reimbursement Plan if the distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year that includes the date of such order or call. If the distribution is for the entire amount of unused Elective Contributions available in the Medical Expense Reimbursement Plan, then no additional reimbursement requests will be processed for the remainder of the Plan Year.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

(a) Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

(b) Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.

(c) For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

(d) Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

(e) Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

(f) Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.

(g) Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more

than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

(a) "Dependent" (for purposes of this Section IX) means any individual who is:

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

(b) "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:

(i) provides care for more than six individuals (other than individuals who reside at the facility);

(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and

(iii) satisfies all applicable laws and regulations of a state or unit of local government.

(c) "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;

(ii) paid or payable to a Dependent Care Service Provider; and

(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

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

(i) a Dependent Care Center, or

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

SECTION X

HEALTH SAVINGS ACCOUNTS

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

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

10.03 TERMS, CONDITIONS AND LIMITATION:

(a) Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.

(b) Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

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

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

SECTION XI

AMENDMENT AND TERMINATION

11.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

(a) General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

(b) Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

(c) Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

(a) Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

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

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

(b) Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

(c) Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

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

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

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

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

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

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

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

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

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

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

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

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

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

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

SECTION XIII

MISCELLANEOUS PROVISIONS

13.01 INABILITY TO LOCATE PAYEE: If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

13.02 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant or Dependent.

13.04 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

13.05 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.06 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

13.07 CONSTRUCTION:

(a) Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

(b) Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

13.08 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.09 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.

PD 0217sw

"The Island City"

MEMORANDUM

211 N. Main Street
Plainwell, Michigan 49080
Phone: 269-685-6821
Fax: 269-685-7282

TO: Erik J. Wilson, City Manager

FROM: Brian Kelley, City Treasurer

DATE: July 20, 2018

SUBJECT: Encumbrance Rollover from 2017/2018 to 2018/2019 budget

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ACTION RECOMMENDED: The City Council approve a budget amendment for the 2018/2019 budget in order to appropriate a prior year encumbrance into the current fiscal year.

An encumbrance reserves funds when a contract or purchase order is approved. The encumbrances also commit an equivalent budget amount for an expenditure line item. All prior year encumbrances reserved for obligations of materials and/or services that have not yet been delivered by year-end are to be closed in the prior year and reopened (carryover) in the current fiscal year. Annually, the budget appropriations for these obligations are moved from the prior fiscal year into the current fiscal year (2018/2019), allowing for the funds on these encumbrances to be expended in the current fiscal year.

City staff recently reviewed a listing of the outstanding encumbrances as of June 30, 2018 and determined those encumbrances that require re-appropriating into the current fiscal year in order to complete the purchases or services as intended. Upon review, eight (8) encumbrances are being brought forth for rollover:

PO 5099 – Fleis & Vandenbrink Inc. – Wellhead Protection Program - $1,659.30
Account Code 591-560-801.000
PO 5147 – Fleis & Vandenbrink Inc. – Sherwood Park Restroom Design – $ 10,000.00
Account Code 101-691-801.000
PO 5211 – Fleis & Vandenbrink Inc. – Well 4 Improvement Engineering – $ 14,900.00
Account Codes 591-970-971.000
PO 5230 – Civica Engineering PLLC – City Parking Lot Engineering - $ 2,700.00
Account Code 494-000-801.000
PO 5247 – Moore Electrical Services Inc. – Hill St. Lift Station Electrical - $ 9,470.00
Account Code 590-970-971.000
PO 5248 – Balkema Excavating Inc. – Hill St. Lift Station Excavating - $ 43,335.00
Account Code 590-970-971.000
PO 5251 – Waterway LLC – Fire Hose Testing - $ 2,413.20
Account Code 101-336-930.000
PO 5257 – Perceptive Controls Inc. – Hill St. Lift Station Programming - $ 3,200.00
Account Code 590-970-971.000

Approving the request for this budget amendment will ensure that work on existing obligations will continue and that there will be no impact on services planned for the current fiscal year. There is no impact to the city for rolling over prior year encumbrances. These funds have already been budgeted in prior year and were considered reserved and unavailable for purposes of the current fiscal year budget. The total amount being rolled over is $ 87,677.50.

Purchase Order Report FOR CITY OF PLAINWELL
Status: Open & Partial
Post Dates From 01/01/1901 To 06/30/2018

PO NUMBER	PO STATUS	PO TYPE	REQUIRED DATE	DATE POSTED	AMOUNT	PO BALANCE	VENDOR INFORMATION
ENTERED BY		DEPARTMENT					
DESCRIPTION							
000005099	Partial	Regular		07/01/2017	3,700.00	1,659.30	000153
Sheryl		560 UTILITY ADMINISTRATION					FLEIS & VANDENBRINK INC
UPDATE PLAINWELL WHP PROGRAM - CITY'S HALF							Contact:
							Phone:
000005147	Open	Regular		09/20/2017	10,000.00	10,000.00	000153
Denise		691 PARKS DEPT					FLEIS & VANDENBRINK INC
SHERWOOD PARK RESTROOM ENGINEERING/DESIGN							Contact:
							Phone:
000005211	Open	Regular	02/15/2018	02/13/2018	14,900.00	14,900.00	000153
Rick		970 CAPITAL OUTLAY					FLEIS & VANDENBRINK INC
DESIGN AND CONSTRUCTION ENGINEERING ON WELL 4 IMPROVEMENTS							Contact:
							Phone:
000005230	Open	Regular		03/13/2018	2,700.00	2,700.00	003028
BKELLEY		000 OPERATIONS					CIVICA ENGINEERING PLLC
CITY CENTER PARKING LOT ENGINEERING							Contact:
							Phone:
000005247	Open	Regular	05/18/2018	05/21/2018	9,470.00	9,470.00	004769
Bryan		540 PUMPING & TREATMENT					MOORE ELECTRICAL SERVICES INC
ELECTRICAL FOR NEW HILL ST LIFT STATION							Contact:
							Phone:
000005248	Open	Regular	05/18/2018	05/21/2018	43,335.00	43,335.00	004874
Bryan		540 PUMPING & TREATMENT					BALKEMA EXCAVATING, INC.
INSTALLTION AND EXCAVATION FOR HILL ST LIFT STATION 5-2-18 BID DOC							Contact:
							Phone:
000005251	Open	Regular	06/15/2018	06/12/2018	2,413.20	2,413.20	002642
Bill		336 PUBLIC SAFETY - FIRE DIVISION					WATERWAY LLC
ANNUAL HOSE TESTING							Contact:
							Phone:
000005257	Open	Regular	06/18/2018	06/13/2018	3,200.00	3,200.00	001829
Bryan		540 PUMPING & TREATMENT					PERCEPTIVE CONTROLS INC
PLC PROGRAMMING AND STARTUP FOR HILL ST LIFT STATION AS PART OF CAPITAL							Contact:
							Phone:
Grand Totals:		8			89,718.20	87,677.50	

PLAINWELL PUBLIC SAFETY

Police, Fire and Medical First Responder Services

MONTHLY REPORT
April 2018

Prepared by Director Bill G. Bomar

Plainwell Department of Public Safety

Scheduled Hours By Activity for April 2018

The categories listed below are based on law enforcement related activities and the hours that scheduled road patrol personnel spend in the 4 major areas.

	Total Hours	Percentage of Total Hours
TOTAL ROAD PATROL HOURS SCHEDULED FOR THE MONTH	**976**	
The Hours officers are scheduled for road patrol or other uniformed functions. These are fixed shifts which generally carry assigned duties.		
Totals of all the below mentioned areas.		
HOURS SPENT INVESTIGATING OR HANDLING CRIMINAL COMPLAINTS	**78**	**8.03%**
The Hours Scheduled for criminal investigations of complaints that are in violation of a criminal law that an individual could be arrested and jailed for.		
Examples include: Burglaries, Robberies, Drunk Driving, All Sex Offenses, Alcohol Offenses, Larcenies, Etc.		
HOURS SPENT INVESTIGATING OR HANDLING NON-CRIMINAL COMPLAINTS	**205**	**20.95%**
The Hours Scheduled for Calls for Service or Complaints that require investigation but are not criminal in nature.		
Examples include: Auto Accidents, Accidental Fires, Traffic Citations, Property Inspections, Etc.		
HOURS SPENT ON SUPPORT OR PERIPHERAL ACTIVITIES	**308**	**31.59%**
The Hours Scheduled for required duties however are not criminal or non-criminal in nature and are supporting functions.		
Examples include: Report Writing, Court, Directed Patrol, Foot Patrol, On Duty Training, Transport of Paperwork to the Court, Evidence to the Crime Lab, Etc.		
TOTAL UNOBLIGATED PATROL HOURS	**385**	**39.43%**
The Hours of Scheduled Road Patrol left over that officers are not assigned to an activity or working on a complaint.		
Examples include: General Preventive Patrol, Building Security Checks, Etc. ***Note:*** *This also includes any break time the officers take during their shift.*		
TOTAL HOURS OBLIGATED TO DUTIES, COMPLAINTS, INVESTIGATIONS, ETC.	**591**	**60.57%**

It is recommended by the International Association of Chiefs of Police (IACP) that no more than 65% to 70% of an officers time on duty, be obligated to complaints, investigations, activities or assigned responsibilities. The rationale behind this is to assure that officers are available for emergencies without unreasonable delay and provide for preventive and traffic patrol duties.

Plainwell Department of Public Safety

Complaints/Activities for April 2018

ARRESTS

CUSTODIAL ARRESTS	**8**	*An individual taken into custody for a criminal offense and jailed for that offense.*
ARREST COUNTS	**9**	*Criminal complaints or cases cleared by the custodial arrest or issuance of a warrant(s).*

TRAFFIC ENFORCEMENT & CITATIONS

HAZARDOUS CITATIONS	**10**	*Uniform Law Citations issued by officers to individuals for moving traffic violations.(Drag racing, Speeding, etc.)*
NON-HAZARDOUS CITATIONS	**13**	*Uniform Law Citations issued by officers to individuals for NON-moving traffic violations. (Registration, Equipment, Etc.)*
DRUNK DRIVING CITATIONS	**1**	*This is an activity that we specifically monitor that would normally be considered a hazardous citation.*
PARKING CITATIONS	**15**	*Citations issued in violation of city ordinance. This would include Overnight Parking, Time Limitation Parking, etc.*
VERBAL WARNINGS	**7**	*Traffic enforcement where no citation was issued but warnings were given.*
TOTAL TRAFFIC CITATIONS/WARNINGS	**46**	

COMPLAINTS

ORIGINAL DISPATCH COMPLAINTS	**190**	*Complaints that are call in or the officer is dispatched to by Allegan County Central Dispatch (911) or our business office.*
PATROL INITIATED COMPLAINTS	**7**	*Complaints observed by the officer while on patrol or came to their attention by personal observation.*
TOTAL COMPLAINTS	**197**	

OTHER ACTIVITIES

MOTORISTS ASSISTS	**33**	*Motorist contacts caused by mechanical breakdown or similar problem.*
PROPERTY INSPECTIONS	**0**	*Checks of homes or business specifically requested by a home or business owner.*
MOTOR VEHICLE ACCIDENTS	**3**	*Total motor vehicle accidents both on public roads or private property.*
COMMERCIAL BUILDING SECURITY CHECK	**874**	*Nightly security inspections of business' conducted by officers to assure windows and doors are locked.*
FOUND UNSECURED	**54**	*The number of business' found unlocked or unsecured.*

Classification of Crimes Reported

File Class	CRIMES AGAINST PERSON	April	Year to Date
900	Murder and Non-Negligent Manslaughter	0	0
1000	Kidnapping	0	0
1100	Sexual Assault	0	0
1200	Robbery	0	0
1300	Aggravated & Non-Aggravated Assault	3	29
	PROPERTY CRIMES		
2000	Arson	0	0
2100	Extortion	0	0
2200	Burglary	2	7
2300	Larceny	5	22
2400	Motor Vehicle Theft	0	1
2500	Forgery/Counterfeiting	0	0
2600	Fraudulent Activities	1	9
2700	Embezzlement	0	4
2800	Stolen Property - Buying, receiving	0	0
2900	Damage to Property	2	4
3500	Violation of Controlled Substances Act	2	9
	MORALS/DECENCY CRIMES		
3600	Sex Offenses (Other than Sexual Assault)	0	0
3700	Obscenity	0	0
3800	Family Offenses	2	4
4100	Liquor Violations	0	0
	PUBLIC ORDER CRIMES		
4800	Obstructing Police - Offenses Which Interfere with Investigations	0	0
4900	Escape/Flight - Fleeing and Eluding a Officer's Custody	0	0
5000	Obstructing Justice	2	15
5200	Weapons Offenses	0	1
5300	Public Peace	10	42
5400	Traffic Investigations - Any Criminal Traffic Complaints	2	19
5500	Health and Safety	0	3
5600	Civil Rights	0	0
5700	Invasion of Privacy	0	10
6200	Conservation Law Violation	0	0
7300	Miscellaneous Criminal Offense	0	0
	GENERAL NON-CRIMINAL		
9100	Juvenile/Minor/School Complaints	0	0
9200	Civil Custody	0	0
9300	Traffic Non-Criminal (Reports Only - Does not include Citations Issued)	12	60
9400	False Alarm Activation	2	15
9500	Fires (Other than Arson)	4	14
9700	Accidents, All Other	0	0
9800	Inspections, Unfounded FIRS	42	158
9900	General Assistance (All Except Other Police Agencies)	48	233
9911 & 9912	General Assistance (Other Police Agencies)	36	144
FIRS	Medical First Responder	22	92

April Reports for Plainwell Department of Public Safety

PRIORITY 1 ASSISTS OUTSIDE OF JURISDICTION

The Plainwell Department of Public Safety was dispatched to 36 calls for assistance outside the city limits of Plainwell by Allegan County Central Dispatch.

These calls were classified as priority 1 assists.

****

Fire Suppression/Call Out Incident Report

Date	Dispatch Time	Arrival Time	Location	Incident Type	Actions taken	Apparatus	PSO	POC
04/01/18	1809	1812	320 Brigham Street	Medical	Medical	Patrol car, personal	3	4
04/05/18	1648	1653	412 Oaks Crossing	Vehicle fire	Extinguish	E-63, E-11	3	5
04/08/18	1912	1917	555 Lincoln Rd	Fire	Provide water	E-17	1	4
04/15/18	1150	1201	950 Lincoln Pkwy	Structure fire	Extinguish, ventilate	E-17, E-11	3	6
04/16/18	0651	0701	950 Lincoln Pkwy	Structure fire	Extinguish	E-17, E-11	5	4
04/30/18	2346	2351	605 W. Bridge Street	Gas leak	Ventilate	E-11	3	3

****

Calls for Service at Plainwell Schools

Plainwell High School: 2
684 Starr Road

Plainwell Middle School: 1
720 Brigham Street

Early Childhood Development: 0
307 E. Plainwell Street

Admin, Maintenance & Bus Garage: 1
600 School Drive

Gilkey School: 0
707 S. Woodhams Street

Starr Elementary: 0
601 school Drive

Renaissance School: 0
422 Acorn Street

FIRE & MEDICAL FIRST RESPONDER CALL LOG

PATCH	TOTAL	RESPONSE	LOCATION (ADDRESS NOT NAME)	REASON FOR ENTRY	ACTION TAKEN	APPARATUS	PSO	POC	JI
1:50	220	2	950 Lincoln Pky	Business Fire		P5, E11	3	4	
:52	118	2	950 lincoln pkwy,	fire in wall	suport fire ops	2	5	5	
:00	120		950 Lincoln Pkwy,	Fire call					
5:17	8	0	300 BLOCK W,CHART	BURN	PUT OUT				
7:34	11	1	600 Block W. Bridge St.,	Fire Alarm					
3:46	105	4	600 BLOCK W.BRIDGE ST	GAS ODOR	INVESTIGATED	11	1	2	
LS:	10 HRS								
ME (ALL CALLS):	2 MIN								

3:08	32	4	300 Block Brigham St.	Medical/lift assist					
5:42	28	3	300 Block Brigham St.	mfr		car5	1		
7:39	26	1	300 Block Brigham St.	MEDICAL	ASSIST EMS				
:05	25	3	700 Block Benhoy St	Laceration	Called EMS, LEIN Check				
:48	22	5	400 Block Naomi St	MFR	Assist EMS	P5	1		
0:51	39	3	300 Block Brigham St	MFR		P5	1		
2:57	33	1	300 Block Brigham St	ASSIST EMS	ASSIST				
2:26	31	6	500 Block Kaywood St	SUICIDAL SUBJECT	ASSIST				G
5:43	27	4	300 Block Brigham St	MEDICAL	ASSIST				
:41	27	2	600 Block Melrose St	MEDICAL	ASSIST				
3:42	3		300 Block 12th St.	MFR	Called Away to B&E in Progress				
:45	25	3	300 Block Brigham St	MFR		P5	1		
5:30	60	6	Union & Prince	Suicidal Subject / Assist to ACSD					
9:18	32	3	100 Block Prairie St	MEDICAL	ASSIST				
:45	30	6	1200 Block 116th Ave	SUICIDAL SUBJECT	ASSIST				
5:00	14	2	600 Block Melrose St	mfr		car5	1		
0:37	23	3	600 Block Starr Rd	MFR		P1	1		
1:33	16	4	300 Block Brigham St.	mfr					
:30	25	4	300 Block Brigham St.	mfr					
2:06	24	3	100 Block N Main St	MFR		P5	2		
1:54	24	3	300 Block Brigham St	Medical	Assist PEMS				
1:47	7	3	100 Block Prospect St	Medical	Assist PEMS				
2:08	37	9	600 Block 105th Ave	MFR / No TWP Officer Available		P5	2		GUN
0:42	23	2	300 Block 12th St	Suicidal					
0:10	35	4	900 Block Lincoln Pky	MFR		P5	1		
3:38	22	7	300 Block 12th St	Suicidal Subject					
2:55	55	7	300 Block Crossoaks Dr	Suicidal	Assist				Ot
0	110	2	100 Block Florence St	Suicidal/Combative	Rode with EMS				
1	35	0	100 Block Allegan St	Suicidal					

LS: 15 HRS

ME: 4 MIN

RESPONSES OUTSIDE THE CITY LIST THE JURISDICTI

CALLS WITHIN THE CITY WHERE ASSISTANCE WAS RECEIVED BY AN OUTSIDE AGENCY LIST AGE

ER DID NOT LIST RESPONSE TIME

ONSE OUTSIDE THE CITY

POLICE EMERGENCY CALLS (EXCLUDES FIRE AND MFR CALLS)

DATE	DISPATCH	TOTAL	RESPONSE	LOCATION (ADDRESS NOT NAME)	REASON FOR ENTRY	ACTION TAKEN	JURISDICTION
04/01/2018	10:42	18	1	200 Block Park St	Disorderly Person	Trespass Warning	
43192.0487	0.986111	90	0	US 131 & County line,	PIA w/Ejection	Assist to KZOO and EMS	KAL CO
04/05/2018	1:23	32	2	100 Block Allegan St	Susp		
04/05/2018	15:30	270	1	400 Block Naomi St	Mental Commitment	Petition / Security for CMH	ACSD
04/07/2018	17:01	49	4	100 Block E Bridge St	PIA	Ticket/P30749	
04/07/2018	4:23	12	2	600 Block Allegan St	Drugs	Found Drugs	
43198	0.494444	52	2	1200 Block Keith St	B&E suspect running	asst msp	otsego twp
43198	0.53125	30	10	2200 Block Jefferson Rd	DV with gun	asst acsd	otsego twp
04/08/2018	14:07	31	2	300 Block Prince St	mental left pipp	tot wife	msp
04/08/2018	22:41	14	2	400 Block Brigham St	Civil		OPD
04/10/2018	13:35	385	2	E Bridge & Main	OWID	Tests / Arrest / Blood Test / Lodge	
04/10/2018	19:55	43	4	N/B 131 48mm	Assist PIA		
04/11/2018	21:21	21	3	700 Block Benhoy St	Apt A/ DV	Civil	ACSD
43201	0.904167	45	4	1300 Block M-89	DV	Assist	Otsego TWP
43201.2485	0.2375	73	0	1100 Block M-89	RETAIL FRAUD	ASSIST	GUNPLAIN
43202	0.070833	33	3	1200 Block Keith St	Unknown subj w/knife	Assist	Otsego TWP
04/12/2018	17:20	190	0	300 Block Colfax St	Child Abuse		
43202.6103	0.5875	34	3	M89/OAKS CROSSING	PI ACCIDENT	ASSIST	OTSEGO TWSP
43203.6012	0.572917	45	3	500 Block Center St	Subject Trying to Break In	Assisted Dep. Harris w/ Removal	GUNPLAIN TWP
43204.3423	0.325694	41	4	500 Block Kaywood Dr	Domestic Disturbance		GUNPLAIN TWP
04/17/2018	10:29	49	0	100 Block Second Ave	mdop	inves	acsd
04/18/2018	20:40	45	2	700 Block Benhoy St	Apt F, DV/civil	Uncooperative victim	
43211	0.828472	20	0	1200 Block Keith St	DV	Assist	
04/21/2018	20:24	66	4	500 Block 10th St	Check welfare	Warrant	
04/21/2018	21:54	22	1	900 Block N Main St	Subject w/ weapon	Checked on Poss Suspect	
04/21/2018	9:08	21	0	1100 Block N Main St	bol man with sword	goa	
43213.7019	0.670833	49	0	BK / Home Depot	Subjects Stealing Pop from BK / Assist ACSD		OTSEGO TWP
43213.9316	0.847222	27	4	900 Block Versailles St.,	Disorderly Subject	Assist ACSD	GUNPLAIN TWP
04/25/2018	8:51	43	3	300 Block 12th St	SUSP/CIVIL	INVESTIGATE	ACSD
04/25/2018	9:34	61	0	300 Block 12th St	WARRANT ARREST	LODGE	
04/25/2018	15:04	13	6	600 Block Morrell St	ABAN 911	INVESTIGATE	
43216	0.705556	24	1	1300 Block M-89	Shoplifting in progress	R/O and held down scene	Otsego TWP
43218.638	0.621528	25	4	M-89 Sports Bar	Mental Subject Out of Control		OTSEGO CITY
04/29/2018	13:59	61	5	500 Block E Bridge St	Domestic Dusturbance		ACSD
04/30/2018	22:32	18	3	100 Block E Plainwell St	HARRASSMENT	INVESTIGATED	

AVERAGE RESPONSE TIME WITHIN CITY: 2 MIN

TOTAL TIME ON ALL CALLS: 34 HRS

CALLS WITHIN THE CITY WHERE ASSISTANCE WAS RECEIVED BY AN OUTSIDE AGENCY LIST AGENCY INITIALS

RESPONSES OUTSIDE THE CITY LIST THE JURISDICTION ASSISTED

OFFICER DID NOT LIST RESPONSE TIME

RESPONSE OUTSIDE THE CITY

ASSISTS OUTSIDE THE CITY

TOTAL	LOCATION (ADDRESS NOT NAME)	REASON FOR ENTRY	ACTION TAKEN	APPARATUS	PSO	POC
90	US 131 & County line,	PIA w/Ejection	Assist to KZOO and EMS			
15	100 11th st,	asst gpt	pbt to c5 ref poss owi			
30	945 Richelieu,	Assist ACSD Domestic	Staged with 741 at entrance			
36	421 W Allegan, Otsego	BU 741 Domestic	Traffic Stop from address			
30	Allegan/ Farmer,	Traffic Stop CKE 2344	Expired License			
52	1220 keith st,	B&E suspect running	asst msp			
30	2234 jefferson,	DV with gun	asst acsd			
73	1195 M89,,	RETAIL FRAUD	ASSIST			
31	576 KAYWOOD	SUICIDAL SUBJECT	ASSIST			
34	M89/OAKS CROSSING	PI ACCIDENT	ASSIST			
45	587 Center St	Subject Trying to Break In	Assisted Dep. Harris w/ Removal			
41	576 Kaywood Dr	Domestic Disturbance				
18	412 Oaks Crossings	Suspicious Person Sleeping in Van				
50	US 131 SB @ Trestle Bridge	Property Damage Accident				
20	RIVER/FARMER	SUB POSS CARRYING RIFLE	INVESTIGATE			
30	1249B116TH LOT 2	SUICIDAL SUBJECT	ASSIST			
149	106th & 10th	Traffic Arrest / Search of Vehicle / Assist ACSD				
49	BK / Home Depot	Subjects Stealing Pop from BK / Assist ACSD				
37	667 105th Ave	MFR / No TWP Officer Available		P5	2	
45	667 105th Ave,	Assist ACSD Mental	assist ambulance			
55	332 Crossoaks Dr,	Suicidal	Assist			
45	1362 m89,	DV	Assist			
33	1228 Keth,	Unknown subj w/knife	Assist			
24	1329 m89,	Shoplifting in progress	R/O and held down scene			

18 hrs

CALLS IN THE CITY WHERE ASSISTANCE WAS RECEIVED BY ANOTHER AGENCY

H	TOTAL	LOCATION (ADDRESS NOT NAME)	REASON FOR ENTRY	ACTION TAKEN	APPARATUS	PSO	POC
	30	404 W Bridge St	Unsecured Doors	Search interior / Secure Doors			
	270	400 Block Naomi St	Mental Commitment	Petition / Security for CMH			
	31	300 prince,	mental left pipp	tot wife			
	79	127 E Bridge St	Burglary				
	73	715 N Main St	Shattered Window at Business				
	49	119 seacond ave,	mdop	inves			
	43	329 12th C12	SUSP/CIVIL	INVESTIGATE			
	61	518 E Bridge St	Domestic Dusturbance				
	14	404 Brigham,	Civil				
	21	712 Benhoy,	Apt A/ DV	Civil			
	27	622 Allegan,	Drugs	Investigation/warrant request			
	110	100 Florence,	Suicidal/Combative	Rode with EMS			
	35	157 Allegan,	Suicidal				

14 HRS

Complaints/Activities/ Calls for Service

Complaints	Month	Y-T-D
Original Dispatch Complaints	156	761
Complaints that are call in or the officer is dispatched by Allegan County Central (911) or our office		
Patrol Initiated Complaints	7	35
Complaints observed by the officer while on patrol or came to their attention by personal observation		
Total:	163	796

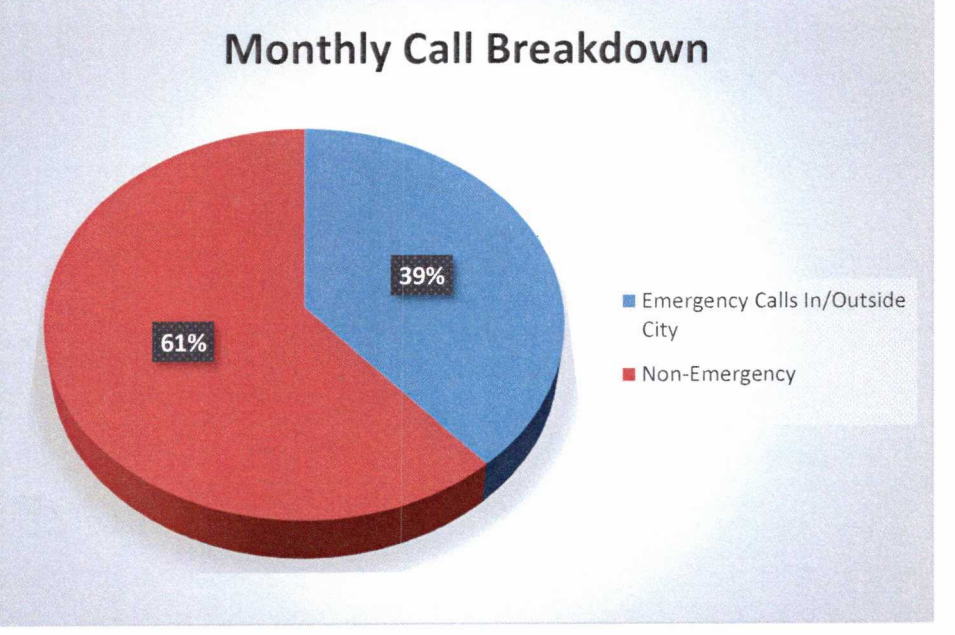
Some complaints were not listed by some officers

Call Priority Breakdown	Month	Y-T-D
Priority 1 Calls for Service	71	312
Emergency calls which require immediate response and there is reason to believe that an immeidate threat exists		
Priority 2 Calls for Service	35	212
Generally non-emergency in nature		
Priority 3 Calls for Service	78	341
Investigative, other		
Total:	184	865

Calls for Service include non-complaint issues such as traffic stops, directed patrol, Citizen Contacts, etc.

Monthly Call Breakdown

Emergency Calls In/Outside City	71
Non-Emergency	113

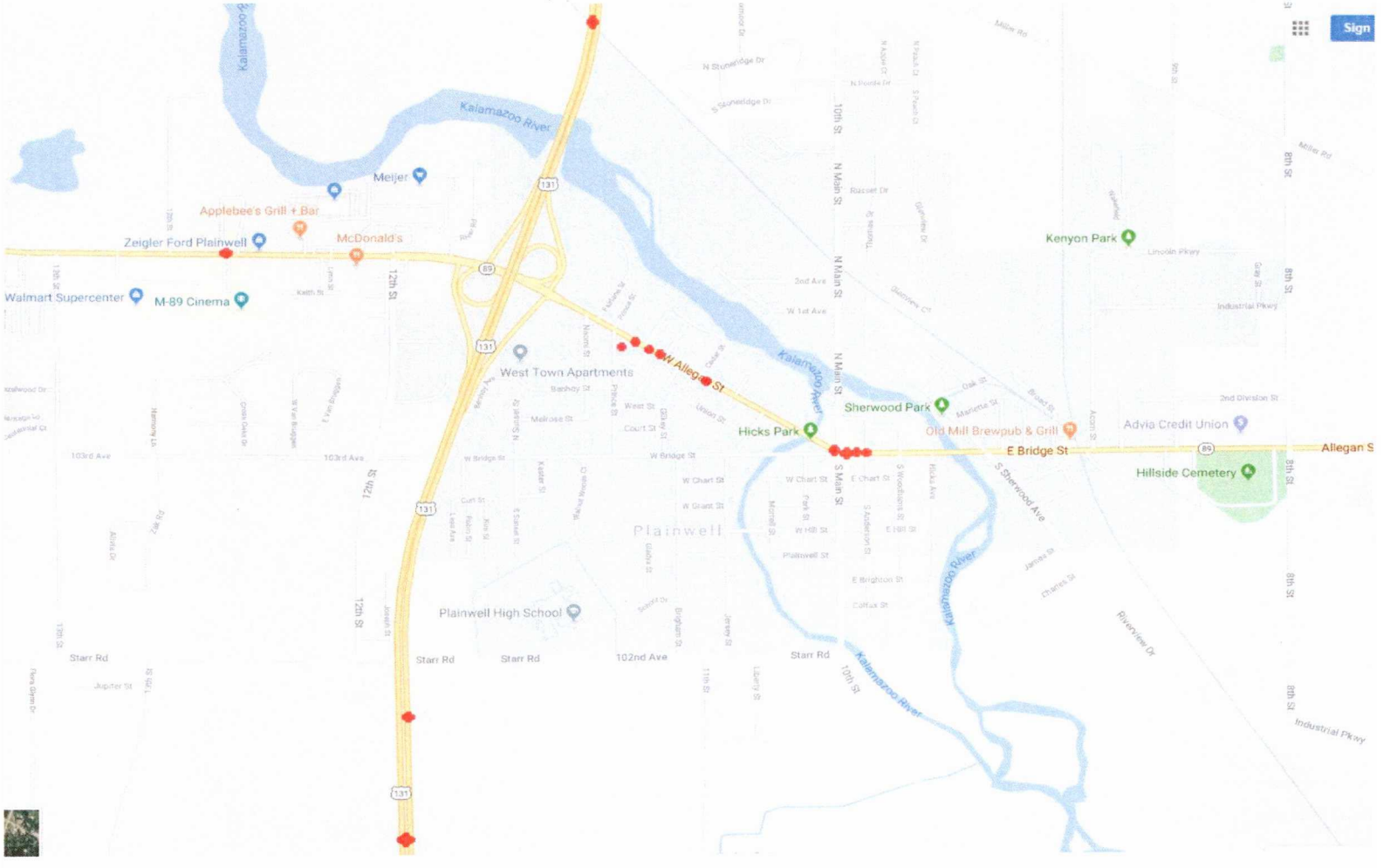


Dispatch Center Total Calls for Service for Plainwell

APRIL: 335 YEAR TO DATE: 1338

Accident Report Data

DATE	DISPATCH	TOTAL	RESPONSE	LOCATION (ADDRESS NOT NAME)	REASON FOR ENTRY	ACTION TAKEN	JURISDICTIO
)2/2018	23:40	90	0	US 131 & County line,	PIA w/Ejection	Assist to KZOO and EMS	KAL CO
)3/2018	12:48	50	9	100 e bridge st,	pda		
)7/2018	14:49	24	17	500 allegan st,	pda drivers exchanged info minor dam		
10/2018	19:55	43	4	N/B 131 48mm	Assist PIA		
12/2018	14:06	34	3	M89/OAKS CROSSING	PI ACCIDENT	ASSIST	OTSEGO TV
15/2018	6:45	50	0	US 131 SB @ Trestle Bridge	Property Damage Accident		GUNPLAIN T
15/2018	10:20	60	2	Main St & Allegan St	Property Damage Accident		
21/2018	2:27	73	3	551 ALLEGAN ST	PRIVATE PROP PDA	INVESTIGATE	
27/2018	17:01	49	3	Allegan & Warrant	Property Damage Accident		
27/2018	17:15	30		300 Block Allegan St.	PDA	Assist 632	
27/2018	19:23	62	3	Allegan & Michigan	PDA	P30859	
28/2018	19:53	50	3	E. Bridge & Anderson	PDA	P30863	
	17:01	49	4	100 E Bridge,	PIA	Ticket/P30749	



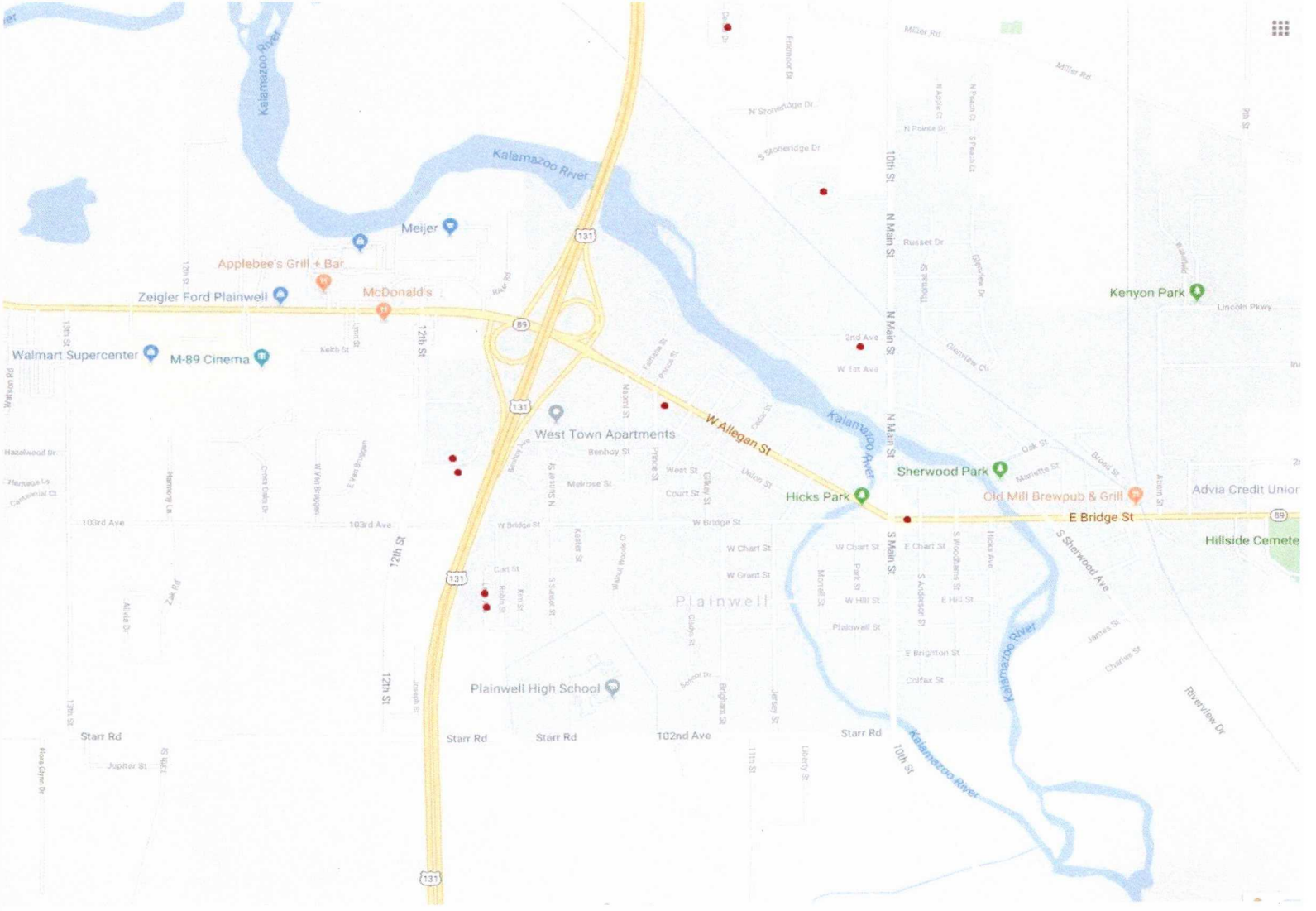
Activity at Plainwell Schools

DATE	DISPATCH	TOTAL	LOCATION (ADDRESS NOT NAME)	REASON FOR ENTRY	ACTION TAKEN
04/09/2018	8:00	60	High School	Traffic	
04/10/2018	16:00	120	PMS	School Safety Committee	
04/10/2018	18:57	17	Starr Rd.	Radar	
04/11/2018	7:00	60	CITY SCHOOLS	PATROL	
04/11/2018	16:25	25	SCHOOLS		
04/13/2018	7:50	30	Schools	Traffic	
04/13/2018	18:02	5	Starr Rd.	Radar	
04/14/2018	18:13	17	Starr Rd.	Radar	
04/15/2018	18:30	17	Starr Rd.	Radar	
04/15/2018	19:00	20	Starr Rd.	Radar	
04/16/2018	11:30	45	684 star rd,	foot patrol	
04/16/2018	20:45	75	SCHOOLS		
04/19/2018	7:00	60	Schools		
04/19/2018	9:40	20	102nd & School Dr		
04/19/2018	10:37	23	684 Starr Rd	MFR	
04/20/2018	8:45	20	GILKEY		
04/23/2018	15:00	50	Starr Elementary		
04/23/2018	18:40	15	Starr Rd.	Radar	
04/23/2018	19:45	25	Starr Rd.	Radar	
04/24/2018	17:05	35	600 School Dr.,	Assault	
04/25/2018	7:15	15	STARR RD	TRAFFIC STOP	35/25
04/25/2018	7:55	10	STARR RD	TRAFFIC STOP	35/25
04/27/2018	7:00	60	High School		
04/27/2018	14:00	60	Schools		
04/27/2018	18:15	13	Starr Rd.	Radar	
04/27/2018	18:28	15	Starr & Brigham St.	Traffic Stop	BRK 084 Expired Plate
04/27/2018	21:24	26	Gilkey School		
04/28/2018	14:00	30	Middle School		
04/28/2018	18:38	11	Starr Rd.	Radar	
04/28/2018	19:03	8	Starr Rd.	Radar	
04/28/2018	19:26	6	Starr Rd.	Radar	
04/28/2018	20:43	30	684 Starr Rd.,	Susp. Sit.	
04/29/2018	18:05	13	Starr Rd.	Radar	
04/30/2018	11:00	45	720 BRIGHAM	SUSP ACTIVITY	INVESTIGATE
	1:00	15	684 Starr,	susp vehicle	parkers
	17:25	35	684 Starr,	Radar	
	16:00	150	720 Brigham St,	Safety Task Force Meeting	
			STARR RD	PATROL	
			STARR RD	PATROL	
			PHS		

TOTAL TIME ON ALL CALLS: 21 HRS

Theft / Damage Crimes

DISPATCH	TOTAL	LOCATION	REASON FOR ENTRY	ACTION TAKEN
8:50	25	1062 wedgewood,	larceny	
13:45	45	587 Center St	Subject Trying to Break In	Assisted Dep. Harris w/ Removal
10:26	79	127 E Bridge St	Burglary	
12:29	45	333 12th st,	apt b5/ b& E	report
10:29	49	119 seacond ave,	mdop	inves
15:00	120	333 12th st apt B5	B&E	Inv
16:28	12	551 ALLEGAN	DRIVE OFF	INVESTIGATE
23:11	17	251 LESA	MDOP VEHICLE	INVESTIGATED
23:28	12	255 LESA	LARCENY FROM MV	INVESTIGATED



PLAINWELL PUBLIC SAFETY

Police, Fire and Medical First Responder Services

MONTHLY REPORT
May 2018

Prepared by Director Bill G. Bomar

Plainwell Department of Public Safety

Scheduled Hours By Activity for May 2018

The categories listed below are based on law enforcement related activities and the hours that scheduled road patrol personnel spend in the 4 major areas.

	Total Hours	Percentage of Total Hours
TOTAL ROAD PATROL HOURS SCHEDULED FOR THE MONTH	**803**	
The Hours officers are scheduled for road patrol or other uniformed functions. These are fixed shifts which generally carry assigned duties.		
Totals of all the below mentioned areas.		
HOURS SPENT INVESTIGATING OR HANDLING CRIMINAL COMPLAINTS	**91**	**11.33%**
The Hours Scheduled for criminal investigations of complaints that are in violation of a criminal law that an individual could be arrested and jailed for.		
Examples include: Burglaries, Robberies, Drunk Driving, All Sex Offenses, Alcohol Offenses, Larcenies, Etc.		
HOURS SPENT INVESTIGATING OR HANDLING NON-CRIMINAL COMPLAINTS	**160**	**19.94%**
The Hours Scheduled for Calls for Service or Complaints that require investigation but are not criminal in nature.		
Examples include: Auto Accidents, Accidental Fires, Traffic Citations, Property Inspections, Etc.		
HOURS SPENT ON SUPPORT OR PERIPHERAL ACTIVITIES	**218**	**27.21%**
The Hours Scheduled for required duties however are not criminal or non-criminal in nature and are supporting functions.		
Examples include: Report Writing, Court, Directed Patrol, Foot Patrol, On Duty Training, Transport of Paperwork to the Court, Evidence to the Crime Lab, Etc.		
TOTAL UNOBLIGATED PATROL HOURS	**333**	**41.52%**
The Hours of Scheduled Road Patrol left over that officers are not assigned to an activity or working on a complaint.		
Examples include: General Preventive Patrol, Building Security Checks, Etc. ***Note:*** *This also includes any break time the officers take during their shift.*		
TOTAL HOURS OBLIGATED TO DUTIES, COMPLAINTS, INVESTIGATIONS, ETC.	**469**	**58.48%**

It is recommended by the International Association of Chiefs of Police (IACP) that no more than 65% to 70% of an officers time on duty, be obligated to complaints, investigations, activities or assigned responsibilities. The rationale behind this is to assure that officers are available for emergencies without unreasonable delay and provide for preventive and traffic patrol duties.

Plainwell Department of Public Safety

Complaints/Activities for May 2018

ARRESTS

CUSTODIAL ARRESTS	**17**	*An individual taken into custody for a criminal offense and jailed for that offense.*
ARREST COUNTS	**41**	*Criminal complaints or cases cleared by the custodial arrest or issuance of a warrant(s).*

TRAFFIC ENFORCEMENT & CITATIONS

HAZARDOUS CITATIONS	**17**	*Uniform Law Citations issued by officers to individuals for moving traffic violations.(Drag racing, Speeding, etc.)*
NON-HAZARDOUS CITATIONS	**15**	*Uniform Law Citations issued by officers to individuals for NON-moving traffic violations. (Registration, Equipment, Etc.)*
DRUNK DRIVING CITATIONS	**1**	*This is an activity that we specifically monitor that would normally be considered a hazardous citation.*
PARKING CITATIONS	**0**	*Citations issued in violation of city ordinance. This would include Overnight Parking, Time Limitation Parking, etc.*
VERBAL WARNINGS	**19**	*Traffic enforcement where no citation was issued but warnings were given.*
TOTAL TRAFFIC CITATIONS/WARNINGS	**52**	

COMPLAINTS

ORIGINAL DISPATCH COMPLAINTS	**197**	*Complaints that are call in or the officer is dispatched to by Allegan County Central Dispatch (911) or our business office.*
PATROL INITIATED COMPLAINTS	**13**	*Complaints observed by the officer while on patrol or came to their attention by personal observation.*
TOTAL COMPLAINTS	**210**	

OTHER ACTIVITIES

MOTORISTS ASSISTS	**11**	*Motorist contacts caused by mechanical breakdown or similar problem.*
PROPERTY INSPECTIONS	**0**	*Checks of homes or business specifically requested by a home or business owner.*
MOTOR VEHICLE ACCIDENTS	**10**	*Total motor vehicle accidents both on public roads or private property.*
COMMERCIAL BUILDING SECURITY CHECK	**424**	*Nightly security inspections of business' conducted by officers to assure windows and doors are locked.*
FOUND UNSECURED	**0**	*The number of business' found unlocked or unsecured.*

Classification of Crimes Reported

File Class	CRIMES AGAINST PERSON	May	Year to Date
900	Murder and Non-Negligent Manslaughter	0	0
1000	Kidnapping	0	0
1100	Sexual Assault	1	1
1200	Robbery	0	0
1300	Aggravated & Non-Aggravated Assault	7	36
	PROPERTY CRIMES		
2000	Arson	0	0
2100	Extortion	0	0
2200	Burglary	0	7
2300	Larceny	11	33
2400	Motor Vehicle Theft	1	2
2500	Forgery/Counterfeiting	0	0
2600	Fraudulent Activities	1	10
2700	Embezzlement	0	4
2800	Stolen Property - Buying, receiving	0	0
2900	Damage to Property	2	6
3500	Violation of Controlled Substances Act	3	12
	MORALS/DECENCY CRIMES		
3600	Sex Offenses (Other than Sexual Assault)	0	0
3700	Obscenity	1	1
3800	Family Offenses	2	6
4100	Liquor Violations	0	0
	PUBLIC ORDER CRIMES		
4800	Obstructing Police - Offenses Which Interfere with Investigations	0	0
4900	Escape/Flight - Fleeing and Eluding a Officer's Custody	0	0
5000	Obstructing Justice	2	17
5200	Weapons Offenses	0	1
5300	Public Peace	6	48
5400	Traffic Investigations - Any Criminal Traffic Complaints	9	28
5500	Health and Safety	0	3
5600	Civil Rights	0	0
5700	Invasion of Privacy	4	14
6200	Conservation Law Violation	0	0
7300	Miscellaneous Criminal Offense	0	0
	GENERAL NON-CRIMINAL		
9100	Juvenile/Minor/School Complaints	0	0
9200	Civil Custody	0	0
9300	Traffic Non-Criminal (Reports Only - Does not include Citations Issued)	10	70
9400	False Alarm Activation	5	20
9500	Fires (Other than Arson)	2	16
9700	Accidents, All Other	0	0
9800	Inspections, Unfounded FIRS	37	195
9900	General Assistance (All Except Other Police Agencies)	69	302
9911 & 9912	General Assistance (Other Police Agencies)	51	195
FIRS	Medical First Responder	15	107

May Reports for Plainwell Department of Public Safety

PRIORITY 1 ASSISTS OUTSIDE OF JURISDICTION

The Plainwell Department of Public Safety was dispatched to 51 calls for assistance outside the city limits of Plainwell by Allegan County Central Dispatch.

These calls were classified as priority 1 assists.

****

Fire Suppression/Call Out Incident Report

Date	Dispatch Time	Arrival Time	Location	Incident Type	Actions taken	Apparatus	PSO	POC
5/18/18	1912	1915	307 N. Sherwood	River rescue	Rescue	Patrol	1	0
5/23/18	0227	0228	320 Brigham Street	Alarm	Investigate	Patrol	1	1
5/25/18	1917	1923	1316 109th Avenue	Structure fire	Extinguish	E-11, E-17	2	5
5/25/18	1953	2010	560 19th Street	Smoke	Investigate	E-17, T-63	2	5
5/26/18	1002	1007	505 S. Woodhams	Medical	Medical	E-11	1	4
5/27/18	1635	1636	210 Allegan Street	River rescue	Rescue	Patrol	3	2
5/28/18	1311	1316	201 W. First Avenue	River rescue	Rescue	Patrol	1	2

****

Calls for Service at Plainwell Schools

Plainwell High School: 4
684 Starr Road

Plainwell Middle School: 4
720 Brigham Street

Early Childhood Development: 0
307 E. Plainwell Street

Admin, Maintenance & Bus Garage: 0
600 School Drive

Gilkey School: 2
707 S. Woodhams Street

Starr Elementary: 1
601 school Drive

Renaissance School: 1
422 Acorn Street

FIRE & MEDICAL FIRST RESPONDER CALL LOG

CH	TOTAL	RESPONSE	LOCATION	REASON FOR ENTRY	ACTION TAKEN	APPARATUS	PSO	POC
	15		707 s woodhams,	fire drill				
	28	2	BRIGHAM/CHART	TREE DOWN	CALL DPW			
	48	6	2nd Division & Florence	Tree & Power Lines Down	Setup Cones / Notify Consumers / DPW			
0	5		320 Brigham St.	Fire Alarm	False Alarm			
3	22	0	1248 M89	CAR FIRE	ASSIST			
9	58	0	411 naomi	fire drill				
2	46	2	N Sherwood	Water rescue				
	22	1	320 Brigham St.	Fire Alarm				
2	58	4	W 1st	Boating	2 subject retreived			
3	17	8	360 shangrila cir	house fire	did not respond tot fire	2	3	
	20		brigham/ w bridge	tree blocking road	asst 636 traffic/ dpw removed tree			
3	53	2	allegan/naomi	pia	p30471 fty stop sign		3	
0	5	0	1232 keith	poss trailer fire otsego twp	mattress fire/ outside			

5 7 HRS ASSISTS OUTSIDE THE CITY SHOW JURISDICTION ASSISTED

: IN CITY 2 MIN ASSISTS TO OUR DEPARTMENT BY AN OUTSIDE AGENCY SHOW THE AGENCY ASSISTING US

: DID NOT RECORD RESPONSE TIME

SES TO ASSIST IN ANOTHER JURISDICTION

CH	TOTAL	RESPONSE	LOCATION	REASON FOR ENTRY	ACTION TAKEN	APPARATUS	PSO	POC
	21	4	400 Block N Main	mfr		car 5	1	
5	35	2	400 Block N Main	MFR	POSS STROKE			
	24	4	900 Block Lincoln Pky	MEDICAL	ASSIST EMS			
1	14	3	300 Block Brigham St	MFR	Pri 3			
375	15	4	400 Block Crossoaks	CPR in Progress	Breathing Upon Arrival			
4	21	1	400 Block N Main	SUICIDAL	ASSIST			
0	25	1	600 Block W Bridge	Suicidal				
	39	6	1100 Block N Main	MFR	Assist EMS	P5	1	
125	21	5	600 Block 105th Ave	mfr	asst acsd		1	
2	38	0	700 Block Brigham St	suicidal	tot parents		1	
	26	3	300 Block Brigham St	MFR				
8	32	3	300 Block W Bridge St	MFR		3x POV	1	
0	30	2	300 Block Brigham St	MFR				
2	28	1	600 Block W Bridge	Suicidal Subject	Turned over to Mom			
3	21	2	403 N Main St	Suicidal	EMS took over			
2	11	3	500 Block S Woodhams	MFR				
	34	3	102 1/2	Suicidal				
	194	6	300 Block Brigham	mfr/ death/ me/ life story	cc/ invest./ asst		1	
7	18	6	400 Block N Main	suicidal subject	made sure scene was safe tot ems			
4	11	1	300 Block 12th St	mfr	none P refused walked to ems			
0	35		400 Block W Bridge	Medical				
			400 Block N Main	MEDICAL	BOWELS			

5 12 HRS ASSISTS OUTSIDE THE CITY SHOW JURISDICTION ASSISTED

: IN CITY 3 MIN ASSISTS TO OUR DEPARTMENT BY AN OUTSIDE AGENCY SHOW THE AGENCY ASSISTING US

: DID NOT RECORD RESPONSE TIME

SES TO ASSIST IN ANOTHER JURISDICTION

POLICE EMERGENCY CALLS (EXCLUDES FIRE AND MFR CALLS)

DATE	DISPATCH	TOTAL	RESPONSE	LOCATION	REASON FOR ENTRY	ACTION TAKEN	APPARATUS	PSO	POC	ASSISTS TO & FROM
05/03/2018	7:15	15	3	100 Block E Plainwell St	Alarm / Glass Breakage	Disregarded on Arrival				
05/03/2018	21:21	78	2	300 Block 12th St,	A14 Intox subject	D/D and R/O				ACSD
05/04/2018	1:00	104	0	700 Block Benhoy,	Fight	3500/warrant				
05/04/2018	5:40	54	0	us 131,	Carrying Concealed Weapon	back up c5 arrest				gunplain twp
05/05/2018	23:29	55	7	300 Block CROSS OAKs	DOMESTIC	ASSIST				OTSEGO TWSP
05/05/2018	1:25	10	3	500 Block 9TH ST	DOMESTIC	ASSIST MSP				GUNPLAIN
05/06/2018	2:24	21	0	400 Block NMAIN	MISSING	INV				
05/06/2018	19:48	22	0	600 Block E Bridge,	Poss OWI 10-38	TIP				
05/07/2018	21:12	170	8	600 Block Allegan,	Susp Subject	Gave ride				
05/10/2018	2:30	45	3	300 Block Cross oaks Dr,	MDP in Progress	Assist ATL				Otsego Twp
05/10/2018	20:50	89	4	200 Block 13th St,	Domestic Assault	Assist OFC safety				Otsego Twp
05/10/2018	11:15	20	0	108th/10th	WARRANT ARREST	OFFICER SAFETY				GUNPLAIN
05/10/2018	17:22	68	8	400 Block Brigham,	CPS removal	Assist CPS				
05/11/2018	0:20	18	8	300 Block Cross oaks Dr,	Susp Subjects	Assist with ATL				Otsego TWP
05/12/2018	13:18	22	0	Burger King	Disorderly Person	UTL				OTSEGO TWP
05/12/2018	15:51	39	4	100 Block Allegan St	Domestic Disturbance	Referee				
05/12/2018	17:39	27	3	8th & Miller	Flee & Elude	Assist T1				GUNPLAIN TWP
05/15/2018	10:15	10	7	116 e plainwell st,	alarm	contact home owner / mistake				
05/15/2018	14:32	48	8	100 Block orchard st,	dv					
05/15/2018	15:36	109	4	400 Block w grant st,	warrants/ suspicious sit	wf one felony one bench to allegan				
05/15/2018	10:30	30	0	200 Block gilkey	welfare					
05/15/2018	11:29	85	3	us131,	asst c5 unk accident	traffic control closed lane				COOPER TWP
05/15/2018	14:19	18	4	300 Block brigham st,	sus veh/ poss bol	tot acsd				
05/16/2018	11:51	189	2	400 Block N Main St	Assault & Battery					
05/17/2018	0:54	20	5	500 Block Center Dr.	DV	Assist T1				Gunplain TWP
05/17/2018	14:57	71	0	700 Block brigham	welfare					
05/17/2018	18:12	24	14	1000 Block 10th	Fleeing	Assist w/ perimeter				Gunplain
05/18/2018	1:32	14	3	200 Block Kim	Susp	Checked area				
05/18/2018	3:39	31	3	500 Block Allegan	Susp	Subject				
05/19/2018	23:12	78	0	600 Block Starr	SuspSubjects					
05/19/2018	19:16	64	1	12th St Kalamazoo CO	Car in Ditch/5400	Assist				COOPER TWP
05/19/2018	22:56	24	5	600 Block Glenview Cir	DV	Civil				OPD
05/19/2018	22:15	41	1	300 Block Crossoaks	DV	Assist				Otsego Twp
05/20/2018	0:45	42	5	300 Block W Orleans	DV	Assist				Otsego
05/20/2018	19:11	19	3	400 Block N Main	Susp sit					
05/20/2018	20:31	104	0	Allegan/Prospect	Swerving	OWI				OPD
05/23/2018	17:02	13	2	200 Block S Main	911 welfare	everything 10-4				
05/24/2018	12:57	83	1	500 Block ALLEGAN	TRESSPASSING	REMOVED				
05/24/2018	16:58	27	5	900 Block Gainder Rd	DV	Scene safety during arrest				Gunplain
05/25/2018	3:48	17	1	200 Block 12th	Susp Sit					Gunplain
05/25/2018	16:38	8	2	131/48mm	Road Hazard					Gunplain
05/25/2018	17:25	86	2	600 Block W Bridge	welfare Check					
05/26/2018	12:55	15	1	500 Block Allegan	Poss Drug Deal	UTL				ACSD
05/26/2018	15:57	13	7	800 Block Wakefield	Alarm	Secure				
05/26/2018	16:13	4	0	1100 Block M89	Susp sit	everything was 10-4				Gunplain
05/26/2018	23:00	17	4	900 Block Versilles	Poss. B&E	Unfounded				Gunplain Twp
05/28/2018	8:05	45	7	400 Block N/MAIN	WELFARE CHECK	WALKING IN TRAFFIC				
05/29/2018	6:25	20	5	200 Block W HAMMOND	DOMESTIC	ASSIST				OTSEGO
05/29/2018	7:11	34	3	100 Block 11TH ST	DOMESTIC	ASSIST				GUNPLAIN
05/30/2018	16:19	6	2	100 Block chuch st	911 hang up	child playing				
05/30/2018	19:45	132	0	Ravine and B Ave	Fleeing w/ assault					ACSD
05/30/2018	22:19	4	0	100 Block N Main	Disorderly/Civil	No Answer				
05/31/2018	0:17	16	2	400 Block Union	Mental	No Answer				ACSD
05/31/2018	22:00	15	1	S/B 53mm	Unknown accident	Assist				GUNPLAIN TWP
05/31/2018	10:11	26	9	us131	road hazard	removed tires parts				
05/31/2018	12:47	43	5	1100 Block n main	sus subject	high sugar tot ems/pipp				
05/31/2018	10:13	53	2	allegan/naomi	pia	p30471 fty stop sign		3		
05/31/2018	11:06	32	2	pd	road rage sub waiting	no violation/ no valid plate				
05/31/2018	15:30	100	0	700 Block brigham	poss intox parent	evl/ transport home				
05/31/2018	17:15	18	4	e bridge/main	sus sub/ man with large knife out	no knife large stick				
05/31/2018	17:25	75	5	500 Block Allegan	indecent exposure					OPD
05/31/2018	20:39	91	3	400 Block Union	R/O Animal Cruelty					
05/31/2018	23:29	6	0	200 Block E Hill	Loud boom					
06/01/2018	1:19	15	4	US131	Welfare check	10yof on HWY				
				1362 EM89	ASSAULT	ASSIST				OTSEGO TWSP
				MARSH/PIERCE	PEOPLE JUMPIN IN TRAFFIC	ASSIST				GUNPLAIN
				MAIN/ALLEGAN	ASSAULT	ARREST / LODGE				

TOTAL TIME ON ALL CALLS 48 HRS

AVERAGE RESPONSE TIME IN CITY 3 MIN

OFFICER DID NOT RECORD RESPONSE TIME

RESPONSES TO ASSIST IN ANOTHER JURISDICTION

ASSISTS OUTSIDE THE CITY SHOW JURISDICTION ASSISTED

ASSISTS TO OUR DEPARTMENT BY AN OUTSIDE AGENCY SHOW THE AGENCY ASSISTING US

ASSISTS OUTSIDE THE CITY

TOTAL	LOCATION	REASON FOR ENTRY	ACTION TAKEN	APPARATUS	PSO	POC	JUR
17	1198 M89	FTP	ASSIST				GU
10	500 Block 9TH ST	DOMESTIC	ASSIST MSP				GU
40	1200 Block Joseph,	Motorist Assist	Assisted T3				G
20	108th/10th	WARRANT ARREST	OFFICER SAFETY				GU
24	1000 Block 10th	Fleeing	Assist w/ perimeter				G
20	9TH/110TH	VEHICLE IN DITCH OCCUPIED	ASSIST C5				GU
27	900 Block Gainder Rd	DV	Scene safety during arrest				G
17	200 Block 12th	Susp Sit					G
8	131/48mm	Road Hazard					G
4	1100 Block M89	Susp sit	everything was 10-4				G
34	100 Block 11TH ST	DOMESTIC	ASSIST				GU
23	300 Block 8TH ST	CARDIAC	ASSIST EMS				GU
	10/106th	PDA	ASSIST C5				GU
	MARSH/PIERCE	PEOPLE JUMPIN IN TRAFFIC	ASSIST				GU
54	us 131,	CCW	back up c5 arrest				gun
39	200 Block 12th St.	Unknown (officer did not specify)	Assist T1				Gun
21	600 Block 105th ave,	mfr	asst acsd		1		gun
20	500 Block Center Dr.	DV	Assist T1				Gunp
20	500 Block Center Dr.	DV	Assist T1				Gunp
17	900 Block Versilles	Poss. B&E	Unfounded				Gun
15	500 Block 10th St.	Susp. Sit.	Assist ACSD				Gun
17	300 Block shangrila cir	house fire	did not respond tot fire	2	3	4	gun
	965 Versailles,		SEARCH RESIDENCE- 911 HANGUP				GUNF
64	12th St Kalamazoo CO	Car in Ditch/5400	Assist				K
	131/47	BOL	ASSIST C5				K
85	us131,	asst c5 unk accident	traffic control closed lane				
15	S/B 53mm	Unknown accident	Assist				
6	700 Block S. Farmer St.	Trespass	Assist 712				C
42	300 Block W Orleans	DV	Assist				C
20	200 Block W HAMMOND	DOMESTIC	ASSIST				O
	400 Block W ORLEANS	DOMESTIC	ASSIST				OTSI
15	412 Cross Oaks,	CPR in Progress	Breathing Upon Arrival				Ots
45	300 Block Cross oaks Dr,	MDP in Progress	Assist ATL				Ots
89	200 Block 13th St,	Domestic Assault	Assist OFC safety				Ots
18	300 Block Cross oaks Dr,	Susp Subjects	Assist with ATL				Ots
22	Burger King	Disorderly Person	UTL				OTSI
31	400 Block oaks crossing	dog in car 72 *	asst msp out of position/ veh goa				ots
41	300 Block Crossoaks	DV	Assist				Ots
25	Aldis	Assiston traffic stop					Ots
14	300 Block 12TH ST	UNWANTED SUBJECT	ASSIST				OTSE
55	300 Block CROSS OAKS	DOMESTIC	ASSIST				OTSE
22	1200 Block M89	CAR FIRE	ASSIST				OTSE
	1362 EM89	ASSAULT	ASSIST				OTSE
28	1100 Block M89	Unknown (officer did not specify)	Assist T1				Unkr

ALLS 18 HRS

CALLS IN THE CITY WHERE ASSISTANCE WAS RECEIVED BY ANOTHER AGENCY

PATCH	TOTAL	LOCATION	REASON FOR ENTRY	ACTION TAKEN	JURISD
1:21	78	300 Block 12th St,	A14 Intox subject	D/D and R/O	AC
9:04	13	700 Block E.BRIDGE	WELFARE CHECK	UTL	AC
1:05	10	100 Block Allegan St.	ATL	Michael Houseman	AC
9:12	46	300 Block N Sherwood	Water rescue		AC
2:56	24	600 Block Glenview Cir	DV	Civil	OF
0:31	104	Allegan/Prospect	Swerving	OWI	OF
2:55	15	500 Block Allegan	Poss Drug Deal	UTL	AC
9:45	132	Ravine and B Ave (Orig in City)	Fleeing w/ assault		AC
1:17	16	400 Block Union	Mental	No Answer	AC
7:25	75	500 Block Allegan	indecent exposure		OF

ALLS 9 HRS

10

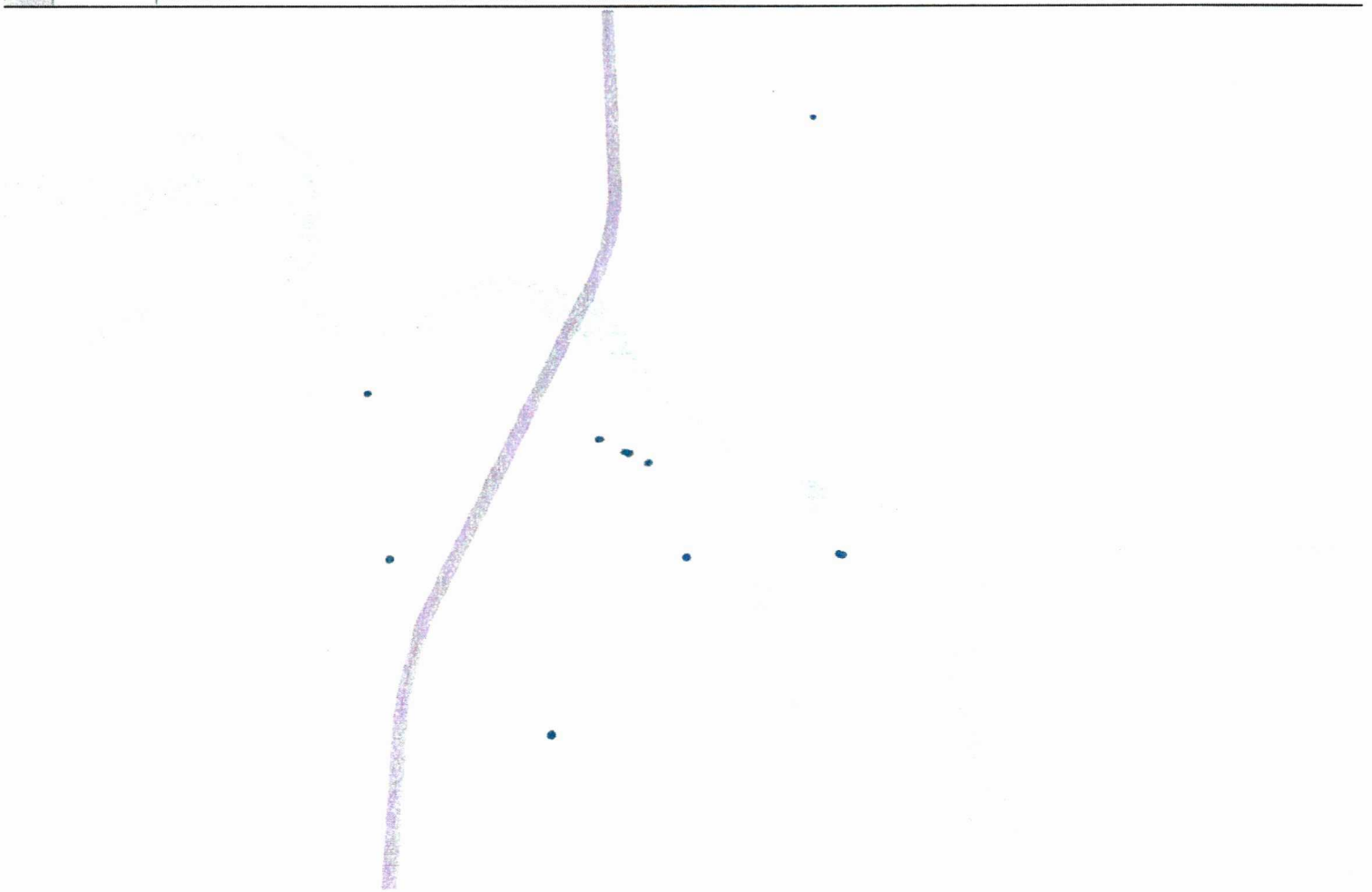
Activity at Plainwell Schools

SPATCH	TOTAL	LOCATION	REASON FOR ENTRY	ACTION TAKEN
8:10	20	600 starr rd,	radar	
8:30	10	707 s woodhams,	security	
8:40	15	707 s woodhams,	fire drill	
8:55	7	684 starr rd,	lock down	
9:23	37	684 starr rd,	lock down	
7:00	15	High School	Traffic	
15:10	25	Gilkey School	Handicap Violation	Warned
7:00	60	Schools	Traffic Presence	
7:20	40	High School	BOL Subject Threatening	Watched entrance
14:20	25	High School	Traffic	
17:55	10	PHS	Vehicle Setup	
16:00	150	720 Brigham,	Meeting at MS	
19:30	60	684 Starr,	Foot Patrol	
7:00	60	Schools	Traffic	
13:02	38	720 brigham st,	suicidal student	tot parents
7:00	60	Schools	Traffic	
8:25	35	707 s woodhams	gilkey school	
9:44	36	684 starr rd	csc 1	tot 611
14:57	71	720 brigham	welfare	
1:00	15	HS	Checked School Grounds	
23:12	78	684 Starr	SuspSubjects	
23:35	10	684 Starr	Building check	
7:30	60	684 Starr Rd,	Bully Prevention training & Sexting	
6:30	90	Schools	Directed Patrol	
14:36	39	684 Starr Rd	Private Property Accident	Report
18:55	35	707 S. Woodhams St.	Assault	
18:50	170	HS	Graduation	
9:30		684 Starr Road,	Walk Thru School	
10:00		720 Brigham,	Walk Thru School	
14:30	150	684 Starr Rd,	Threats	
13:10	33	707 s woodhams	a&b	
14:10	35	707 s woodhams	follow up 1114	school
16:00	90	Middle School	Safety Task Forcemeeting	
8:05	15	gilkey school	patrol	
15:30	100	720 brigham	poss intox parent	evl/ transport home
		SCHOOLS		
		SCHOOLS		
		720 BRIGHAM	COUNSELING	
		PHS	THREATS	ASSIST 611

.S 28 HRS

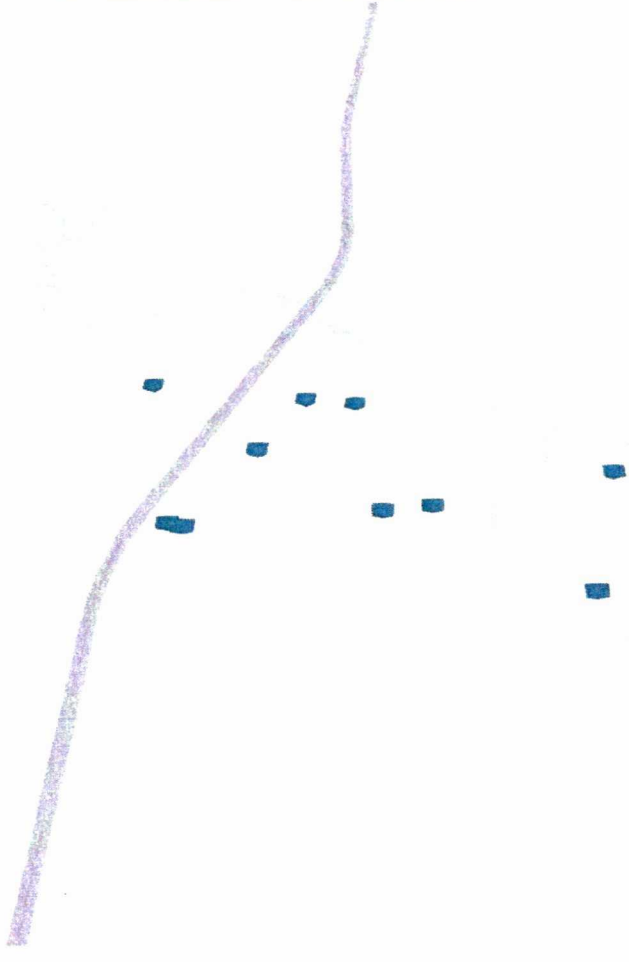
Accident Report Data

ATCH	TOTAL	LOCATION	LATITUDE	LONGITUDE	REASON FOR ENTRY	ACTION TAKEN
49	41	M-89 @ Home Depot	42.449969	-85.663945	Property Damage Accident / Blocking	Assisted with Traffic / Wreckers
02	48	Allegan & Prince	42.447268	-85.651642	PDA	
01	45	Allegan & Main	42.442841	-85.64192	PDA	
13	53	allegan/naomi	42.447836	-85.652833	pia	p30471 fty stop sign
00	25	ALLEGAN/PRINCE	42.447203	-85.651438	PDA	INVESTIGATE
19	21	MAIN/BRIDGE	42.442801	-85.641806	HIT N RUN	INVESTIGATE
20	70	533 Allegan St.	42.446774	-85.650544	Hit & Run Accident	Report
36	39	684 Starr Rd	42.43587	-85.654511	Private Property Accident	Report
45	29	W Bridge/ Brigham,	42.442723	-85.648808	Accident	Citation - Accident Report
		10/106th	42.464523	-85.641906	PDA	ASSIST C5
		12TH ST	42.442669	-85.662087	PDA	ASSIST C5



Theft / Damage Crimes

ISPATCH	TOTAL	LOCATION	LATITUDE	LONGITUDE	REASON FOR ENTRY	ACTION TAKEN
18:10	50	600 Block Melrose St.,	42.44403	-85.65547	Car B&E	
12:20	60	200 Block Robin Ave	42.43987	-85.658	Larceny	Report
8:04	26	300 Block Brigham St.	42.44067	-85.64995	MDP	Report / Photo's
11:10	65	300 Block 12th St.	42.44806	-85.66071	Larceny of Tires	Report / Crime Scene
15:30	50	400 Block W Grant St	42.44094	-85.64787	Larceny of Checks	Report / Instructions
19:00	23	500 Block Allegan St.	42.44684	-85.65136	Fail to pay	
14:00	30	400 Block Naomi St	42.44711	-85.65361	Larceny	Report
20:17	68	500 Block Allegan St.	42.44684	-85.65136	Fail to Pay	
18:57	35	700 Block S Main	42.43668	-85.64153	Larceny from car	
6:30	30	200 Block e Bridge St,	42.44272	-85.64008	B&B Veh	Inv/ Process Scene
		200 Block LESA	42.44007	-85.65869	UDAA	INVESTIGATE



Water Renewal

Superintendent: Bryan Pond

June 2018

Significant Department Actions and Results

The construction crew for the Hill St project were not able to get here this month so the work is scheduled to be done July 16th.

The flow meter and the level detector both failed at 12th St lift station, and were replaced this month.

All lift station wet wells were cleaned out as part of bi-annual maintenance.

The permit required PFAS PFOS collection system survey was completed we averaged about 2.7 parts/trillion. No further action is needed by the City.

Pending Items (including CIP)

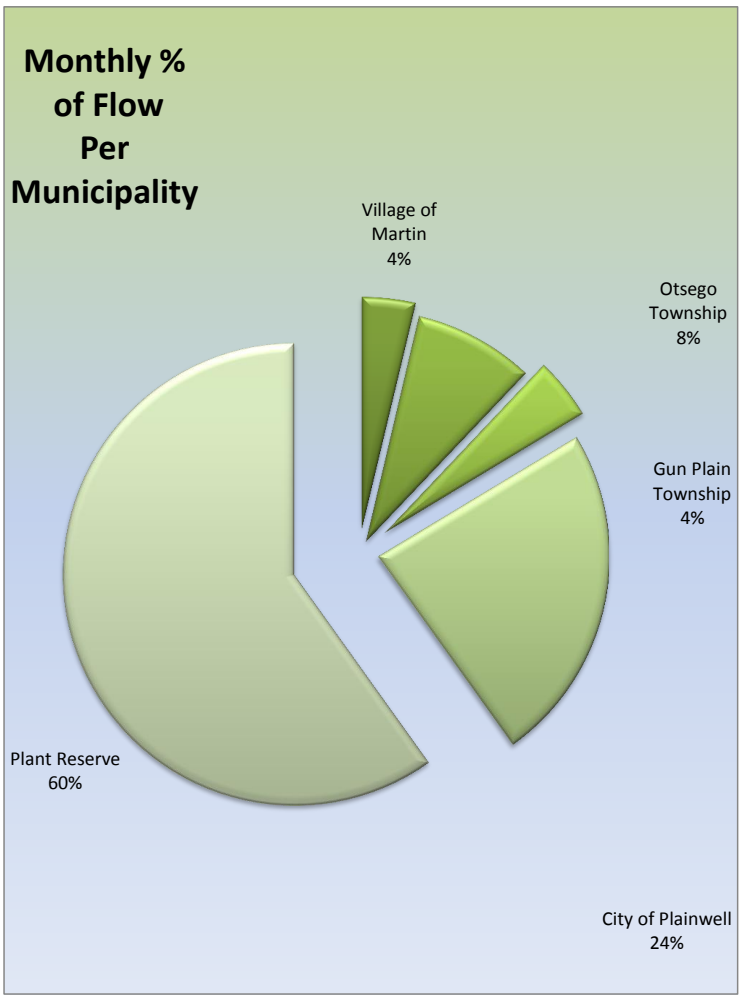
Expenditure Summary/Issues

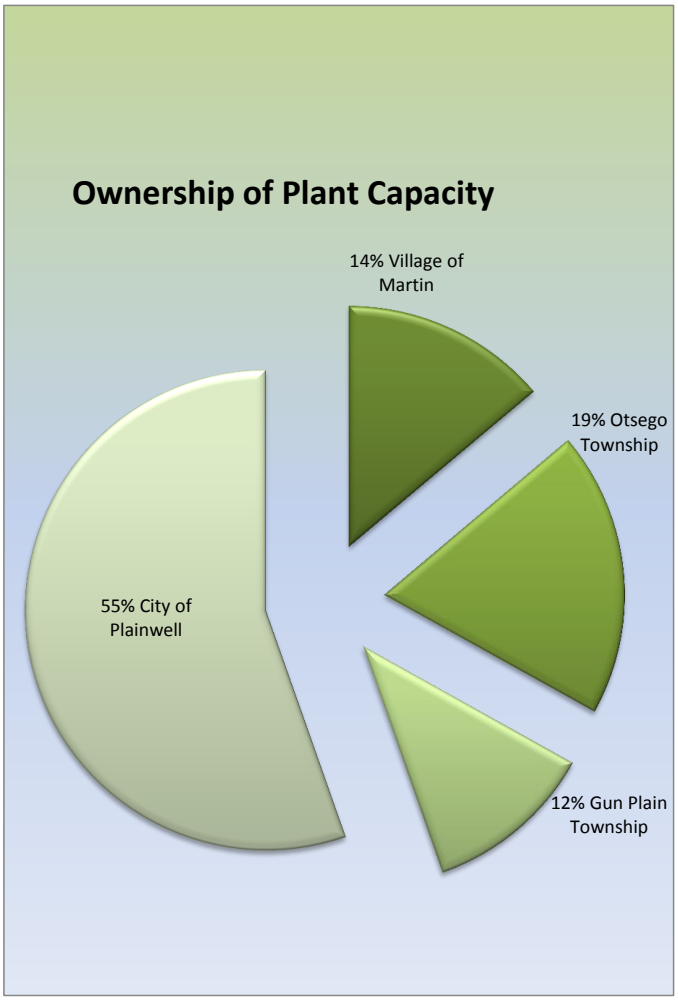
	(budgeted)	(completed)	
Replace Bio -Filter Media	$30,000	100%	$23,189
Replace Hill St lift Station (Remainder of project rolled to fy 18/19)	$90,000	33%	$31,000
Engineering to replace Srew Pumps	$37,114	100%	$23,715
Paint back Room and Chemical Room	$28,000	100%	$19,690
Six new Radios SRM 6230	$13,000	0%	$0
	$198,114		$97,594

Monthly Flow Data

Our permitted volume of treatment is 1,300,000 gallons per day. The table and graph below shows the breakdown of average monthly flow from our customer communities, the percent ownership of our customer communities.

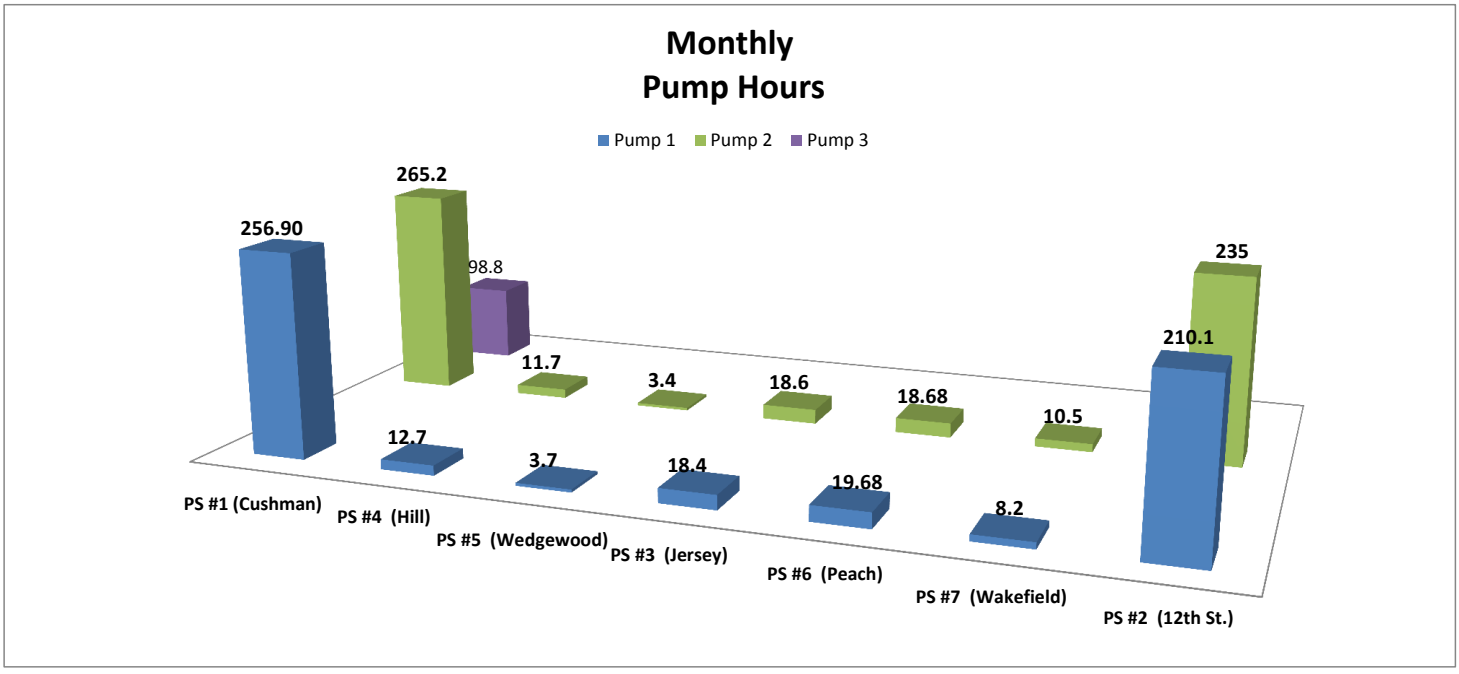
	Total Gallons	Permitted Daily Flow Gallons	Reserve	Ownership of Plant Capacity
Village of Martin	939,010			
Gun River MH Park	437,000			
US 131 Motor Sports Park	54,440			
Total:	1,430,450			
AVG. DAILY:	51,088	180,000	72%	14%
Otsego Township **Total:**	3,270,000			
AVG. DAILY:	116,786	250,000	53%	19%
Gun Plain Township **Total:**	1,132,000			
North 10th Street	317,790			
Gores Addition	234,000			
AVG. DAILY	60,135	150,000	60%	12%
City of Plainwell **Total:**	9260421			
AVG. DAILY:	308680.71	720,000	57%	55%
Avg. Daily Plant Flow from entire service district	0.50			





State Required Reporting Compatible Pollutants

	MI State Requirement	City Benchmark	Monthly Avg. Reported/MDEQ
Carbonaceous Biochemical oxygen demand (CBOD-5):	25 mg/l	15	9.92
This test measures the amount of oxygen consumed by bacteria during the decomposition of organic materials. Organic materials from wastewater treatment facility act as a food source for bacteria.			
TOTAL SUSPENDED SOLIDS (TSS):	30 mg/l	15	12
Includes all particles suspended in water which will not pass through a filter. As levels of TSS increase, a water body begins to lose its ability to support a diversity of aquatic life.			
PHOSPHORUS (P):	1.0 mg/l	0.45	0.49
Controlling phosphorous discharges is a key factor in preventing eutrophication of surface waters. Eutrophication is caused by water enrichment of inorganic plant nutrients. Eutrophication negatively effects water bodies due to increases in algal blooming, causing excessive plant growth which depletes dissolved oxygen in the river which is necessary for aquatic life to survive.			
Total Coliform (COLI):	200counts/ml	50	7
A group of bacteria found in soil, on vegetation and in large numbers in the intestine of warm-blooded animals, including humans. Water is not a natural medium for coliform organisms and their presence in water is indicative of some type of contamination.			



Pumps convey the waste where gravity sewers cannot, run times are a indicator of how the station is operating and being maintained.

CITY OF PLAINWELL
MINUTES
Planning Commission
July 18, 2018

1. Call to Order at 7:00 p. m. by Lubic

2. Pledge of Allegiance was given by all present.

3. Roll Call: Present: Jay Lawson, Rachel Colingsworth, Lori Steele, Diana Lubic, Jim Higgs, Gary Sausaman
   Excused: Chris Haas
4. Approval of Minutes – 05/16/18
   Sausaman motioned to approve minutes, as received seconded by Steele. Minutes approved on an all in favor voice vote.

5. Chairperson's Report: - None

6. New Business:
   A. **Propane Tank** a **motion by Jim Higgs to approve the Ace Hardware Propane Tank concept plan as presented by City Manager, Wilson was made and seconded by Lawson. All in favor vote to accept the concept plan was passed.** The permit is issued by the State of Michigan and City Council will need to approve and determining compensation for leasing up to 3 City owned parking spaces.

   B. Discussion regarding amending the ordinance in the Industrial Zone to allow for lesser setback. Higgs feels strongly that amending the ordinance would not be a good idea. The setbacks have worked great in the last several years; things should not change for one business. Planning Commission recommends keeping the setbacks as is.

7. Old Business: None

8. Public Comments – None

9. Reports and Communications:
   A. None
10. Staff Comments:
    Siegel, Community Development Manager gave an update on the 150 year celebration for 2019; Bennett Family Agency ribbon cutting and Grand Opening, July 6; and the upcoming movie, Friday, July 27
    Wilson, City Manager gave an update on the cleanup of the Mill, beginning in August. Curb cut out will be going in along M89 and Island Ave. for the trucks to use during the cleanup. The cleanup will progress into 2019.
12. Commissioner Comments:
13. Adjournment:
    The meeting was adjourned at 8:06 p.m.

Minutes submitted by Denise Siegel, Community Development Manager

EXP CHECK RUN DATES 07/23/2018 - 07/23/2018
BOTH JOURNALIZED AND UNJOURNALIZED
BOTH OPEN AND PAID

Vendor Code	Vendor Name / Invoice	Description	Amount
000111	AMERICAN WATER WORK ASSN		
	7001576803	10/1/18 - 9/30/19 MEMBERSHIP FOR B. NIEUWENHUIS	330.00
TOTAL FOR: AMERICAN WATER WORK ASSN			330.00
004803	ARROW ENERGY INC		
	88149	AIRPORT FUEL 1801 GALLONS	7,581.16
TOTAL FOR: ARROW ENERGY INC			7,581.16
000007	BATTERIES PLUS BULBS		
	385-P3497968	BATTERIES FOR FIRE DEPT	118.93
TOTAL FOR: BATTERIES PLUS BULBS			118.93
001423	BORGESS MEDICAL CENTER		
	191677C10634	SEASONAL DPW DRUG SCREENS	186.00
TOTAL FOR: BORGESS MEDICAL CENTER			186.00
002458	CHAMPION LAW OFFICES		
	2018-03/04A	ATTORNEY FEES MARCH/APRIL 2018 CORRECTED BILL	801.71
TOTAL FOR: CHAMPION LAW OFFICES			801.71
004884	CNC SURETY		
	63694745N	NOTARY BOND FOR JO SURVILLA 6/19/18 - 2/21/25	55.00
TOTAL FOR: CNC SURETY			55.00
000114	COLUMBIA PIPE & SUPPLY CO. INC		
	2721330	WR SUPPLIES	452.22
TOTAL FOR: COLUMBIA PIPE & SUPPLY CO. INC			452.22
001802	CRONEN SIGNS		
	2572	T-62 2012 CHEVY TAHOE	400.00
TOTAL FOR: CRONEN SIGNS			400.00
000867	DETROIT PUMP & MFG INC		
	1051212	O- RINGS DPW	29.38
TOTAL FOR: DETROIT PUMP & MFG INC			29.38
002030	DRUG SCREEN PLUS INC		
	18QTR.3.1339	DRUG SCREENING 7/6/18	56.00
TOTAL FOR: DRUG SCREEN PLUS INC			56.00
000984	EVOQUA WATER TECHNOLOGIES LLC (SIEM		
	903609682	6/1/18 - 6/30/18 ODOR CONTROL WR	300.00
TOTAL FOR: EVOQUA WATER TECHNOLOGIES LLC (SIEM			300.00
000166	FISHER SCIENTIFIC		
	2464940	ANNUAL PURCHASE OF DETRERGENT FOR LAB GLASSWE	1,342.87
TOTAL FOR: FISHER SCIENTIFIC			1,342.87
000153	FLEIS & VANDENBRINK INC		
	49656	6/2/18 - 6/29/18	342.80
TOTAL FOR: FLEIS & VANDENBRINK INC			342.80
002650	FUEL MANAGEMENT SYSTEM PACIFIC PRID		
	20308	PD/FIRE GAS 7/15/18	656.76
TOTAL FOR: FUEL MANAGEMENT SYSTEM PACIFIC PRID			656.76

002651	GBS GOVERNMENTAL BUSINESS INC		
	18-32586	ELECTION SUPPLIES	389.53
TOTAL FOR: GBS GOVERNMENTAL BUSINESS INC			389.53
004241	GHD SERVICES INC		
	936634	2017/2018 COMMON AREA/CITY HALL UTILITIES/MAINT	1,373.78
TOTAL FOR: GHD SERVICES INC			1,373.78
004885	GREEN ETHAN		
	17/18 SHOE ALLOWANCE	17/18 SHOE ALLOWANCE	31.12
TOTAL FOR: GREEN ETHAN			31.12
000104	HARDINGS MARKET 380		
	2018-06	WATER FOR FIRE CALL	31.50
	2018-06A	DPW WATER FOR VOLUNTEERS/ ICE FOR WR TO KEEP SA	5.18
	2018-07	ICE FOR FESTIVAL PD	3.38
TOTAL FOR: HARDINGS MARKET 380			40.06
003067	HELPNET (BBC-HELPNET)		
	19942	7/1/18 - 9/1/18 EMPLOYEE ASSISTANCE PROGRAM	299.88
TOTAL FOR: HELPNET (BBC-HELPNET)			299.88
000243	JIFFY PRINT		
	20634	BUSINESS CARDS FOR ROBERT NIEUWENHUIS	56.70
TOTAL FOR: JIFFY PRINT			56.70
002301	JOYFUL CLEANING - LINDA TUBBS		
	1007	JULY 2018 CLEANING	964.00
TOTAL FOR: JOYFUL CLEANING - LINDA TUBBS			964.00
001993	KERKSTRA PORTABLE RESTROOMS INC		
	124952	AIRPORT RESTROOMS FOR THE 4TH OF JULY 2018	785.00
TOTAL FOR: KERKSTRA PORTABLE RESTROOMS INC			785.00
000014	MICHIGAN GAS UTILIITIES CORP.		
	2018-06	6/12/18 - 7/10/18 GAS BILLS	783.09
TOTAL FOR: MICHIGAN GAS UTILIITIES CORP.			783.09
000609	MIDWAY CHEVROLET		
	60232	WHEEL ALIGNMENT TRUCK #4 DPW	84.00
TOTAL FOR: MIDWAY CHEVROLET			84.00
001854	MODEL FIRST AID,SAFETY & TRAINING		
	120686	DPW SAFETY/ MEDS/ GLASSES	150.47
TOTAL FOR: MODEL FIRST AID,SAFETY & TRAINING			150.47
001455	MODERNISTIC CARPET CLEANING CO		
	16940	CARPET CLEANING @ DPS/FIRE DEPT	140.00
TOTAL FOR: MODERNISTIC CARPET CLEANING CO			140.00
002708	MORGAN BIRGE' & ASSOCIATES		
	36382	JULY 2018 PHONE MAINTENANCE	130.00
TOTAL FOR: MORGAN BIRGE' & ASSOCIATES			130.00
004837	MUNICIPAL WEB SERVICES		
	53092	JULY 2018 WEBSITE	200.00
TOTAL FOR: MUNICIPAL WEB SERVICES			200.00
002023	NAPPS GREENHOUSE		
	18529	FLOWERS FOR 2018 PLANTINGS CITY-WIDE	4,377.00
TOTAL FOR: NAPPS GREENHOUSE			4,377.00
001965	NIGHT MAGIC, INC.		
	10908	FIREWORKS DISPLAY JULY 4, 2018	7,000.00

TOTAL FOR: NIGHT MAGIC, INC.			7,000.00
000096	NYE UNIFORM CO INC		
	659139	M. BRUCE UNIFORM	70.78
	659794	B. BOMAR UNIFORM	19.10
TOTAL FOR: NYE UNIFORM CO INC			89.88
000095	ONE WAY PRODUCTS INC		
	642821	TOILET PAPER FOR THE PARKS	205.28
TOTAL FOR: ONE WAY PRODUCTS INC			205.28
004852	PACE ANALYTICAL SERVICES LLC		
	1846210805	SAMPLES WESCO/EAST SIDE/PLANK RD/BOYLAN/SCHOO	70.00
	1846210806	SAMPLES WELL 4 & WELL 7	28.00
TOTAL FOR: PACE ANALYTICAL SERVICES LLC			98.00
004855	PLAINWELL ACE HARDWARE		
	1037	ROLLER FRAME	5.99
	1044	FLOWERBED FENCING FOR THE FESTIVAL	7.98
	1046	FLOWERBED FENCING	13.18
	1049	ANDERSON PKING LOT FENCING	139.96
	1057	HORNET SPRAY + RETURNS	9.96
	1060	WATER TOWER	7.18
	1063	#73 BEFCO MOWER FASTENERS	0.85
	1075	SUPPLIES TO REPAINT CITY SIGNS	110.90
	1080	PAINT/SUPPLIES TO PAINT LIGHT POLES	39.52
	1083	MISC FASTENERS	2.25
	1086	LOCKS FOR STOCK & SPRAY FOR FLOWERS	179.85
	1088	PAINTING TOOL	9.99
	1096	TRAINING SUPPLIES	13.98
TOTAL FOR: PLAINWELL ACE HARDWARE			541.59
002582	PLAINWELL REDI MIX - COSGROVE ENTER		
	7880	SIDEWALK REPAIR UNION & CHURCH ST	476.25
TOTAL FOR: PLAINWELL REDI MIX - COSGROVE ENTER			476.25
004221	R.W.LAPINE INC MECHANICAL CONTRACTO		
	7034	REPAIR AIR CONDITIONER @ CITY HALL	171.50
TOTAL FOR: R.W.LAPINE INC MECHANICAL CONTRACTO			171.50
004830	RICHMOND, MICHAEL J		
	2018-07	2018/2019 ASSESSING SERVICES 7/1/18 - 7/31/18	1,400.00
	2018-08	2018/2019 ASSESSING SERVICES 8/1/18 - 8/31/18	1,400.00
TOTAL FOR: RICHMOND, MICHAEL J			2,800.00
000010	RIDDERMAN & SONS OIL CO INC		
	25173	JUNE 2018 GAS FOR MOWING THE AIRPORT	75.65
	25298	JULY 2018 GAS FOR MOWING @ THE AIRPORT	87.07
TOTAL FOR: RIDDERMAN & SONS OIL CO INC			162.72
001873	SCHANZ TIRE & AUTO SUPPLY INC.		
	141264	AMMO - MISC POLICE TRAINING	250.50
	141323	TIRE REPAIR #22	32.00
TOTAL FOR: SCHANZ TIRE & AUTO SUPPLY INC.			282.50
002070	SIGNWRITER - SUNSET ENTERPRISES		
	39170	DOG PARK SIGN	65.00
TOTAL FOR: SIGNWRITER - SUNSET ENTERPRISES			65.00
000149	SPARTAN DISTRIBUTORS		
	11769880	DECK BELT	85.85
TOTAL FOR: SPARTAN DISTRIBUTORS			85.85
004880	SPX FLOW US LLC LIGHTNIN & PLENTY M		

	92398253	LUBRICANT	41.82
TOTAL FOR: SPX FLOW US LLC LIGHTNIN & PLENTY M			41.82
002402	STEENSMA LAWN & POWER EQUIPMENT		
	530332	WEED EATER PARTS	24.86
TOTAL FOR: STEENSMA LAWN & POWER EQUIPMENT			24.86
001041	TELE-RAD INC		
	886414	CHARGING BASES FOR FIRE PAGERS	1,112.50
TOTAL FOR: TELE-RAD INC			1,112.50
002002	USA BLUEBOOK-HD SUPPLY FACILITIES M		
	609407	FLOAT SWITCH HOOK MOUNT WR	93.62
TOTAL FOR: USA BLUEBOOK-HD SUPPLY FACILITIES M			93.62
002653	VAN MANEN OIL COMPANY		
	2173356	DIESEL GAS DPW 7/2/18	881.49
	2173357	REGULAR GAS DPW 7/2/18	944.64
TOTAL FOR: VAN MANEN OIL COMPANY			1,826.13
001536	WASHWELL-STADIUM DRIVE GROUP-SOAP		
	2091	JUNE 2018 DRYCLEANING	70.70
TOTAL FOR: WASHWELL-STADIUM DRIVE GROUP-SOAP			70.70
000714	WEBB CHEMICAL SERVICES		
	477302A	FERRIC CHLORIDE	4,273.28
TOTAL FOR: WEBB CHEMICAL SERVICES			4,273.28
004200	WIGHTMAN & ASSOCIATES INC		
	59118	ENGINEERING SERVICES - NORTH PRINCE STREET PROJEC	1,791.50
TOTAL FOR: WIGHTMAN & ASSOCIATES INC			1,791.50
004814	WILLIAMS & WORKS		
	85330	ZONING ISSUES 621 S MAIN ST & 691 W BRIDGE ST	348.00
TOTAL FOR: WILLIAMS & WORKS			348.00
000947	WYOMING ASPHALT & PAVING INC.		
	2018-197	ASPHALT 7/1/18	104.16
TOTAL FOR: WYOMING ASPHALT & PAVING INC.			104.16
TOTAL - ALL VENDORS			44,122.60

INVOICE AUTHORIZATION

Person Compiling Report

I verify that to the best of my knowledge the attached invoice listing is accurate and the procedures in place to compile this invoice listing has been followed.

Insert Signature:

Cheryl Pickett

Digitally signed by Cheryl Pickett
DN: c=US, st=Michigan, l=Plainwell, o=City of Plainwell, ou=CoP, cn=Cheryl Pickett, email=cpickett@plainwell.org
Date: 2018.07.19 11:01:56 -04'00'

Brian Kelley, City Clerk/Treasurer

I verify that I have reviewed the expenditures attributed to my department and to the best of my knowledge the attached invoice listing is accurate and complies with the City's purchasing policy.

Insert Signature:

Brian Kelley

Digitally signed by Brian Kelley
Date: 2018.07.20 14:00:40 -04'00'

Bryan Pond, Water Renewal Plant Supt.

I verify that I have reviewed the expenditures attributed to my department and to the best of my knowledge the attached invoice listing is accurate and complies with the City's purchasing policy.

Insert Signature:

Bryan Pond

Digitally signed by Bryan Pond
Date: 2018.07.20 15:06:05 -04'00'

Bill Bomar, Public Safety Director

I verify that I have reviewed the expenditures attributed to my department and to the best of my knowledge the attached invoice listing is accurate and complies with the City's purchasing policy.

Insert Signature:

Bill Bomar

Digitally signed by Bill Bomar
Date: 2018.07.20 14:22:01 -04'00'

Bob Nieuwenhuis, Public Works Supt.

I verify that I have reviewed the expenditures attributed to my department and to the best of my knowledge the attached invoice listing is accurate and complies with the City's purchasing policy.

Insert Signature:

Erik J. Wilson, City Manager

I verify that I have reviewed the expenditures attributed to my department and to the best of my knowledge the attached invoice listing is accurate and complies with the City's purchasing policy.

Insert Signature:

Erik Wilson

Digitally signed by Erik Wilson
DN: c=US, st=Michigan, l=Plainwell, o=City of Plainwell, ou=CoP, cn=Erik Wilson, email=ewilson@plainwell.org
Date: 2018.07.20 10:37:12 -04'00'

Check Date	Bank	Check	Vendor Name	Description	Amount
Bank CBGEN Chemical Bank - General AP Account					
Check Type: ACH Transaction *(property tax distributions)*					
07/13/2018	CBGEN	1331(A)	ALLEGAN COUNTY TREASURER	2018 SUMMER TAX COLLECTED W/E 07/07/2018	18,136.82
07/13/2018	CBGEN	1332(A)	RANSOM DISTRICT LIBRARY	2018 SUMMER TAX COLLECTED W/E 07/07/2018	920.17
07/20/2018	CBGEN	1336(A)	ALLEGAN COUNTY TREASURER	2018 SUMMER TAX COLLECTED W/E 07/14/2018	38,115.62
07/20/2018	CBGEN	1337(A)	RANSOM DISTRICT LIBRARY	2018 SUMMER TAX COLLECTED W/E 07/14/2018	5,311.78
				Total ACH Transaction:	62,484.39
Check Type: EFT Transfer					
07/10/2018	CBGEN	1333(E)	SILVERSCRIPT INSURANCE COMPANY	JULY 2018 RETIREE PRESCRIPTION COVERAGE	29.10
07/10/2018	CBGEN	1334(E)	SILVERSCRIPT INSURANCE COMPANY	JULY 2018 RETIREE PRESCRIPTION COVERAGE	29.10
07/17/2018	CBGEN	1338(E)	CHEMICAL BANK	JUNE 2018 CHEMICAL BANK SERVICE CHARGES	306.57
08/01/2018	CBGEN	1335(E)	USDA RURAL DEVELOPMENT	DEBT SERVICE - USDA LOAN - PUBLIC SAFETY	21,857.99
				Total EFT Transfer:	22,222.76
Check Type: Paper Check					
07/24/2018	CBGEN	12661	HARRINGTON, CHARLENE	UB refund for account: 04-00058400-04	2.56
07/24/2018	CBGEN	12662	HADDEN, GARY	UB refund for account: 01-00007600-07	37.98
07/24/2018	CBGEN	12663	MICHIGAN GAS UTILIITIES CORP.	GAS UTILITY 06/12-07/11/2018 140 FORBES	73.67
08/01/2018	CBGEN	12609	C.O.P.S. TRUST INSURANCE	AUGUST 2018 DENTAL AND VISION INSURANCE	1,608.39
				Total Paper Check:	1,722.60
CBGEN TOTALS:					
Total of 12 Checks:					86,429.75
Less 0 Void Checks:					0.00
Total of 12 Disbursements:					***86,429.75***

Off Cycle Payment Authorization

Brian Kelley, City Clerk/Treasurer	Erik J. Wilson, City Manager
I verify that I have reviewed the off-cycle payments listed above and to the best of my knowledge the listing is accurate and complies with the City's purchasing policy.	I verify that I have reviewed the off-cycle payments listed above and to the best of my knowledge the listing is accurate and complies with the City's purchasing policy.
Insert Signature: Brian Kelley Digitally signed by Brian Kelley Date: 2018.07.20 14:08:36 -04'00'	Insert Signature: Erik Wilson Digitally signed by Erik Wilson DN: c=US, st=Michigan, l=Plainwell, o=City of Plainwell, ou=CoP, cn=Erik Wilson, email=ewilson@plainwell.org Date: 2018.07.20 14:15:24 -04'00'

MICHIGAN STATE UNIVERSITY | Extension

Greetings from Michigan State University Extension!

Our Government and Public Policy team is here to support you and your community with educational programming and technical assistance. We provide strong, evidence-based information that can help with sound governance and management. Our team of educators have expertise in issues such as economics, fiscal management, boardsmanship, parliamentary procedure, land use planning and zoning, and public policy.

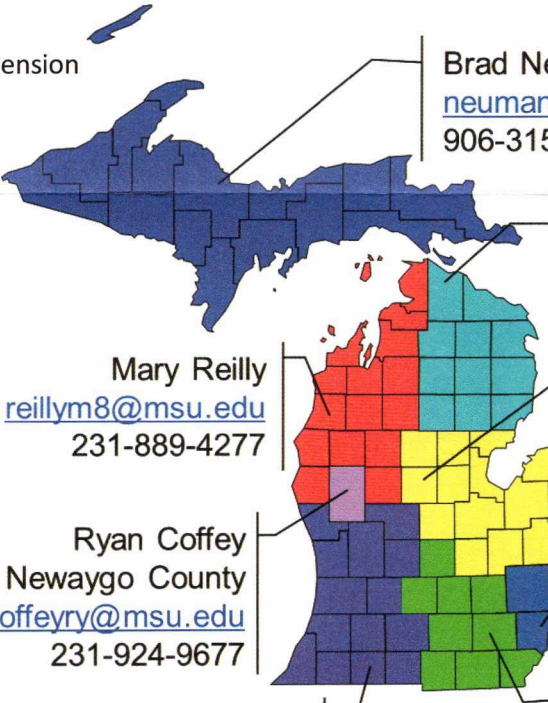
We are excited to share information about our educational opportunities. Included in this letter are brochures about **Citizen Planner**, a land use education program for locally appointed and elected planning officials and interested residents throughout Michigan. This non-credit course leads to a certificate of completion awarded by MSU Extension. Advanced training through the Master Citizen Planner (MCP) credential is also available. The Citizen Planner Program is offered in a classroom or via video conference setting, or through a convenient self-paced opportunity called Citizen Planner Online.

We ask that you please take a look at the enclosed brochure and share the extra copies with members of your boards and commissions who may like to learn more. Below is a map with each educator on our team who is available to assist in arranging a Citizen Planner Program near you. Please reach out to the educator closest to you with any questions about land use policy or governance.

Thank you for your service, we look forward to working with you.

Sincerely,

Your friends at MSU Extension



Brad Neumann
neuman36@msu.edu
906-315-2661

Lindsey Gardner
lgardner@msu.edu
231-627-8815

Mary Reilly
reillym8@msu.edu
231-889-4277

David Rowley
rowleyd2@msu.edu
989-317-4079

Ryan Coffey
Newaygo County
coffeyry@msu.edu
231-924-9677

Crystal Wilson
cwilson2@msu.edu
313-309-1674

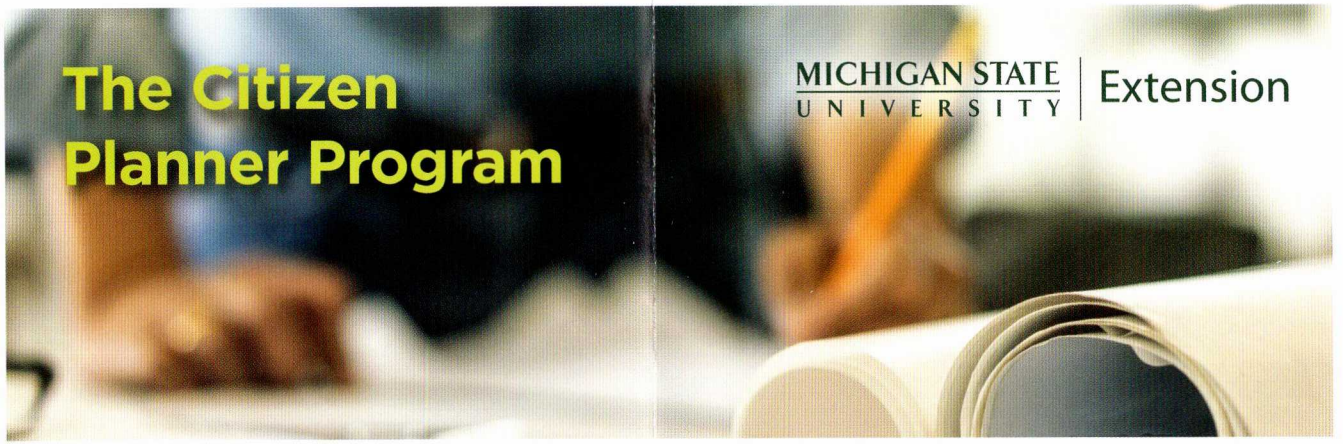
Harmony Gmazel (temp)
gmazelh@msu.edu
734-222-3832

Harmony Gmazel
gmazelh@msu.edu
734-222-3832

MSU EXTENSION

Attn: Janean Danca
Citizen Planner
801 Hazen St., Suite D
Paw Paw, MI 49079

269-657-8213
269-657-8212
cplanner@msu.edu
msue.msu.edu



The Citizen Planner Program

MICHIGAN STATE UNIVERSITY | Extension

The Michigan State University (MSU) Extension Citizen Planner Program offers land use education for locally appointed and elected planning officials, zoning administrators and interested residents throughout Michigan.

Citizen Planner is a time-tested educational program proven to be comprehensive without being overwhelming. The program is delivered locally to provide a convenient way for busy community leaders to obtain the latest technical knowledge and the proficiency they need to perform their duties more effectively and responsibly.

WHY CITIZEN PLANNER?

Local officials have a responsibility to help their communities manage the impacts of economic change and be part of the solutions to challenges their communities face. Local communities that proactively plan to succeed in the New Economy can improve their quality of life and overall sustainability. The Citizen Planner Program empowers local officials to shape the future of their communities by providing them with the tools and education they need to lead.

MSU Extension awards Citizen Planner Classroom Program participants a certificate of completion.

CITIZEN PLANNER CURRICULUM:

Classroom Program

Instructors for the training program include MSU faculty, MSU Extension educators, planners and attorneys. The classroom program consists of six sessions:

- **Understanding the Planning and Zoning Context –** Learn the legal framework for your role, know the sources and limitations of planning and zoning authority, and explore your understanding of ethical decision-making.
- **Planning for the Future of Your Community –** Recognize the function and importance of a master plan, know the statutory and general process for developing one, and understand the master plan's relationship to zoning.
- **Implementing the Plan with Zoning –** Discover the importance of zoning, learn how zoning is administered and gain confidence in your zoning reviews, including site plans.
- **Making Zoning Decisions –** Know how to adopt and amend a zoning ordinance, understand the role of the zoning board of appeals and obtain skills in basic property development methods.
- **Using Innovative Planning and Zoning –** Reflect on the ways your community has changed over time, learn innovative urban and rural planning and zoning techniques, and strategize with placemaking and design-based solutions for local and regional success in the New Economy.
- **Successfully Fulfilling Your Role –** Strengthen your skills in analyzing how to proceed through an ethical issue, reinforce your ability to apply standards to your decision-making and know when to ask for help.

ALSO AVAILABLE:

Citizen Planner Online

Citizen Planner Online includes similar content to the classroom program, but it is offered in a flexible, self-paced, online format. Citizen Planner Online is different from other courses – the concepts are conveyed through stories about issues unfolding in a fictitious community called Spartyville. The situations Spartyville planning officials face are similar to those many communities must address. The online series of seasons and episodes follows a creative storyline that all learners will enjoy. All you need is a broadband internet connection and a computer, laptop or tablet. The online version of the program includes access to:

- Resources similar to the classroom program.
- Relevant web resources, decision-making tools and online exercises.

THE MASTER CITIZEN PLANNER CREDENTIAL

Participants who complete the Citizen Planner Classroom Program or Citizen Planner Online are eligible to earn the Master Citizen Planner (MCP) credential. In addition to completing the course, the MCP credential requires passing an online exam and capstone presentation, and meeting annual continuing education requirements.

Master Citizen Planners may receive incentives, such as future course discounts, exclusive training opportunities, and scholarships for annual conferences and regional training offered by partnering organizations. The MCP designation is an achievement recognized as the standard of excellence among planning officials and community leaders in Michigan.

Photo © istock.com/Zhikevych

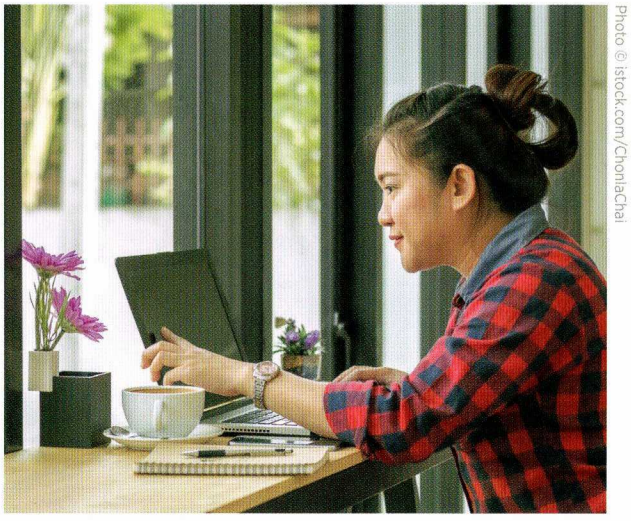


Photo © istock.com/ChonlaChai

For More Information

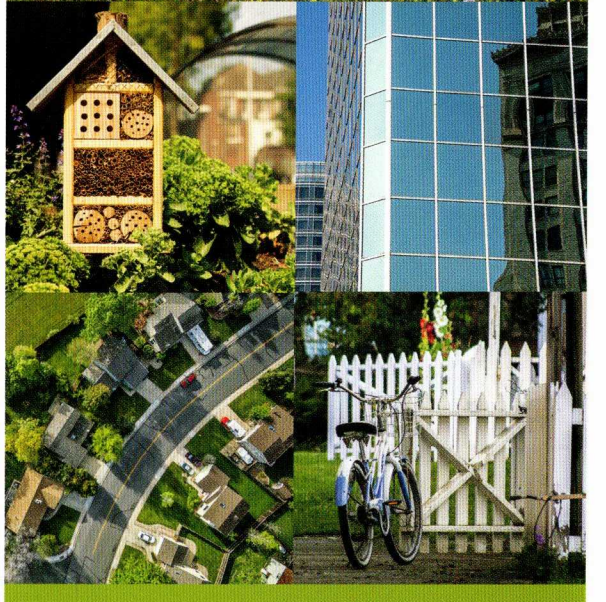
To learn more about the Citizen Planner Classroom Program or to register for Citizen Planner Online, contact Janean Danca, Citizen Planner coordinator, at 269-657-8213 or cplanner@msu.edu. Visit http://citizenplanner.msu.edu/.

MICHIGAN STATE UNIVERSITY | Extension

MICHIGAN STATE UNIVERSITY | Extension

Citizen Planner Program

A Land Use Training and Certificate Course for Community Land Use Decision-Makers



CITIZEN PLANNER IS A PROGRAM OF MSU EXTENSION

Trash piles up in US as China closes door to recycling

12 Jul 2018

12
JUL
2018

AFP / SAUL LOEB

At a recycling facility in the Baltimore-Washington area, bales of compacted plastics and paper are cluttering the plant because China is not buying it as they once did

For months, a major recycling facility for the greater Baltimore-Washington area has been facing a big problem: it has to pay to get rid of huge amounts of paper and plastic it would normally sell to China.

Beijing is no longer buying, claiming the recycled materials are "contaminated."

For sure, the 900 tons of trash dumped at all hours of the day and night, five days a week, on the conveyor belts at the plant in Elkridge, Maryland -- an hour's drive from the US capital -- are not clean.

Amid the nerve-shattering din and clouds of brown dust, dozens of workers in gloves and masks -- most of them women -- nimbly pluck a diverse array of objects from the piles that could count as "contaminants."

That could be anything from clothes to cables to tree branches to the bane of all recyclers: plastic bags, which are not supposed to go in recycling bins because they snarl up the machinery.

"We've had to slow our machinery, and hire more people" to clean up the waste, says Michael Taylor, the head of recycling operations for Waste Management, the company that runs the plant.

At the end of the sorting line is the end product -- huge bales of compacted waste containing paper, cardboard or plastics.

These have been bought up for decades by businesses, most of them based in China, which clean them up, crush them and transform them into raw materials for industrial plants.

Last year, China bought up more than half of the scrap materials exported by the United States.

AFP / SAUL LOEB

Some workers must go through the recyclables by hand to remove items seen as "contaminants"

Globally, since 1992, 72 percent of plastic waste has ended up in China and Hong Kong, according to a study in the journal Science Advances.

But since January, China has closed its borders to most paper and plastic waste in line with a new environmental policy pushed by Beijing, which no longer wants to be the world's trash can, or even its recycle bin.

For other waste products such as cardboard and metal, China has set a contamination level of 0.5 percent -- a threshold too low for most current US technology to handle.

US waste handlers say they expect China will close its doors to all recycled materials by 2020 -- an impossibly short deadline.

"There is no single and frankly, probably not even a group of countries, that can take in the volume that China used to take," warns Adina Renee Adler of the Washington-based Institute of Scrap Recycling Industries.

- A brutal transition -

The Waste Management facility in Elkridge manages to sell its plastic bottles to a buyer in South Carolina and ships its cardboard abroad.

But its haul of mixed paper and mixed plastics is effectively worthless, and the plant pays subcontractors to haul it away.

Other US recycling plants have broken a major taboo and no longer bother sorting plastic and paper, and instead simply send it straight to landfills.

AFP / Ivan Couronne

At the Fort Totten Transfer Station in Washington, trash is piled up before being taken by truck to a factory where it is incinerated

"Nobody wants to say it out loud, because nobody likes the fact that they're having to do it," said Bill Caesar, the head of waste company WCA in Houston.

Waste Management and Republic Services, another industry heavyweight, have admitted doing it under limited circumstances, while some small towns, particularly in Florida, have simply stopped collecting recyclable waste.

Other scrap importer countries such as Indonesia, Vietnam or India are incapable of absorbing the tens of millions of tons that China had previously taken.

And few American industries possess the ability to treat the waste.

"The biggest issue here is that China just gave very little time for the industry to transition," said Adler.

Darrell Smith, president of the National Waste and Recycling Association, added: "Eventually we will have such a large backup that more and more will have to start being diverted to landfills if we don't find new markets and new uses for the recycled materials."

- More and more expensive -

The messy problem is starting to get punted down the line to cities and towns during the renegotiation of municipal contracts.

That is compounded by the fact that many cities already have ambitious recycling targets: Washington wants to see 80 percent of household waste recycled, up from the current 23 percent.

AFP / Ivan Couronne

At the top, an unrecycled trash pile at the Fort Totten Transfer Station. At the bottom, a pile of recyclable waste, still containing many plastic bags

The US capital already pays $75 a ton for recycling, compared to $46 for waste that is burned to generate electricity.

"There was a time a few years ago when it was cheaper to recycle. It's just not the case anymore," said Christopher Shorter, director of public works for the city of Washington.

"It will be more and more expensive for us to recycle," he said.

To avoid mounting costs, according to Shorter, the city wants to "better educate our residents about what should and should not be recycled" -- especially about not putting plastic bags in the blue recycling bin.

And to further reduce the amount of waste being recycled or burned, Washington is considering offering a third trash can to residents for organic waste, and building a facility to compost it.

And the city is thinking of making residents pay based on the weight of the waste they produce.

In Houston, WCA's Caesar has a warning for Americans: "They're going to have to start paying more for the privilege of recycling."

BACK TO SUMMARY NEXT

Allegan County
Administrative
Offices

County Services Building
3283 – 122nd Avenue
Allegan, MI 49010
269.673.0203

July 12, 2018

Board of Commissioners Update
Administrator's Report

ENGAGEMENT

Employment –
Number of Active Regular Full-Time and Regular Part-Time Employees: 353

New Hires: 0

Left Employment: 2

Last Name	First Name	Position
Shepardson	Joshua	Telecommunicator Supervisor
Kelley	Andrew	Child Care Worker - Detention

Open Positions: 15
(3) Telecommunicators; Treatment Specialist – Cheever; (2) Corrections Officers; IRPT Animal Control; Client Financial Svc Clerk FOC; IRPT Janitor; Deputy District Court Clerk; Personal Health Secretary; Professional Engineer; Telecommunicator Supervisor; Child Care Worker – Detention

For more information regarding this matter, please contact Lyn Holoway, Human Resources Manager, at 269-673-0203 extension 2646.

OPERATIONS

Probation Parole Construction Project – Staff completed move-in on June 29. The new office is officially open. According to the Director, Michele Newton, initial feedback from the staff has been extremely positive. Ms. Newton has hosted visits with Probation/Parole personnel from other offices. Each visit has resulted in positive feedback regarding the space. In August, the Probation/Parole Team plans to host a formal open house. The date has not yet been set. Plans are also being formed to host a walkthrough for the Board of Commissioners that will be aligned to the existing Board schedule. For more information on the project please contact Shawn Stenberg, Director of Facilities Management at 269-673-0207.

Register of Deeds Software Upgrade – The County has received about a dozen questions from potential bidders. So far the Request for Proposal (RFP) process is progressing as anticipated. For more information please contact Valdis Kalnins, Project Manager at vkalnins@allegancounty.org.

Key Dates:
Request for Proposals issued ..... June 11, 2018
Deadline for Questions to be submitted .....3:00 PM on June 27, 2018
Deadline for County's response to questions..... 5:00 PM on July 2, 2018
Due date for proposals ..... 3:00 PM on July 13, 2018
Bid Opening ..... 4:00 PM on July 13, 2018

Energy Savings Opportunities – A representative from Consumers Energy is coming by on July 13, to do a walkthrough assessment. This preliminary assessment is free of charge and may help more accurately project energy savings estimates; next steps can then be determined.

A service provider to facilitate the project(s) may be selected through an open process similar to a Request for Qualification (RFQ). Interested energy savings vendors will be open to submit their interest. Either in conjunction with a vendor, or possibly in-house, a "proof of concept" of energy savings strategies, utilizing one of our small buildings, may help us measure actual savings. If things work out as projected (i.e payback in less than 3 years), we will evaluate taking the initiative to other buildings.

Prior to putting any new lighting in place all safety aspects will be researched and validated by the appropriate officials. Programs such as increased recycling efforts and alternative energy (I.e. solar power if feasible) also being evaluated.

277 North Street Property – The County is currently working with CBRE to finalize a brokerage agreement for the sale of this property (ACC - Mental Health Building.) There were several requested changes from CBRE that have now been reviewed and commented on by the County's legal counsel. The final draft agreement was sent to CBRE on July 3. Unfortunately, contract negotiations have pushed this project about 30 days behind schedule.

The County is also finalizing an agreement with the State of Michigan to lease of this building to the Secretary of State office in August. It is still an expectation that marketing and showings of the building would continue even through the lease arrangement. For more information please contact Steve Sedore, Executive Director of Operations (ssedore@allegancounty.org).

Facilities Vulnerability Assessments and Capital Asset Planning – A proactive assessment (Operations Based Threat, Risk and Vulnerability Assessment) of the current vulnerability of our facilities to threats (i.e. weather, fire, hostile related threats) is being used to aide in the prioritization of capital planning recommendations. The focus is to ensure that citizens and employees are in safe functional facilities to conduct business. A team of qualified individuals is assisting in the assessment and expects to be done by October of 2018. For more information please contact Shawn Stenberg, Director of Facilities Management at 269-673-0207.

Service Area Accountability and Transparency Walls – For the past year, administrative service areas have been working diligently to construct physical accountability walls within their office space in alignment to the County's strategy of providing transparency, feedback and accountability. The goal of these walls were to provide a highly visible account of the projects, initiatives and objectives undertaken for the current year. They also contain metrics and key performance indicators of these objectives as well as the delivery of services. These walls can now be seen across Administration, Finance, Human Resources, Information Services, Facilities Management, Equalization, Central Dispatch, Parks, Public Health, Transportation, and Senior & Veterans Services. For more information please contact Steve Sedore, Executive Director of Operations (ssedore@allegancounty.org).

FINANCIAL

Public Act 202 of 2017 – Commissioners may recall a discussion of the "Protecting Local Government Retirement and Benefits Act" (Form 5572) in the February 8 update. The two-page form (one page for the Defined Benefit plan, and the other for Law Enforcement Retiree Health Care Stipend) must be submitted to the Michigan Department of Treasury by June 30 of each year. The form must be sent electronically to the Board, which it is, as Attachment A to this document. Finally, the form must also be posted on the County's website. It may be found under the "Allegan County Dashboard" heading. The Form reports figures from the December 31, 2016 actuarial report from Municipal Employees' Retirement System (MERS). This report does not consider the $6.3 million additional payment that was made in the spring of 2017. Please contact Lorna Nenciarini, Executive Director of Finance, at 673-0228, for more information.

Defined Benefit Retirement Plan Funding Ratio – The County recently received its annual actuarial valuation report from MERS. The report contains data through December 31, 2017, so it does include the additional $6.3 million payment that was made in the spring of 2017. The one-page Executive Summary is attached for your review (Attachment B). The County's sustained focus on long-term fiscal stability has resulted in a 99% funding level. It is important to keep in mind that this funding level assumes a 7.75% annual rate of return, which will likely be reduced by MERS next year. A reduced assumed return will reduce the percent funding level. As an offset on the positive side, the figures have not yet included the plan changes that were approved during 2017 collective bargaining. Finally, the MERS report does not consider the approximately one million dollar annual UAL bond payment that is funded through department operations. Please contact Lorna Nenciarini, Executive Director of Finance, at 673-0228, for more information.

2017 Audit Report – The annual audit of the County's financial records has been completed. The County received an unmodified opinion, which is the highest achievement possible. We have also maintained our "low risk" designation for our handling and reporting expenditures of federal grant funds. The report has been transmitted as a separate communication, due to its size. It is also posted on the County's website, at http://cms.allegancounty.org/sites/Office/Finance/Resources/2017%20Financial%20Statements.pdf . Bound copies of the report will be distributed as soon as they are received from the auditors. A July 12 presentation is targeted, with the July 26 meeting as an alternate date. Please contact Lorna Nenciarini, Executive Director of Finance, at 673-0228, for more information.

SERVICES

Medical Examiner Services – County Administration has been in negotiations with Western Michigan University for a new Medical Examiner Services Contract. Western has proposed a new fee structure and significantly higher increases. The County Administrator continues to analyze and discuss costs with the Medical Examiner. A number of other counties are partners in this system. Western is gathering information for the County regarding costs for the full system and the County Administrator is developing a system that will be fair and equitable for all participants. For more information regarding this matter, please contact Rob Sarro, County Administrator at 269-673-0239.

Allegan County Cities, Townships and Villages – The next meeting will be Monday, July 29, 2018, 7:00 p.m. at the Allegan Township Hall. Please see the agenda in Attachment C.

421 Helen Avenue Property – On June 26, a meeting with stakeholders of the former Rock Tenn property was held. The Michigan Department of Environmental Quality (DEQ), the U.S. Environmental Protection Agency (EPA) Region 5 – Superfund Division, environmental consultants, City of Otsego, Allegan County and Lakeshore Advantage meet to discuss all options for clean-up and next steps for sale and development. Despite efforts to secure the property, trespassing continues to be a challenge. In addition, there is continued need for authorized access in the pursuit of sale and development of the property. As such, there is concern regarding structural integrity and the presence of asbestos, which may represent risk to human health in and/or around the Power House and the adjacent building(s). The EPA being aware of time critical cleanup of friable asbestos and of developer interest has confirmed they will be cleaning up the friable asbestos. EPA funding has been approved for this project and a project lead has been assigned. Allegan County is working together with the City Of Otsego on a plan with an interested developer to remove the intact asbestos in the Power House on boilers and piping. Currently, there are developers interested in redeveloping the site. The DEQ is planning additional ground water testing in the adjacent area.

Economic Development – Lakeshore Advantage is hiring a Business Solutions Manager for primary employer outreach in Allegan County. This person will be assisted by the Lakeshore Advantage team of specialists in project management, research, talent attraction and development, investor engagement and entrepreneurial support. Online applications closed on July 9, 2018. Interviews to follow.

Allegan County Transportation (ACT) – Recently, the Michigan Department of Transportation (MDOT) approved an agreement with Motorola as the sole source provider of 800 MHz radio equipment for public transit. MDOT has also provided a grant in the amount of $94,903 toward the total cost of $125,667 to equip all transit vehicles and the transit dispatch office for compatibility to the County 800 MHz radio system. The equipment should be installed and operational in the next 60 days.

Public Health EH Field Service Delivery Update - Currently 87% of applications, received through June 8, were issued within eligible timeframe (5/26/2018- 6/8/2018), were completed within the 14 business day benchmark. 96% of all customers (6/2/2018 - 6/22/2018) were contacted within 5 business days of submitting their application. Our automatic reply upon receipt of the application has been working well.

We are still in the process of on-boarding and training the new sanitarians. The areas were re-worked and assigned the week on June 25th. As the sanitarians get more used to their areas, we anticipate the 14 business day benchmark number increasing. Please see Attachment D.

We are continuing to maintain our Soil Erosion and Sedimentation Control inspections, throughout the summer, while we are closing out finished SESC projects. All of the gravel pits, we were allowed to inspect, were inspected again this month. There are some gravel pits which have not paid their fees for this year. We are currently working with finance on a procedure for collecting the fees.

If there are any questions or constituent concerns please contact the Environmental Health Services Manager directly and he can provide the objective data for those concerns or questions. **Please get the address of the concern so that we can identify in the tracking log easier. The address is what a facility file is created from which has all documentation and history for that address.**

Public Health Update Allegan Metal Finishing Company (AMFCO) Superfund Site - As discussed in previous Board updates, the U.S. Environmental Protection Agency (EPA) got final approval for establishing municipal water supply to the end of 29 Street and Jefferies in Allegan Township. Three water supplies in that area are currently on a no drinking advisory. Two of those are connected to the AMFCO Superfund site as a chromium plume and the other is not connected to the AMFCO site because it is lead and arsenic. Michigan Department of Environmental Quality (MDEQ) has offered bottled water to all residents impacted. Tricia Edwards from the EPA is requesting to come and update the Board of Commissioners at an August meeting on the project and timeline. If you have additional questions or concerns contact the Health Officer Angelique Joynes at 269-673-5411 or ajoynes@allegancounty.org or the Environmental Health Service Manager Randy Rapp at 269-673-5411 or rrapp@allegancounty.org.

Public Health-Proposed Statewide Sanitary Code - Allegan County Health Department does not support the proposed legislation as currently written to establish a statewide sanitary code through the amendment of 1994 PA 451 "Natural Resources and Environmental Protection Act" (MCL 324.101 to 324.90106) by adding part 50.

- HB 5752 of 2017 Environmental protection; sewage; onsite wastewater treatment systems; regulate, and provide for assessments and evaluations. Amends 1978 PA 368 (MCL 333.1101 - 333.25211) by adding pt. 128. TIE BAR WITH: HB 5753'17 Last Action: 4/10/2018 bill electronically reproduced 03/22/2018
- HB 5753 of 2017 Environmental protection; sewage; onsite wastewater treatment systems; regulate and provide for assessments and evaluations. Amends sec. 12752 of 1978 PA 368 (MCL 333.12752) & adds secs. 12802, 12808 & 12809. TIE BAR WITH: HB 5752'17 Last Action: 4/10/2018 bill electronically reproduced 03/22/2018

The Health Officer and Environmental Health Services Manager believe that the proposed Sanitary Code provides a strong foundation to protect public health and prevent groundwater contamination by finding failed or failing systems sooner. However, this will be an increase in resources to track, inspect, and enforce these new regulations with no funding to support it nor a current data base infrastructure or proposed infrastructure to support the new inspections requirements. The additional workload on local jurisdictions will create a significant strain on programs already underfunded by the state. This feedback was provided to the bill sponsors Reps. Lower and Hammoud from the Michigan Association of Local Environmental Health Administrators (MALHEA) forum.

The sponsors have developed revisions to the bill to address the funding issue. The revision has not been shared with MALHEA or the Michigan Association for Local Public Health Association (MALPH) Board formally. This will become an unfunded mandate with impossible expectations without a current infrastructure in place to track properties if the appropriate funding mechanisms and database infrastructure is not included in this bill.

If you have additional questions or concerns please contact the Health Officer, Angelique Joynes, at 269-673-5411 ajoynes@allegancounty.org or the Environmental Health Services Manager, Randy Rapp, at 269-673-5411 or rrapp@allegancounty.org.

Public Health Update on My Community Dental Centers (MCDC) - Allegan County partnered with MCDC to provide dental services in Allegan County in 2016. This last May the center has been open for 2 years. This valuable partnership has provided access to adults with Medicaid and uninsured individuals to receive oral health services. In 2017 there were 5,274 Office visits, 3,043 were 21-60 years of age, and 41.4% seen were Medicaid, Healthy Michigan Plan (Expanded Medicaid), or uninsured (MyPP, NDP). There has been a recent change in

leadership at MCDC. Deborah Brown, D.M.D., has been selected as the new Chief Executive Officer (CEO) to lead MCDC starting in August. She is relocating from New Jersey. Dr. Brown has spent years working in the non-profit as well as for profit areas of dental care. She has a Masters in Healthcare Administration as well as being Board Certified in Healthcare Administration. Dr. Brown is also certified in healthcare compliance. She has knowledge of Medicaid coverages and has implemented dentistry programs to better serve children. If there are any questions or concerns please contact the Health Officer, Angelique Joynes, at 269-673-5411 or ajoynes@allegancounty.org.

Public Health Hepatitis A Grant Update – The Allegan County Health Department has been granted additional funding to be utilized to increase access of the Hepatitis A immunization for high risk populations which tentatively ends at the end of September. This grant campaign has focused on utilizing established partnerships in non-traditional settings and removing barriers to access such as transportation and cost. Increasing awareness of Hepatitis A information in a variety of methods such as via social media, stakeholder talking points for referral and print materials have been developed for utilization in innovative locations; food pantries, transient housing locations and substance abuse clinics.

Currently, there have been around 144 doses of grant funded vaccine given with community partners or by public health nurses in May and June. To help mitigate this outbreak nationally and in Michigan we need to increase vaccination rates to provide a herd immunity (enough people vaccinated so the virus will not spread easily because of vaccinated individuals having antibodies towards Hepatitis A). Please share the marketing material with agencies that might provide services to individuals that are high risk; Attachment E. Public Health is willing to provide clinics at their agencies if that would reduce barriers. There are also free walk in clinics on Mondays from 12:00 pm-4:00 pm at the Human Service Building (3255 122nd Ave Suite 200, Allegan MI, 49010, Health Department Clinic). If there are questions please contact the Personal Health Services Manager, Lisa Letts, at 269-673-5411 or lletts@allegancounty.org.

Public Health/Resource Recovery Program, Kent County Sustainable Business Park – Kent County contacted the SWPC requesting a letter of consistency with the County's Solid Waste Plan for their proposed Sustainable Business Park. On May 22, 2018 the SWPC tabled the request and will revisit this agenda item as more information becomes available. The Kent County, Board of Public Works, will hold a work session on August 2, 2018 at 8:30 am on this subject (more information to follow). The Director of the Department of Public Works, Darwin Baas, has invited Allegan County stakeholders to attend this meeting. Attached are the communications received by Allegan County regarding the proposed park; Attachment F. Please contact the Resource Recovery Coordinator Rosemary Graham at 269-673-5411 or rgraham@allegancounty.org for additional information.

Michigan Department of Treasury

5572 (02-18)

Public Act 202 of 2017 Pension Report

Enter Local Unit Name	Allegan County
Enter Six-Digit Municode	030000
Unit Type	County
Fiscal Year (four-digit year only, e.g. 2017)	2017
Contact Name (Chief Financial Officer)	Lorna Nenciarini
Title if not CFO	Executive Director of Finance
CFO (or designee) Email Address	lnenciarini@allegancounty.org
Contact Telephone Number	269-673-0228

Instructions/Questions: For a list of detailed instructions on how to complete and submit this form, visit michigan.gov/LocalRetirementReporting. For questions, please email LocalRetirementReporting@michigan.gov. **Return this original Excel file. Do not submit a scanned image or PDF.**

Pension System Name (not division) 1	Allegen Co (0302)
Pension System Name (not division) 2	
Pension System Name (not division) 3	
Pension System Name (not division) 4	
Pension System Name (not division) 5	

If your pension system is separated by divisions, you would only enter one system. For example, one could have different divisions of the same system for union and non-union employees. However, these would be only one system and should be reported as such on this form.

Line	Description	Source of Data	Statute Reference	System 1	System 2	System 3	System 4	System 5
1	Provide the name of your retirement pension system	Most Recent Actuarial Valuation Report	Sec. 5(6)	Allegen Co (0302)				
2	Enter retirement pension system's assets (system fiduciary net position ending)	Most Recent Audit Report	Sec. 5(4)(b)	53,766,163				
3	Enter retirement pension system's liabilities (total pension liability ending)	Most Recent Audit Report	Sec. 5(4)(b)	63,684,208				
4	Date (system year ending) of valuation of system's assets and liabilities (e.g. 12/31/2016)	Most Recent Audit Report	Sec. 5(6)	12/31/16				
5	Actuarially Determined Contribution (ADC)	Most Recent Audit Report	Sec. 5(4)(b)	909,864				
6	Governmental Fund Revenues	Most Recent Audit Report	Sec. 5(4)(b)	49,121,384				
7	Pension Trigger Summary							
8	Is this unit a primary unit (County, Township, City, Village)?	From Municode		YES	YES	YES	YES	YES
9	Funded ratio	Calculated	Sec. 5(4)(b)	84.4%				
10	All systems combined ADC/Governmental fund revenues	Calculated	Sec. 5(4)(b)	1.9%	0.0%	0.0%	0.0%	0.0%
11	Does this system trigger "underfunded status" as defined by PA 202 of 2017?	**Primary unit triggers:** Less than 60% funded AND greater than 10% ADC/Governmental fund revenues. **Non-Primary unit triggers:** Less than 60% funded	Sec. 5(4)(b)	NO	NO	NO	NO	NO

By emailing this report to the Michigan Department of Treasury, the local unit of government acknowledges that this report is complete and accurate in all known respects. Act 202 of 2017 also requires the local unit of government to electronically submit the report to its governing body.

Michigan Department of Treasury

5572 (02-18)

Public Act 202 of 2017 Health Care (OPEB) Report

Enter Local Unit Name	Allegan County
Enter Six-Digit Municode	030000
Unit Type	County
Fiscal Year (four-digit year only, e.g. 2017)	2017
Contact Name (Chief Financial Officer)	Lorna Nenciarini
Title if not CFO	Executive Director of Finance
CFO (or designee) Email Address	lnenciarini@allegancounty.org
Contact Telephone Number	269-673-0228

Instructions/Questions: For a list of detailed instructions on how to complete and submit this form, visit michigan.gov/LocalRetirementReporting. For questions, please email LocalRetirementReporting@michigan.gov. **Return this original Excel file. Do not submit a scanned image or PDF.**

OPEB System Name (not division) 1	Retiree Health Care
OPEB System Name (not division) 2	
OPEB System Name (not division) 3	
OPEB System Name (not division) 4	
OPEB System Name (not division) 5	

If your OPEB system is separated by divisions, you would only enter one system. For example, one could have different divisions of the same system for union and non-union employees. However, these would be only one system and should be reported as such on this form.

Line	Description	Source of Data	Statute Reference	System 1	System 2	System 3	System 4	System 5
1	Provide the name of your retirement health care system	Most Recent Actuarial Valuation Report	Sec. 5(6)	Retiree Health Care				
2	Enter retirement health care system's actuarial value of assets	Most Recent Audit Report	Sec. 5(4)(a)	-				
3	Enter retirement health care system's actuarial accrued liabilities	Most Recent Audit Report	Sec. 5(4)(a)	-				
4	Date (system year ending) of valuation of system's assets and liabilities (e.g. 12/31/2016)	Most Recent Audit Report	Sec. 5(6)					
5	Annual required contribution (ARC)	Most Recent Audit Report	Sec. 5(4)(a)	-				
6	Governmental Fund Revenues	Most Recent Audit Report	Sec. 5(4)(a)	49,121,384				
7	Health Care Trigger Summary							
8	Is this unit a primary unit (County, Township, City, Village)?	From Municode		YES	YES	YES	YES	YES
9	Funded ratio	Calculated	Sec. 5(4)(a)					
10	All systems combined ARC/Governmental fund revenues	Calculated	Sec. 5(4)(a)	0.0%	0.0%	0.0%	0.0%	0.0%
11	Does this system trigger "underfunded status" as defined by PA 202 of 2017?	**Primary unit triggers:** Less than 40% funded AND greater than 12% ARC/Governmental fund revenues. **Non-Primary unit triggers:** Less than 40% funded	Sec. 5(4)(a)	NO	NO	NO	NO	NO

By emailing this report to the Michigan Department of Treasury, the local unit of government acknowledges that this report is complete and accurate in all known respects. Act 202 of 2017 also requires the local unit of government to electronically submit the form to its governing body.

Executive Summary

Funded Ratio and Required Employer Contributions

The MERS Defined Benefit Plan is an agent multiple-employer plan, meaning that assets are pooled for investment purposes but separate accounts are maintained for each individual employer. Each municipality is responsible for their own plan liabilities; MERS does not borrow from one municipality's account to pay for another.

The funded ratio of a plan is the percentage of the dollar value of the accrued benefits that is covered by the actuarial value of assets.

Your Funded Ratio:

	12/31/2017 *	12/31/2016
Funded Ratio	99%	89%

* Reflects assets from Surplus divisions, if any.

Michigan Law requires that pension plans be pre-funded, meaning money is set aside now to pay for future benefits. Pension plans are usually funded by employer and employee contributions, and investment income.

How quickly a plan attains the 100% funding goal depends on many factors such as:

- The current funded ratio
- The future experience of the plan
- The amortization period

It is more important to look at the trend in the funded ratio over a period of time than at a particular point in time.

ACCTV

(Allegan County Cities, Townships and Villages)
Quarterly Meeting

WHEN

July 30, 2018
7:00 pm

WHERE

Allegan Township Hall

3037 - 118th Avenue, Allegan

FEATURING · Legal Aspects of Indian Land Trust & Reservation Claims · County Updates · Roundtable

PLEASE JOIN US AND SPREAD THE WORD!

LET US CONTINUE TO MAKE CONNECTIONS AND INTERACT WITH EACH OTHER FOR THE BETTERMENT OF ALLEGAN COUNTY.

AGENDA:

LEGAL ASPECTS OF INDIAN LAND TRUST AND RESERVATION CLAIMS

Presenters:

- Thad Morgan, Fraser Trebilcock

COUNTY UPDATES

ROUNDTABLE

Your opportunity to share the latest from your area

REFRESHMENTS

As always, the coffee pot will be on, water bottles and other refreshments

SAVE THE DATE

October 29th

Environmental Health - Benchmark Data
Board of Commissioner Report

	January		February		March		April		May		June		July	August	September	October	November	December
Total Applications Received for the Month	108		113		238		201		282		225							
14 Business Days for the Month are Permits received during	1/1 thru 1/11	1/12 thru 1/22	1/23 thru 2/2	2/3 thru 2/14	2/15 thru 3/2	3/3 thru 3/14	3/15 thru 4/6	4/7 thru 4/20	4/21 thru 5/14	5/15 thru 5/25	5/26 thru 6/8							
Incomplete and/or Unpaid Submissions within 14 Business Days	0	6	19	4	10	7	18	5	16	0	6							
Total Eligible for Completion within 14 business day window	34	34	66	36	60	64	139	99	175	84	120							
Submissions Not Completed within Elligible Time Period	9	5	11	7	3	4	20	15	31	8	16							
Total Completed	25	29	59	29	57	60	119	84	144	76	104							
Percentage Complete	74%	85%	89%	81%	95%	94%	86%	85%	82%	90%	87%							

	Number	Percentage
Applications completed prior to 14 day turnaround (only those with proper documentation and fees paid): **Total Completed divided by Total Eligible for Completion within 14 business day window = Percentage Complete**	104/120	87%

14 business days from May 26 = June 8

	January		February		March		April		May		June		July	August	September	October	November	December
Total Applications Received	108		113		238		201		282		225							
5 Business Days for Communication	1/1 thru 1/24	1/25 thru 2/2	2/5 thru 2/12	2/13 thru 2/22	2/23 thru 3/2	3/5 thru 3/12	3/13 thru 3/20	3/21 thru 3/30	4/2 thru 4/13	4/16 thru 5/7	5/8 thru 6/1	6/2 thru 6/22						
Total Eligible for Communication	84	31	24	43	39	43	69	96	80	175	211	165						
Total Not Communicated to within 5 Business Days	5	1	0	9	5	8	8	9	4	3	0	6						
Total Communicated to within 5 Business Days	79	30	24	34	34	35	61	87	76	172	211	159						
Percentage Complete	94%	97%	100%	79%	87%	81%	88%	91%	95%	98%	100%	96%						

	Number	Percentage
Customers that have been contacted within 5 business days: **Total Communicated to within 5 Business Days divided by Total Eligible for Communication**	159/165	96%

5 business days from June 2 = June 22

Environmental Health - Total Services
Board of Commissioner Monthly Report

APPLICATIONS RECEIVED

	January	February	March	April	May	June	July	August	September	October	November	December	YTD Total
Well	30	44	72	58	65	68							337
Septic	39	32	81	60	88	67							367
Loan Eval.	7	10	16	25	39	27							124
MDHHS Eval.	2	0	9	12	12	9							44
SESC	18	16	32	25	44	25							160
Raw Land/Soil Eval.	10	6	25	16	23	19							99
Investigative Fieldwork	2	5	3	5	11	10							36
Monthly Totals	108	113	238	201	282	225	0	0	0	0	0	0	1167

SERVICES PROVIDED

PERMITS ISSUED	January	February	March	April	May	June	July	August	September	October	November	December	YTD Total
Well	39	35	58	64	76	64							336
Septic	42	30	59	69	71	75							346
Loan Eval.	9	4	14	21	31	22							101
MDHHS	0	0	1	16	8	16							41
SESC	23	26	28	31	44	24							176
Raw Land/ Soil Eval.	17	4	14	14	24	13							86
Monthly Totals	130	99	174	215	254	214	0	0	0	0	0	0	1086

Other Services Completed	January	February	March	April	May	June	July	August	September	October	November	December	YTD Total
Well Finals	27	98	100	31	55	16							327
Septic Finals	5	12	22	30	45	51							165
SESC Inspections	2	18	8	200	217	260							705
Investigative Fieldwork	2	5	2	5	11	10							35
Monthly Totals	36	133	132	266	328	337	0	0	0	0	0	0	1232

Total Services Provided	166	232	306	481	582	551	0	0	0	0	0	0	2318

Hepatitis A is in Michigan communities.



Hepatitis A is a liver disease caused by the hepatitis A virus (HAV). Hepatitis A is spread through contaminated food or water and close contact with persons who are infected. Hepatitis A can affect anyone. Frequent hand washing with soap and warm water after using the bathroom, changing a diaper, or before preparing food can help prevent the spread of Hepatitis A.

The best way to protect against hepatitis A is to get the hepatitis A vaccine. Talk to your health care provider to get the two doses you need for protection. Need help paying for vaccines? Your local health department or your federally qualified health center may have hepatitis A vaccine available for little cost.

Stop the spread. Get vaccinated today.

www.michigan.gov/HepatitisAOutbreak

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

Free Hepatitis A Vaccine Coupon

Hepatitis A can make you very sick and could even cause death.

Protect yourself

GET THE SHOT

No appointments needed on Mondays from noon to 4:00 pm

(Closed May 28th and September 3rd) **Expires 9/29/2018**

Appointments are also available!

Free Hepatitis A Vaccine Coupon

Allegan County Health Department Clinic

3255 - 122nd, Suite 200

Allegan, Michigan 49010

Telephone: 269-673-5411

Call the Allegan County Health Department for information and ask about the no cost - to - low cost hepatitis A vaccine program

www.Allegancounty.org/health ***0001***

KENT COUNTY DEPARTMENT OF PUBLIC WORKS

April 2, 2018

Ms. Rosemary Graham
Solid Waste/Recycling Coordinator
Allegan County Health Department – EHS
3255 122nd Avenue, Suite 200
Allegan, MI 49410

RE: Kent County Sustainable Business Park – Letter of Consistency/Setback Requirements

Dear Ms. Graham,

Thank you for the opportunity to meet with you last week to provide an update on the Sustainable Business Park masterplan process.

The Kent County Department of Public Works has operated the South Kent Landfill, a Type II, municipal solid waste disposal facility located in Byron Township, Kent County for over thirty years. Since the 1990's, the DPW strategically acquired adjacent properties in Dorr Township, Allegan County for the long term MSW disposal needs of Kent County, Allegan and neighboring counties.

Over the past three years, the DPW adopted landfill disposal reduction goals of 20% by 2020 and 90% by 2030, a sustainable materials management strategic vision and a sustainable business park concept to encourage public and private investment in waste utilization and conversion infrastructure to significantly reduce the need for future landfill expansion while spurring economic development of technologies supporting zero waste to landfill strategies. Last fall, I was given the opportunity to present these plans to the Allegan County Solid Waste Management Committee.

Currently in a master planning phase, the Sustainable Business Park is envisioned to manage mixed waste and source separated materials for the purposes of construction and demolition debris processing, composting, conversion, reuse, energy recovery, remanufacturing and/or complimentary processes to support agriculture, manufacturing, construction and other industries.

We are requesting a letter of consistency with the Allegan County Solid Waste Management Plan including setback requirements to right-of-way and domiciles

2020 20% REDUCE LANDFILL WASTE 20% by 2020 | 90% by 2030 2030 90%

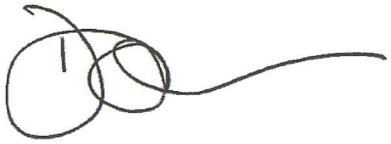
Earl G. Woodworth Building
1500 Scribner Avenue NW
Grand Rapids, MI 49504

616.632.7920 tel
616.632.7925 fax
kcdpw@kentcountymi.gov

for non-landfill facilities that may include a transfer station, solid waste processing and processing of source separated materials to support recovery, utilization and/or conversion activities.

Please let me know if you have any questions or need additional information. I've included several attachments to provide more detail. Please note the preliminary concept plan is very conceptual to help provide an idea of how the property might be utilized. We anticipate changes as we firm up the masterplan later this year and intend to provide education, tour as well as built and natural resource interpretive areas to be in a final design.

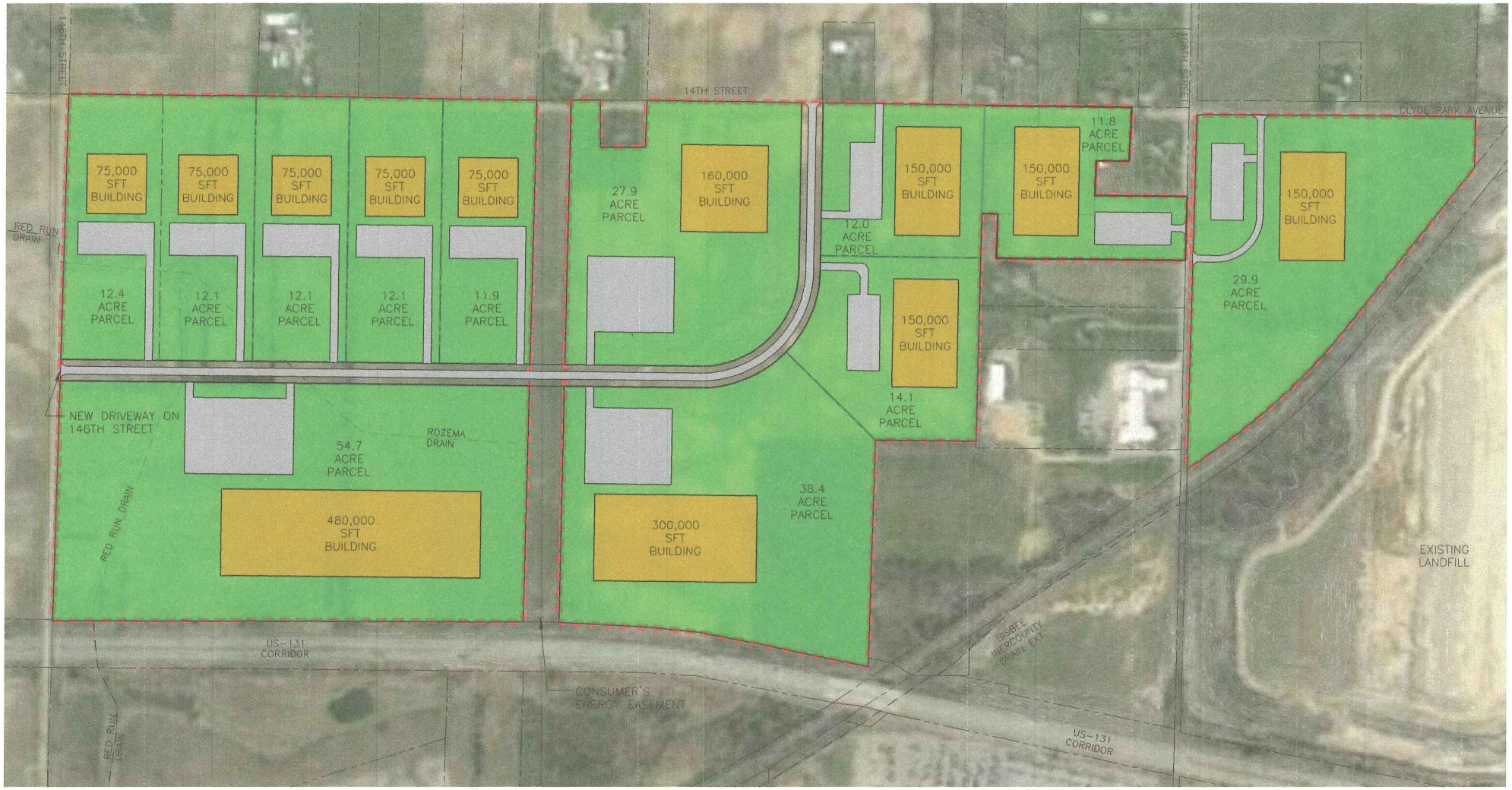
Sincerely,



Darwin J. Baas
Director

Attachments:

Kent County Sustainable Business Park – Preliminary Concept Plan
The Opportunity – Description of the Sustainable Business Park
20%x2020 – 90%x2030 Flyer



PRELIMINARY CONCEPT PLAN

SCALE: 1" = 200'

NORTH

0 100 200 400

SYMBOL LEGEND

PROPERTIES PROPOSED FOR DEVELOPMENT

PROPERTIES PROPOSED FOR DEVELOPMENT

Kent County Sustainable Business Park

Master Plan

fishbeck, thompson, carr, & huber, inc.

October 20, 2017

171565

THE OPPORTUNITY

KENT COUNTY DEPARTMENT OF PUBLIC WORKS

Attract new business and investment to Kent County while accelerating our progress toward a more sustainable community.

REIMAGINE TRASH

The Kent County Dept. of Public Works has the opportunity to put West Michigan on the map as a national leader in recycling and waste reduction while helping protect our air, land and Great Lakes. Each year, Kent County DPW processes over ***1 billion pounds of trash***, of which ***more than 75% could be reused, recycled or repurposed.*** The Kent County DPW has set a bold goal to **divert 90% of trash from the landfill by 2030,** and the Sustainable Business Park is a key part of achieving this goal. This new approach to cutting back on trash dumped in the South Kent Landfill just makes sense: it will extend the life of the current landfill, protect the environment, and create new jobs and spark investment in our community.

SUSTAINABLE BUSINESS PARK

Building a Sustainable Business Park in Kent County will help our community cut down on trash buried in landfills and attract investment and jobs from companies that convert waste into usable products. The Park will take waste materials that would otherwise be dumped into a landfill and reuse or recycle those materials into products like compost for agriculture, fuel pellets, plastic pellets for new plastic products, biofuels and textiles. A variety of complementary businesses, entrepreneurs and startups that need access to raw materials could tap into these reclaimed or converted materials, incorporating them into their production processes or transforming them into entirely new products.
The Park has tremendous potential for preserving open space, establishing a center for innovation, and both producing and using renewable energy to power operations, which will help save money on electricity costs and further protect our air and Great Lakes.

OUR PLAN OF ACTION

We're bringing together national and local experts to engage in a plan for the 200-acre Sustainable Business Park to make West Michigan a national leader in circular economy thinking. The plan will look at the necessary improvements, costs, funding sources, and a proposed implementation schedule. As part of the plan, the DPW is actively working with the business community to attract potential tenants and complementary technologies.

A TRIPLE BOTTOM LINE WIN

It's a win for the **people** of West Michigan who can rest assured that their waste will continue to be managed responsibly but in a way that benefits future generations instead of burdening them.

It's a win for the **planet** when we look toward innovative ways to reintroduce discards back into the value stream as feedstock, plastic pellets, fuels, & more.

It's a win for our **economy** when we localize the processing of materials. The Sustainable Business Park will support local jobs and our West Michigan economy, all while capturing the $52 million in 'easily recoverable' materials of value that are currently going into landfills in West Michigan.

PROJECT CONTACT
Kristen Wieland | 616.632.7923 | kristen.wieland@kentcountymi.gov | www.reimaginetrash.org/vision

M-40/M-89 CORRIDOR COMMITTEE

July 31, 2018
10:00 a.m.
Allegan County Road Commission
1308 Lincoln Road, Allegan, Michigan 49010.

AGENDA

1. Welcome and Introductions
2. Review of Minutes (Enclosed)
3. Guest Speaker – Don Poppe, Michigan Department of Natural Resources
4. MDOT Update
5. Allegan County Road Commission Update
6. Allegan County Sheriff's Department Update
7. West Michigan Regional Planning Commission Update
8. Macatawa Area Coordinating Council
9. Local Businesses – Issues & Concerns
10. Round Table/Corridor Issues
11. Future Meeting Dates
    - October 30
12. Future Agenda Items
13. Other Business
14. Adjournment

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF CONSTRUCTION CODES
NOTICE OF PUBLIC HEARING

Part 8. Electrical Rules (ORR#2017-001LR)

The Department of Licensing and Regulatory Affairs, Bureau of Construction Codes, will hold a public hearing on the revision of the Part 8. Electrical Rules. The public hearing will be held on August 10, 2018, at 9:00 a.m. in the Ottawa Building, Conference Room UL 3, 611 W. Ottawa Street, Lansing, MI 48933. The Part 8. Electrical rules are proposed to take immediate effect after filing with the Secretary of State.

The proposed revisions to the Part 8 Electrical Code rules will adopt the 2017 edition of the National Electrical Code, a national industry standard, and provide Michigan-specific amendments. The hearing is being conducted by the Department under the authority of Section 4 of 1972 PA 230, MCL 125.1504, and Executive Reorganization Order Nos. 1996-2, 2003-1, 2008-4 , 2011-4, and 2017-1, MCL 445.2001, 445.2011, 445.2025, 445.2030, and 339.3102.

The proposed rules will be published in the August 1, 2018, *Michigan Register*. You may download a free copy of the proposed amendments by visiting the Bureau's website at www.michigan.gov/bcc. The amendments are located under "What's Happening" on the front page of the website.

Oral or written comments may be presented in person at the hearing on August 10, 2018, or submitted in writing by mail, email, or facsimile no later than 5:00 p.m., August 10, 2018, to the address stated below. If your presentation at the public hearing is in written form, please provide a copy to the Rules Specialist, at the conclusion of your testimony at the hearing.

Department of Licensing and Regulatory Affairs
Bureau of Construction Codes
Administrative Services Division
P.O. Box 30254
Lansing, MI 48909
Telephone (517) 241-6312
Facsimile (517) 241-9570
matsumotos@michigan.gov

The meeting site and parking are accessible. Individuals attending the meeting are requested to refrain from using heavily scented personal care products, in order to enhance accessibility for everyone. People with disabilities requiring additional services (such as materials in alternative format) in order to participate in the meeting should call Shannon Matsumoto at (517) 241-6312 (voice) at least 14 days prior to the hearing. LARA is an equal opportunity employer/program.

STATE OF MICHIGAN
BEFORE THE MICHIGAN PUBLIC SERVICE COMMISSION

NOTICE OF HEARING
FOR THE ELECTRIC
CUSTOMERS OF
CONSUMERS ENERGY COMPANY
CASE NO. U-20164

- Consumers Energy Company requests Michigan Public Service Commission approval for reconciliation of its 2017 demand response program costs.

- The information below describes how a person may participate in this case.

- You may call or write, Consumers Energy Company, One Energy Plaza, Jackson, MI 49201-2276 for a free copy of its application. Any person may review the application at the offices of Consumers Energy Company.

- The prehearing conference in this matter will be held:

DATE/TIME:	**Tuesday, July 24, 2018, at 9:00 A.M.**
BEFORE:	Administrative Law Judge Sally L. Wallace
LOCATION:	Michigan Public Service Commission 7109 West Saginaw Highway Lansing, Michigan 48917
PARTICIPATION:	Any interested person may attend and participate. The hearing site is accessible, including handicapped parking. Persons needing any accommodation to participate should contact the Commission's Executive Secretary at (517) 284-8090 in advance to request mobility, visual, hearing or other assistance.

The Michigan Public Service Commission (Commission) will hold a hearing to consider Consumers Energy Company's (Consumers Energy) May 31, 2018 application for reconciliation of its 2017 demand response program costs. Consumers Energy requests the Commission approve: 1) the recovery of all incremental capital expenditures incurred by Consumers Energy in 2017 beyond the amounts previously approved by the Commission in Case Nos. U-17990 and U-18322; 2) the deferred regulatory accounting treatment of the actual revenue requirement for Demand Response (DR) program capital expenditures and Operations and Maintenance (O&M) expenses incurred in 2017 compared to authorized revenue requirement resulting in the creation of a regulatory liability of $489,633 which will be reflected in a future electric general rate case; 3) the deferred regulatory accounting treatment of Consumers Energy's requested financial compensation mechanism for DR and financial incentive of $1,461,181, creating a regulatory asset which will be reflected in a future electric general rate case; and 4) other relief.

All documents filed in this case shall be submitted electronically through the Commission's E-Dockets website at: michigan.gov/mpscedockets. Requirements and instructions for filing can be found in the User Manual on the E-Dockets help page. Documents may also be submitted, in Word or PDF format, as an attachment to an email sent to: mpscedockets@michigan.gov. If you require assistance prior to e-filing, contact Commission staff at (517) 284-8090 or by email at: mpscedockets@michigan.gov.

Any person wishing to intervene and become a party to the case shall electronically file a petition to intervene with this Commission by **July 17, 2018**. (Petitions to intervene may also be filed using the traditional paper format.) The proof of service shall indicate service upon Consumers Energy Company's Legal Department – Regulatory Group, One Energy Plaza, Jackson, MI 49201.

Any person wishing to appear at the hearing to make a statement of position without becoming a party to the case may participate by filing an appearance. To file an appearance, the individual must attend the hearing and advise the presiding administrative law judge of his or her wish to make a statement of position. All information submitted to the Commission in this matter becomes public information, thus available on the Michigan Public Service Commission's website, and subject to disclosure. Please do not include information you wish to remain private.

Requests for adjournment must be made pursuant to the Commission's Rules of Practice and Procedure R 792.10422 and R 792.10432. Requests for further information on adjournment should be directed to (517) 284-8130.

A copy of Consumers Energy Company's request may be reviewed on the Commission's website at: michigan.gov/mpscedockets, and at the office of Consumers Energy Company. For more information on how to participate in a case, you may contact the Commission at the above address or by telephone at (517) 284-8090.

Jurisdiction is pursuant to 1909 PA 106, as amended, MCL 460.551 et seq.; 1919 PA 419, as amended, MCL 460.54 et seq.; 1939 PA 3, as amended, MCL 460.1 et seq.; 1969 PA 306, as amended, MCL 24.201 et seq.; and Parts 1 & 4 of the Michigan Administrative Hearing System's Administrative Hearing Rules, Mich. Admin Code, R 792.10101 through R 792.10137, and R 792.10401 through R 792.10448.

[THE MICHIGAN PUBLIC SERVICE COMMISSION MAY APPROVE, REJECT, OR AMEND PROPOSALS MADE BY CONSUMERS ENERGY.]

1094-E

Reports & Communications:

A. WR – Installation of SCADA Radio Antennas and Coaxial:
Related to the SCADA system radio hardware replacement, Superintendent Pond recommends collaborating with Perceptive Controls to install the antennas and coaxial.
Recommended action: Consider approving the contract with Perceptive Controls for installation of the SCADA antennas and coaxial at a cost of $8,272.00.

B. Resolution 18-20 - Section 125 Plan Document Amendment:
Personnel Manager Lamorandier has reviewed the plan document and recommends changes to reflect recent law change, eligibility requirements and policy changes. The Resolution formally adopts changes to the Plan Document and the Summary Plan Description
Recommended action: Consider adopting Resolution 18-20 as presented.

C. 2018/2019 Budget Amendment – Encumbrance Rollover:
This is an annual housekeeping item to move purchases approved and budgeted for in the 2017/2018 fiscal year into the 2018/2019 budget because the purchases will be completed after July 1, 2018.
Recommended action: Consider approving the budget amendment as presented

Reminder of Upcoming Meetings

- July 26, 2018 – Allegan County Board of Commissioners – 1:00pm
- August 14, 2018 – Plainwell DDA/BRA/TIFA Board – 7.30am
- August 1, 2018 – Plainwell Planning Commission – 7:00pm
- August 13, 2018 – Plainwell City Council – 7:00pm

Non-Agenda Items / Materials Transmitted

- Michigan State University Citizen Planner Program – Information Only
- AFP News Article about recycling – July 12, 2018
- Allegan County Board of Commissioners Administrator's Report – July 12, 2018
- Notice of Public Hearing – Consumers Energy Electric Customers – July 24, 2018 9am
- M40/M89 Corridor Committee Meeting – Road Commission Offices – July 31, 2018 10am
- Notice of Public Hearing – Revisions to Electrical Code – Lansing, MI – August 10, 2018 9am
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