MONROE COUNTY, MICHIGAN

RETIREE HEALTH CARE PLAN

Restated Effective June 7, 2016

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ARTICLE I
PREAMBLES

Section 1.01 **Adoption of Plan**. The County of Monroe, Michigan ("Employer"), established, effective January 1, 1996, a health care plan for certain Retirees, Spouses and Dependents, to be known as the Monroe County Retiree Health Care Plan ("Plan"), which Plan has been amended and restated on several occasions, and, hereby is amended and restated effective March 15, 2016.

Section 1.02 **Purpose**. The purpose of the Plan is to provide medical and health benefits to eligible Retirees and their Eligible Dependents. Benefits under the Plan are funded through a combination of Employer, Employee, and Participant contributions. The Employer reserves the right to enter into a contract with a commercial insurance carrier, a health maintenance organization or preferred provider organization to provide retiree health care benefits under the Plan or to self-fund the retiree health care benefits through the Employer, Employee and Participant contributions and through a trust fund or other reserves created for that purpose.

Section 1.03 **Interpretation and Law**. The Plan is intended to qualify as a accident and health plan under Code Sections 105 and 106 of the Internal Revenue Code of 1986, as amended ("Code"), the regulations promulgated thereunder, and applicable Michigan law. Where not governed by Michigan law, the Plan shall be administered and construed in accordance with applicable Federal law.

Section 1.04 **Defined Terms**. Throughout the Plan, various terms are used repeatedly. These terms have specific and definite meanings when capitalized in the text. For convenience, capitalized terms are collected and defined in Article II. Whenever capitalized terms appear in the Plan, they shall have the meanings specified in that Article.

Section 1.05 **Construction**. Whenever any words are used in the Plan in the masculine gender, they shall be construed as though they also were used in the feminine gender in all cases where they would so apply, and wherever any words are used in the Plan in the singular form, they shall be construed as though they also were used in plural form in all cases where they would so apply. Headings of sections and paragraphs of this document are inserted for convenience of reference. They constitute no part of the Plan and are not to be considered in the construction of the Plan.

ARTICLE II
DEFINITIONS

Section 2.01 "**Administrator**" means the central office of the Administrator/Chief Financial Officer of the County of Monroe, Michigan, which is charged with the responsibility to administer and oversee the day to day operations of the Plan.

Section 2.02 **Benefits Guide**. The actual plan documents, including insurance contracts, benefits-at-a-glance documents, booklets, summaries or administrative services agreements, entered into by the Employer and that govern the retiree health care benefits

described in this document and are hereby incorporated by reference into this document. The Employer may change insurers or third party administrators from time to time, and, thus, a Participant occasionally should request an updated Benefits Guide from the Administrator.

Section 2.03 "**Board**" or "**Board of Commissioners**" means the Board of Commissioners for the County of Monroe, Michigan.

Section 2.04 "Code" means the Internal Revenue Code of 1986, as amended. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provision of any legislation which amends or replaces such section or subsection.

Section 2.05 "Eligible Dependent" means:

(a) The Retiree's Spouse (as defined below);

(b) The Retiree's child until the end of the calendar year in which such child attains age 26, or

(c) The Retiree's child of any age if such child is totally and permanently disabled by either a physical or mental condition prior to age 26, and qualifies as the Retiree's dependent for federal tax purposes under Code Section 152.

As used herein, "child" shall only include a Retiree's ***unmarried*** natural child, adopted child, child lawfully placed with the Retiree for adoption, or child for whom legal guardianship has been awarded to the Retiree, but only if such child is in the Retiree's custody and qualifies as a tax dependent of the Retiree (without regard to the earnings limit under §152(d)(1)(B), the special exclusions under §152(b)(1) or (2), or the age or student status requirements under §152(c)(3)). Notwithstanding anything in this Plan to the contrary, if a Benefits Guide has a more restrictive definition of Eligible Dependent (e.g. contains additional dependent eligibility conditions), then the more restrictive conditions under the Benefits Guide will apply, but only to the extent they are consistent with applicable federal law.

Section 2.06 "Employee" means:

(a) a management or non-union common law employee of the Employer who was employed on a full-time basis by the Employer on or after January 1, 1996, but hired on or before October 27, 2003, and is a member of or eligible to participate in the Retirement System; or

(b) an individual who is covered by a collective bargaining agreement with the Employer that specifically states that retirement health care benefits under the Plan shall be provided to eligible Retirees (subject, however, to the terms of the collective bargaining agreement that may require the individual to be employed on or before a certain date).

The term "Employee" shall exclude any (i) management or non-union common law employee hired by the Employer on or after October 27, 2003, (ii) union employee whose collective bargaining agreement does not require retirement health care benefits or hired by the Employer

on or after a date specified in the applicable collective bargaining agreement, (iii) any other employee not eligible to participate under the Retirement System, or (iv) individual for whom the Employer designates as an independent contractor, leased or contract employee, or self-employed individual, regardless of a finding by the Employer or any third party as to the common law employment status or reclassification of any such person.

Section 2.07 "Employer" means the County of Monroe, Michigan.

Section 2.08 "Participant" means a Retiree or his/her Eligible Dependents who are covered by and entitled to retiree health care benefits under the terms of the Plan.

Section 2.09 "Plan" means the Monroe County Retiree Health Care Plan as described in this document and any subsequent amendments, and any Benefit Guide incorporated by reference into the Plan.

Section 2.10 "Plan Year" means the period commencing on January 1st and ending on December 31st.

Section 2.11 "Retiree" means an Employee who satisfies the eligibility requirements of Article III:

Section 2.12 "Retirement System" means the Monroe County Employees Retirement System.

Section 2.13 "Spouse" means a Retiree's Spouse by legal marriage at the time of the Employee's retirement, if recognized under the laws of Michigan, but specifically excluding (i) any common law marriages or same sex marriages, even if recognized under the laws of the Retiree's state of domicile, or (ii) any individual for whom a decree of divorce, separate maintenance or legal separation from the Retiree has been entered. For these purposes, the legal married status between a Retiree and his/her Spouse must have existed at the time of the Retiree's initial enrollment under the Plan and also at the time that the expense was incurred for which reimbursement is claimed. After the Retiree's initial enrollment period, he/she will not be permitted to enroll a spouse (e.g. he may not enroll a new spouse or a spouse he/she failed to initially enroll for any reason). A Spouse who is covered under the Plan at the time of a Retiree's death may continue to participate in the Plan as long as the Spouse receives the Retiree's survivor payments under the Retirement System; provided that if the Spouse remarries, his or her new spouse is not eligible to receive coverage under the Plan.

Section 2.14 "**Third Party Administrator**" means the organization or insurance carrier that has been engaged or contracted by the Employer to perform benefit claims processing or other administrative services on behalf of the Plan.

Section 2.15 "Trust" means the Trust Agreement Resolution for the Monroe County Retiree Health Care Fund.

ARTICLE III
BENEFIT ELIGIBILITY

Section 3.01 Eligible Retirees. An Employee is eligible to enroll in the Plan and continue to receive coverage during a Plan Year only if he/she satisfies **each** of the following conditions:

(a) The Employee separates for purposes of retirement from employment with Employer.

(b) As of the date of retirement and severance from employment with the Employer, the Employee is entitled to begin receiving his or her normal retirement pension from the Retirement System (employees who are only entitled to a deferred retirement pension under the Retirement System are not eligible for coverage under this Plan).

(c) The Employee is not terminated from employment by reason of gross misconduct, as determined in the sole discretion of the Employer.

(d) When the Retiree becomes entitled to Medicare (e.g. at age 65), he/she timely enrolls in Medicare Part B.

(e) The Employee elects to receive retiree health coverage under the Plan in lieu of, and thus waive, COBRA continuation health coverage to which he/she may have otherwise been entitled under the Monroe County Group Health Plan covering active Employees of the Employer.

(f) The Employee agrees in writing to and actually makes any required monthly contribution for retiree coverage, which cost is determined by the Employer from time to time. If a Retiree fails to timely pay his/her required contribution, retiree coverage will end and he/she will not thereafter again resume participation in the Plan as a Retiree.

(g) The Employee elects to receive retiree coverage under the Plan in writing by the date specified by the Administrator, but in no event later than **60 days** after his/her severance from employment with the Employer for retirement. If an Employee fails to timely elect retiree coverage, such Employee and his/her Eligible Dependent will not be eligible to elect or receive retiree coverage under the Plan at any later date.

(h) The Employee satisfies any other eligibility requirements set forth in the applicable Benefits Guide.

Section 3.02 Eligible Dependent Coverage. A Retiree also may enroll his or her Eligible Dependents (as defined in Article II) in the **same** benefit options under the Plan only if **each** of the following conditions are satisfied:

(a) The Retiree has timely enrolled himself/herself in retiree coverage under the Plan as well as the Eligible Dependent in accordance with the enrollment procedures established by the Administrator.

(b) The Eligible Dependent elects to receive retiree coverage under the Plan in lieu of, and thus waives, COBRA coverage to which he or she may have otherwise been entitled (except as otherwise permitted under the limited circumstances described below).

(c) Such individual must have qualified as the Retiree's Eligible Dependent as of the date of his/her retirement and severance from employment from the Employer. A Retiree will not be entitled to subsequently enroll any other dependents (e.g. a new spouse or existing spouse who was not initially enrolled due to other coverage) after the Retiree's initial enrollment period connected to his/her retirement from employment date.

(d) The Retiree's Eligible Dependent is not currently *eligible* to participate in his/her own past or present employer-sponsored group health plan.

Section 3.03 Surviving Eligible Dependents. A Spouse who is enrolled under the Plan at the time of a Retiree's death may continue to participate in the Plan as long as he or she continues to satisfy the eligibility conditions set forth above and continues to receive the Retiree's survivor benefits under the Retirement System. An Eligible Dependent child who is enrolled under the Plan at the time of a Retiree's death may continue to participate in the Plan if the child continues to satisfy the eligibility conditions set forth above as a dependent-child of the Spouse and either the Spouse or such child receives the Retiree's survivor benefits under the Retirement System, until such child reaches ages 26.

Section 3.04 Determining Eligibility. The Administrator has full and final discretion to determine if a retired employee or his/her spouse or dependent-children satisfy the eligibility requirements for coverage under this Plan, including determining if they had been timely enrolled in the manner which satisfies Plan requirements. The Administrator also has the right, retroactively or prospectively, to terminate coverage for a Retiree, Spouse and/or other Eligible Dependents as of the date that they no longer satisfy the Plan's eligibility requirements and receive reimbursement from such individuals for any benefits when the Plan's eligibility requirements are not satisfied.

ARTICLE IV
PARTICIPATION

Section 4.01 Commencement of Participation. A Participant shall begin receiving benefits under the Plan on the first day he or she satisfies the eligibility requirements of Article III, provided the individual has timely enrolled for coverage on such date in the manner and by the deadline established by the Administrator. If a Retiree fails to timely and accurately complete the enrollment process, he/she and/or his/her Eligible Dependents will not be covered under the Plan.

Section 4.02 Enrollment. The Administrator generally will give each Retiree written notice of his or her right to enroll under the Plan; provided, however, that a Retiree is ultimately responsible to request such forms when he/she retires from employment. The Retiree must enroll for coverage on a form or forms provided by and filed with the Administrator, and furnish all pertinent information requested by the Administrator, including but not limited to, the names,

relationships and birthdates of the Retiree's Eligible Dependents. The Administrator may rely upon all such forms and information furnished.

Section 4.03 Making Enrollment Changes — Retiree's Responsibility. A Retiree is responsible for keeping his/her enrollment records up-to-date so the Plan can process claims quickly and correctly. The Retiree must promptly report any changes to his/her personal information (i.e. home address) or any eligibility changes (divorce, death, remarriage of surviving spouse, dependent-child's marriage or attainment of the limiting age, etc.) to the Administrator within **30 days** of the change.

ARTICLE V
TERMINATION OF PARTICIPATION

Section 5.01 Termination Events. Except as provided in Section 5.02, participation in the Plan shall terminate in accordance with the Plan and/or Contract on the earliest of:

(a) the Employer's termination of the Plan, in whole or in part;

(b) a Participant's non-payment of any required contributions under the Plan or to the Trust;

(c) the death of the Participant;

(d) the loss of Eligible Dependent status;

(e) failure to timely enroll in Medicare Part B benefits, if and when he/she becomes eligible for such benefits;

(f) with respect to an Eligible Dependent, the Retiree's death, except as otherwise provided under Section 3.03.

Notwithstanding anything to the contrary, if a Retiree or Eligible Dependent permits any other person who is not a qualified Participant to use any identification card issued by the Third Party Administrator or otherwise fraudulently claims a benefit or falsifies information on a benefit claim form, the Administrator or Third Party Administrator may give the Retiree written notice that his/her (or such other person) is no longer a covered Participant for benefits under the Plan. If the Administrator or Third Party Administrator gives such written notice: the Retiree and/or Eligible Dependent will cease to be eligible for the benefits under the Plan as of the date specified in such written notice, and no benefits will be paid after that date. Any action by the Administrator or Third Party Administrator under this provision is subject to review in accordance with the Claims and Claims Review Procedures under the Plan. Coverage under the Plan also will end on any other date specified in the Benefits Guide.

Section 5.02 COBRA Continuation Coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). At the time that an Employee retired from employment with the Employer, such Retiree and his/her covered Eligible Dependents elected retiree coverage under this Plan in

lieu of, and thereby waived, all rights to COBRA coverage under this federal law. The only exception to this waiver of COBRA rights is if the coverage of the Retiree's Spouse or Dependent-child under this Plan terminates as a result of any event which is deemed a "qualifying event" under COBRA. In which case, such covered Spouse and/or Dependent-child may elect COBRA continuation coverage under this Plan in accordance with the remaining provisions of this Section 5.02.

(a) *COBRA Continuation Coverage*. Upon the termination of a Retiree Spouse's or Dependent-child's coverage under this Plan due to a Qualifying Event, the Retiree, Spouse or Dependent-child may elect to purchase continuation coverage for such spouse or dependent-child. The election will be effective only if made in writing and filed within the election period, as further described below. Continuation coverage is not indefinite and will only last as described below or as otherwise required by law.

(b) *Qualifying Events*. COBRA coverage is available to a Retiree's covered Spouse and/or Dependent-child, if his or her coverage under this Plan would otherwise end due to:

- divorce or legal separation from the Retiree;
- no longer satisfying the eligibility conditions (e.g. attainment of a limiting age); or
- the Retiree's death or Medicare entitlement.

(c) *Member Notice Requirements*. A Retiree or his/her covered Spouse and/or Dependent-child, or any representative acting on their behalf, must inform the Administrator of the occurrence of a Qualifying Event within **60 days** from the date that such Qualifying Event occurs. The Notice must be sent in writing by U.S. mail to the Administrator and must contain the following information:

- The Retiree's name and the last 4 digits of his/her social security number;
- The name of any covered Spouse or Dependent-child;
- A statement that such person is covered under the Plan;
- A description of the Qualifying Event; and
- The date on which such event occurred.

The Administrator may require that the notice be supplemented with any additional information as it deems necessary to administer these COBRA provisions. Notices the Administrator shall be addressed as follows:

County of Monroe
Administrator of the Retiree Health Care Plan
125 E. Second Street
Monroe, Michigan 48161

Failure to timely provide written notice to the Administrator will cause the Retiree's covered Spouse and/or Dependent-child to lose the right to receive COBRA coverage.

(d) *Electing COBRA*. When the Administrator receives notification of a Qualifying Event, a covered Spouse and/or Dependent-child losing coverage will be notified of the right to continue coverage. If continuation is desired, the election of COBRA coverage for a Spouse and/or Dependent-child must be made within **60 days** of the date the notice was sent. If a covered Spouse or Dependent-child does not timely elect to purchase COBRA continuation coverage, such Spouse's and/or Dependent-child's coverage under the Plan will end. In considering whether to elect COBRA continuation coverage, a Spouse and/or Dependent-child should take into account that a failure to continue his/her group health plan coverage will affect future rights under federal law. First, a Spouse and/or Dependent-child can lose the right to avoid having a pre-existing condition exclusions applied to her or him by other group health plans if such Spouse and/or Dependent-child has more than a 63-day gap in health coverage, and election of continuation coverage may help a Spouse and/or Dependent-child not have such a gap. Second, a Spouse and/or Dependent-child may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if such Spouse and/or Dependent-child does not get COBRA continuation coverage for the maximum time available to him or her. Finally, the Spouse and/or Dependent-child should take into account that he or she has special enrollment rights under federal law. A Spouse and/or Dependent-child has the right to request special enrollment in another group health plan for which he or she otherwise is eligible (such as a plan sponsored by a Spouse's employer) within 30 days after a Spouse's and/or Dependent-child's group health coverage ends because of the Qualifying Event listed above. A covered Spouse and/or Dependent-child also will have the same special enrollment right at the end of COBRA continuation coverage if such Spouse and/or Dependent-child gets continuation coverage for the maximum time available to him or her.

(e) *Cost of Continuation Coverage*. COBRA continuation coverage is at the covered Spouse's and/or Dependent-child's expense. The monthly cost of this continued coverage will be included in the COBRA notice sent to a Spouse and/or Dependent-child. The amount of the COBRA premiums generally will not exceed 102 percent of the applicable premium for the coverage (which includes the employer plus retiree share of premium costs).

(f) *Making Premium Payments*. For coverage to continue, the first premium must be received by the date stated in the notice. Normally this date will be 45 days after the continuation coverage is elected. Premiums for every following month of continuation coverage must be paid monthly on or before the premium due date stated in the notice. There is a 30 day grace period for these monthly premiums. If the premium is not paid

within 30 days after the due date, continuation coverage will end on the first day of that period of coverage. Coverage cannot be reinstated. A COBRA continuee will not receive a monthly bill/voucher for such COBRA premiums. The COBRA continuee has the sole obligation and responsibility to make timely payment of COBRA premium(s).

(g) *Spousal and/or Dependent-Child COBRA Continuation Coverage Period*. A covered Spouse or Dependent-child has the right to continue his or her COBRA coverage under this Section up to 36 months following their loss of coverage due to a Qualifying Event.

(h) *Level of Coverage*. If a Spouse or Dependent-child elects COBRA continuation coverage, he or she will be offered the same level of benefits that such Spouse or Dependent-child had at the time he or she lost coverage. If benefit levels change for similarly situated retirees, Spouses or Dependent-children, it also will change for such Spouse or Dependent-child who elects COBRA coverage under this Section.

(i) *Events Causing Termination of Continuation Coverage*. A covered Spouse and/or Dependent-child may continue the COBRA coverage he or she elects until the earliest of the following situations:

- The end of the 36-month continuation period;
- The date the Employer no longer provides group health coverage to any of its Employees;
- The date a Retiree or his/her Spouse and/or Dependent-child do not make timely payment for COBRA coverage;
- The date a covered Spouse or Dependent-child becomes covered under another group health care plan (unless that plan includes exclusions or limitations about preexisting conditions that apply to such Spouse and/or Dependent-child, or unless this other coverage was effective prior to electing COBRA coverage);
- The date a Spouse or Dependent-child becomes entitled to (i.e. enrolled in) Medicare (unless such Spouse or Dependent child became entitled to Medicare prior to electing COBRA coverage).

(j) *Other COBRA Information*. In order to protect COBRA rights, a Retiree and/or his/her Spouse and/or Dependent-child should keep the Administrator informed of any changes in their addresses. A Retiree and his/her Spouse and/or Dependent-child also should keep a copy of any notices that are sent to the Administrator for their own records. If a Participant requires more information regarding continuation of coverage, he/she should contact the Administrator.

Section 5.03 Conversion Privilege. To the extent the Plan is fully-insured through an insurance contract, a Participant may, if permitted by and in accordance with the terms of such insurance contract, convert his or her coverage under the Plan to an individual medical expense

policy with the insurance carrier, without the necessity of a medical examination and with no interruption in coverage. The cost of such individual conversion coverage shall be paid solely by the affected individual. It is the Participant's sole responsibility to timely contact and apply for individual conversion coverage in accordance with the terms of the insurance contract.

ARTICLE VI
IMPORTANT LAWS IMPACTING A PARTICIPANT'S COVERAGE UNDER THE PLAN

Section 6.01 Federal Laws Unless Employer Opts Out. Unless the Employer has timely elected to opt out of compliance with these laws, the Plan shall comply with the following:

(a) The Plan will provide benefits for any hospital stay in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the mother's (or newborn's) attending provider may, after consulting with the mother, discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable).

(b) To the extent the Plan offers coverage for a mastectomy, the Administrator will notify a Participant of his/her rights related to benefits provided through the Plan in connection with the mastectomy, including the right to coverage to be provided in a manner determined in consultation with his/her attending physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the Plan's regular deductible and co-payment amounts. A Participant should refer to the Benefits Guide for further details and/or contact the Third Party Administrator for more information.

(c) The Plan shall not:

- Use genetic information to determine eligibility for coverage or to impose pre-existing condition exclusions;
- Adjust a Participant's premium and contribution amounts on basis of genetic information;
- Request or require a Participant or a family member to undergo a genetic testing;
- Request, require or purchase genetic information for underwriting purposes; or

- Request, require or purchase genetic information about an individual prior to or in connection with an individual's enrollment under the Plan.

(d) If the Plan provides benefits for mental health or substance abuse disorders, the Mental Health Parity Act ("MHPA") requires equal treatment of mental health and substance abuse benefits in parity with medical/surgical benefits. This generally means that:

- Financial requirements and treatment limits applicable to mental health and substance abuse are no more restrictive than those limits and requirements on medical/surgical (e.g. deductibles, copays, coinsurance, out-of-pocket, treatment limits, not just annual and lifetime dollar limits);

- Out-of-Network Benefits provided for medical/surgical also must be available for mental health and substance abuse; and

- Criteria for medical necessity and reason for claim denials must be made available.

The Benefits Guide will provide an explanation of the covered and excluded benefits, which will comply with the Mental Health Parity Act (unless the Employer has timely opted out of compliance).

Section 6.02 Patient Protection and Affordable Care Act of 2010. New federal health care reform legislation was enacted on March 23, 2010, requiring most group health plans to comply with certain market reform and consumer protection provisions. These provisions include items such as extending a child's coverage under a plan until age 26, eliminating certain lifetime and annual limitations and pre-existing condition exclusions, and other consumer and patient protection rights.

These new market reforms and consumer protection provisions **DO NOT** apply to this Plan, because this Plan covers only retired employees of the Employer (and their eligible spouses and dependents), and does not cover any active employees of the Employer. The Department of Health and Human Services (along with the Department of Labor and Internal Revenue Service) issued guidance that confirms that retiree-only health plans will not be subject to the new market reform and consumer/patient protection provisions of the new Health Care Reform legislation.

Accordingly, this Plan will not be amended to reflect the market reform and consumer protection provisions that a Participant may have heard about through the media (unless the Employer, in its sole discretion decides to voluntarily amend the Plan to include such a provision). If a Participant would like additional information, he/she can contact the Administrator or may visit the Department of Health and Human Services' website at http://www.hhs.gov/ or Department of Labor's website at http://www.dol.gov/ for general information.

ARTICLE VII
BENEFITS AND FUNDING

Section 7.01 Scheduled Benefits. The Plan generally provides medical and prescription drug benefits to Participants. The Benefits Guide, as prepared by the Third Party Administrator, describes the actual benefits (covered and excluded) and tiers of coverage available to Participants under the Plan as well as any annual and life-time maximums, pre-authorization or certification requirements and other limitations and exclusions applicable to Participants under the Plan. The Appendices to this Plan also contain information regarding the design of the Plan. When a Participant becomes eligible for Medicare (e.g. at age 65), he/she must timely enroll in Medicare Part B or coverage under this Plan will end.

Section 7.02 Cost of Coverage. The Employer may require Participants to share in the cost of coverage through various cost-sharing mechanisms, including premium contributions, deductibles, copayments, coinsurance and other payment limitations or requirements. The Administrator will notify Participants annually of any required Participant premium-contributions, which amount may vary for different retiree groups, and also regarding any other cost through deductibles, co-payments, co-insurance (see Appendix A).

Section 7.03 Funding and Employee Contributions. At this time, the Plan provides retiree medical and prescription drug benefits through a self-insured arrangement. Self-insured means that the benefits are not insured through an insurance carrier, but rather are paid by the Employer through the Trust. Certain Employee groups also are required to make mandatory contributions, through current payroll deductions, to the Trust, as provided in Appendix B and each applicable collective bargaining agreement. To the extent that Trust assets are insufficient to pay benefits under the Plan, any shortfall shall be paid by the Employer.

The Employer has entered into a service agreement with a Third Party Administrator to administer the Plan, including claims adjudication. Only to the extent the Plan remains self-funded and administered by a Third Party Administrator, the Plan is required to disclose to Participants the following provisions of Michigan's Third Party Administrator's Act (MCL 550.901 et seq):

- In the event the Plan, Trust or the Employer does not ultimately pay health expenses that are eligible for payment under a self-funded Plan option for any reason, the individuals covered by the Plan may be liable for those expenses.

- The Third Party Administrator merely processes claims for such self-funded benefits and does not insure that any health expenses of individuals covered by the Plan will be paid.

- Complete and proper claims for self-funded benefits made by a Participant will be promptly processed but that in the event there are delays in processing claims, the Participants shall have no greater rights to interest or other remedies against the Third Party Administrator than as otherwise afforded them by law.

Section 7.04 Refund of Employee Contributions. If an Employee terminates employment with the Employer prior to becoming eligible for a normal retirement pension under the Retirement System (e.g. the employee is only entitled to a deferred retirement pension), such Employee will not be entitled to receive retiree health care coverage under the Plan and the Employer shall refund the amount of the Employee's contributions to the Plan, plus earnings/losses thereon, as calculated by the Administrator in its sole discretion.

Any Employee also may, at any time during his/her employment, voluntarily and irrevocably waive retiree health care benefits under the Plan for himself/herself, and such waiver automatically will include, without consent, a waiver on behalf of his/her Eligible Dependents. The Employee must complete the waiver form provided by the Employer. Upon executing a voluntary, irrevocable waiver of retiree health care benefits under this Plan for the Employee (and his/her Eligible Dependents), no additional employee contributions from the Employee will be deducted from his/her payroll. The Administrator also shall determine the amount and refund to the Employee, if any, the employee contributions made under to the Trust, along with the accumulated interest, if any, as determined in the sole discretion of the Employer. The refund of any retiree health care contributions shall be made to the Employee within forty-five (45) days of the Employee's properly completed and submitted voluntary, irrevocable waiver of retiree health care benefits to the Administrator.

ARTICLE VIII
COORDINATION OF BENEFITS

Section 8.01 General Rule. The Employer intends that the Plan shall provide each Participant with payment for eligible health care expenses incurred by the Participant as a Retiree and, if eligible, the Retiree's Spouse and/or Dependents. The Employer does not intend that payment under this Plan and any other health care plan shall exceed the amount of the expenses incurred. For this reason, the Plan coordinates benefits with other health care plans in accordance with the State of Michigan's Coordination of Benefits Act as set forth in MCLA § 550.251.

Section 8.02 Reimbursement. If an expense is paid by the Trust on behalf of a Retiree, a Retiree's Spouse and/or Dependents, and such expense subsequently is paid from any other source, in whole or in part, the Retiree, Spouse or Dependent shall remit to the Trust an amount equal to the duplicated benefit. In addition, the Trust may reimburse any other health care plan, person or entity that has paid an expense on behalf of a Retiree, Spouse or Dependent that is an expense payable under this Plan. In such event, the Employer, the Plan, and Trust shall be relieved of all further responsibility with respect to that expense.

Section 8.03 Coordination with Medicare. If a Participant becomes eligible for Medicare, he or she must timely enroll in Medicare Parts A and B. If a Participant fails to timely enroll in Medicare Parts A and B, his/her coverage under the Plan will terminate retroactive to Medicare eligibility date and may not be reinstated. The following rules apply regarding coordinating retiree coverage under this Plan with Medicare:

- Medicare will be primary payer and this Plan will be secondary payer because a Participant is covered under this Plan as a Retiree of the Employer or as an Eligible

Dependent of a Retiree. Generally, a Participant must enroll for Medicare within the three months prior to his/her 65th birthday to be assured of coverage. If a Participant does not timely enroll, Medicare may not approve the Participant's application either for some period or not at all. It is a Participant's responsibility to consult with his/her local Social Security office and obtain details regarding Medicare.

- Notwithstanding the foregoing rules, if a Participant under this Plan is eligible for Medicare solely on the basis of End Stage Renal Disease (ESRD) and he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Plan and Medicare, this Plan will be the primary payer and Medicare will be secondary payer for a period of up to 30 consecutive months. This 30-month period begins on the earlier of: (i) the first day of the month during which a regular course of renal dialysis starts; and (ii) with respect to an ESRD Medicare eligible individual who receives a kidney transplant, the first day of the month during which such Participant becomes eligible for Medicare. After the 30-month period ends, if an ESRD Medicare eligible individual incurs a charge for ESRD benefits, Medicare will be primary payer and this Plan will be secondary payor. If a Participant is eligible for Medicare solely on the basis of ESRD, he or she must be covered by both Parts A and B.

Section 8.04 Coordination with Medicare Part D – Prescription Drug Plan. Part D of Medicare offers prescription drug coverage to individuals enrolled in Medicare Part A and/or Part B. Part D coverage is entirely voluntary. A Participant must pay a monthly premium for Medicare Part D coverage, which is set each year by the Centers for Medicare and Medicaid Services. The initial enrollment period for Medicare Part D will be the same as the period for enrolling in Medicare Part B. There also will be an open enrollment period each year that will run from October 15th through December 31st.

A Participant's prescription drug coverage under this Plan's Medical Program generally will be more valuable than the Medicare Part D benefit. The prescription drug coverage under this Plan generally has no premium costs that are separate from his/her overall premium share for medical coverage. Please request a copy of the "*Important Notice About Your Prescription Drug Coverage and Medicare*" from the Administrator for more information on the Medicare Part D benefit. The Notice also has telephone numbers a Participant can call and web sites a Participant can visit to get more information about Medicare Part D. A Participant should contact the Administrator if he/she has questions regarding prescription drug coverage under this Plan's Medical Program.

If a Participant signs-up for Medicare Part D coverage, he/she will become ineligible to continue participation in the Plan (which includes prescription drug coverage) and the Participant will not be eligible to reenroll for coverage at any date after a Participant has enrolled in Medicare Part D coverage. This limitation applies to any Retiree and to any Eligible Dependent of a Retiree who is eligible for and enrolls in Medicare Part D coverage.

Section 8.05 Subrogation. The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a Participant in a time of need, the Plan may pay covered expenses that may be or become the responsibility of another person, with the intent that the Plan later

receive reimbursement for those payments (hereinafter called "Reimbursable Payments"). Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a Participant expressly agrees to, and becomes subject to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

(a) *Assignment of Rights (Subrogation)*. A Participant automatically assigns to the Plan any rights he may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a Participant or paid to another for his/her benefit. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) a Participant constitute a full or a partial recovery, and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that a Participant may have, whether or not a Participant chooses to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

(b) *Equitable Lien and other Equitable Remedies*. The Plan shall have an equitable lien against any rights a Participant may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien also shall attach to any money or property that is obtained by anybody (including, but not limited to, a Participant, the Participant's attorney, and/or a trust) as a result of an exercise of the Participant's rights of recovery (sometimes referred to as "proceeds"). The Plan also shall be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Administrator, the Plan may reduce any future covered expenses otherwise available to a Participant under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

(c) *Assisting in Plan's Reimbursement Activities*. The Participant has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on a Participant's behalf, and to provide the Plan with any information concerning a Participant's other insurance coverage (whether through automobile insurance, other

group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of a Participant. A Participant is required to (a) cooperate fully in the Plan's exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the Administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Administrator to enforce the Plan's rights.

(d) *Overpayments*. This Plan will have the right to recover any payments that were made to, or on behalf of, a Participant and which causes an overpayment to be made.

(e) *Interpretation*. In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

(f) *Jurisdiction*. By accepting benefits (whether the payment of such benefits is made to a Participant or made on behalf of the Participant to any provider) from the Plan, the Participant agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Participant hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Failure by a Participant to follow the above terms and conditions may result, at the discretion of the Administrator, in a reduction from future benefit payments available to the Participant under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

ARTICLE IX
ADMINISTRATION

Section 9.01 Employer's Duties. Subject to the Board of Commissioners' reserved authority to amend or terminate the Plan, the Administrator has the sole authority to determine the benefit program structure and to administer and oversee the day to day operations of the Plan, including, but not limited to, the determination of plan design and benefit structure; direct the Trust or the Employer to make timely payment of benefit and administrative expenses incurred under the Plan; determine the Participant cost sharing requirements; satisfy all reporting and disclosure requirements; retain and procure all service providers, actuaries, insurers or other third party administrators necessary for the proper administration of the Plan; and fulfill all other Plan administrative functions as are not specifically assigned by contract to a Third Party Administrator. The Administrator, subject to the terms of the Plan, shall have full discretionary authority to interpret and decide all provisions of the Plan, including all questions regarding eligibility to participate in the Plan.

Section 9.02 Insurance Carrier's Duties. To the extent any benefits are provided through fully-insured arrangements, the insurance carrier of such arrangement shall have sole responsibility for interpreting and administering the insurance contract and for processing and paying benefit claims thereunder, and shall provide the Administrator with such information as the Administrator may deem necessary to permit the timely filing of all reports required by law. The insurance carrier also shall provide to the Administrator, for distribution to Participants, the Benefit Guide or other description of benefits provided under the contract.

ARTICLE X
CLAIMS PROCEDURE

Section 10.01 How to File a Claim. A claim for benefits under the Plan must be submitted in writing to the Administrator in accordance with procedures established by the Administrator as communicated in writing to Participants. The arbitration provisions set forth in Section 9.02 shall apply only if no claims procedures are set forth in the Benefit Guide.

Section 10.02 Arbitration. Any dispute by Participants with the Employer as to the interpretation or application of the provisions of the Plan shall be determined exclusively by binding arbitration in Monroe, Michigan in accordance with the voluntary labor arbitration rules of the American Arbitration Association then in effect. Judgment may be entered on the arbitrator's award in any court of competent jurisdiction. All fees and expenses of such arbitration shall be paid equally by the Employer and Participant.

Section 10.03 General Claim Provisions. Notwithstanding anything to the contrary, the following provisions will apply to all benefit claims:

(a) *Finality of Decisions*. The claims administrator has full discretion in determining any matter regarding a claim for Benefits or other claims involving the Plan. The decision of the claims administrator upon review of any claim is binding on a Participant, his or her heirs and assigns, and all other persons claiming by, through or under a Participant.

(b) *Limitation of Claims Procedure*. Subject to any shorter time periods required under a Benefits Guide, any initial claim under this claims procedure must be submitted within 12 months from the earlier of: (i) the date on which a Participant learned of facts sufficient to enable him/her to formulate such claim, or (ii) the date on which a Participant reasonably should have been expected to learn of facts sufficient to enable him/her to formulate such claim.

(c) *Limitation on Court Action*. Any suit brought to contest or set aside a decision of the claims administrator is to be filed in a court of competent jurisdiction within one year from the date of the receipt of written or electronic notice of the claims administrator's final decision. Service of legal process shall be made upon the Plan by service upon the agent for service of legal process or upon the claims administrator.

(d) *Legal Action*. No legal action to recover Plan benefits or to enforce or clarify rights under the Plan shall be commenced in court or arbitrated, whether or not statutory, until a Participant first exhausts the claims and review procedures available to him/her under the Plan.

(e) *Special Rulings*. In order to resolve problems concerning the Plan and to apply the Plan in unusual factual circumstances, the Administrator or Third Party Administrator acting as the claims adjudicator may make special rulings. Such special rulings will be in writing on a form to be developed by the administrator. In making its rulings, the administrator may consult with other third party administrators, legal, accounting, investment, and other counsel or advisers. Once made, special rulings shall be applied uniformly, except that the administrator will not be bound by such rulings in future cases unless the factual situation of a particular case is identical to that involved in the special ruling. Special rulings shall be made in accordance with all applicable law and in accordance with the Plan. It is not intended that the special ruling procedure will be a frequently used device, but that it should be followed only in extraordinary situations. The administrator at all times will have the final decision as to whether resort will be made to this special ruling feature.

ARTICLE XI
TERMINATION OR AMENDMENT

The Employer, by affirmative vote of the Board of Commissioners, reserves and shall have the right at any time to terminate or amend the Plan, in whole or in part. The Employer has no obligation to continue the Plan or any benefit provided under the Plan, and a Participant's right to a benefit always is forfeitable. Notwithstanding the foregoing, any Plan or benefit termination or amendment shall not adversely affect any Participant's right under the Plan to benefits attributable to claims incurred prior to such termination or amendment.

ARTICLE XII
MISCELLANEOUS PROVISIONS

Section 12.01 Employment Relationship Not Affected. This Plan is neither an employment contract, nor is it consideration for, an inducement for, or a condition of the employment of any individual. Nothing in the Plan gives an Employee or a Participant the right to continued employment or limits the right of the Employer to discharge an Employee at any time, with or without cause.

Section 12.02 Governing Law. This Plan shall be construed, enforced and administered in accordance with the Code and laws of the State of Michigan. If any provision of the Plan is held to violate the Code or to be illegal or invalid for any other reason, that provision shall be deemed to be null and void, but the invalidation of that provision shall not otherwise affect the Plan.

Section 12.03 No Third Party Beneficiary; Assignment. The Plan is not intended to benefit any person other than a Participant. An Employee or Participant cannot assign or alienate (voluntarily or involuntarily) his/her rights under or interest in this Plan and every such attempt is void.

Section 12.04 Return of Dividends, Premiums or Reserves. Because the amount of employee or participant contributions is fixed each year and the Employer makes up the difference between those contributions and the costs of the Plan, any dividends, returned

premiums or service fees or reserves, credited by a service provider or insurer are the property of the Employer.

Section 12.05 Tax Consequences. Neither the Employer nor the Plan makes any representations or warranties regarding the federal, state, local or other tax treatment of benefits provided pursuant to the Plan and a Participant shall have no rights against the Employer or the Plan if any tax consequences contemplated are not achieved. It is intended that benefits provided under the Plan shall not be considered deferred compensation and, thus, shall be exempt from Code Section 409A. The provisions of the Plan are to be construed accordingly. However, in no event shall the Employer or the Plan be responsible for any tax or penalty owed by a Participant with regard to benefit payments made under this Plan.

Section 12.06 Facility of Payment. If the Administrator determines that a Participant is incapable of receiving any benefits under the Plan that he/she is entitled to receive because the Participant is ill, or otherwise incapacitated, the Administrator may direct that payment be made on a Participant's behalf.

Section 12.07 Lost Distributees. If the Administrator is unable to locate a Participant when a benefit is due, the Participant's benefit will be deemed to be forfeited. Therefore, it is important that a Participant keep the Administrator informed of any changes to his/her current address.

Section 12.08 Right of Verification. If an Employee or a Participant omits or provides any false information with respect to the Plan or on a benefit claim form, such person may be disqualified from receiving benefits under the Plan. In addition, an Employee may be subject to disciplinary action and/or termination of employment.

ARTICLE XIII
HIPAA PRIVACY AND SECURITY AMENDMENT

Section 13.01 Introduction. Members of the Employer's workforce may have access to the individually identifiable health information of Plan Participants (1) on behalf of the Plan itself and (2) on behalf of the Employer, as the plan sponsor, with respect to plan administrative functions.

The Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing privacy and security regulations (collectively referred to as "HIPAA") restrict the Employer's and Plan's ability to use and disclose certain health information known as "protected health information" ("PHI"). It is the Employer's policy that the Plan and the Employer will comply with HIPAA requirements.

Throughout this Article, various terms are used repeatedly. These terms have specific and definite meanings and generally have been capitalized throughout this Article. Whenever capitalized terms appear, they shall have the meanings specified in HIPAA.

Section 13.02 Protected Health Information (PHI). PHI includes information that the Plan creates or receives that relates to the past, present, or future health or medical condition of

an individual that could be used to identify the individual. Electronic PHI is PHI that is transmitted by or maintained in electronic media (e.g. memory devices in computers, removable/transportable digital memory medium, etc.).

Section 13.03 Use and Disclosure of PHI. The Plan can use or disclose PHI only in a manner consistent with HIPAA, which generally is for purposes of Payment and Health Care Operations. Payment means activities to obtain and provide reimbursement for the health care provided to an individual, including determinations of eligibility and coverage under the Plan, and other health care utilization review activities. Health Care Operations means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management, and administrative activities.

PHI also may be used or disclosed as specifically permitted by HIPAA, including the following examples:

- The Plan may share PHI with government or law enforcement agencies when required to do so or when required to in a court or other legal proceeding;
- The Plan may share PHI to obey Workers' Compensation laws; and
- The Plan may share PHI with the individual if the individual requests access to PHI as described below.

In other situations, the Plan will ask for the individual's written authorization before using or disclosing PHI.

Section 13.04 Employer Certification. The Plan may disclose PHI to the Employer (including certain members of the Employer's workforce) only to perform administrative functions on behalf of the Plan in a manner consistent with HIPAA requirements. In this regard, the Employer, by executing this plan document, hereby provides certification to the Plan that the Employer will appropriately safeguard and limit the use and disclosure of PHI that it receives from the Plan only to perform plan administration functions. Specifically, the Employer agrees to:

- use or further disclose PHI only as permitted by and consistent with this Plan Document and HIPAA;
- ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to Employer with respect to such information;
- not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan;
- report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware;

- make available information in accordance with the HIPAA Rules regarding individual access to PHI;

- make available PHI for amendment in accordance with the HIPAA Rules;

- make available the information required under the HIPAA Rules to provide an accounting of non-routine disclosures to the individual;

- make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules;

- if feasible, return or destroy all PHI received from the Plan that Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

- ensure adequate separation between the Plan and Employer; and

- To the extent required by HIPAA, ensure compliance with the safeguard and other requirements specified under 45 CFR 164.105(a) relating to hybrid entities and the healthcare component of the Plan.

The Employer further agrees that if it creates, receives, maintains or transmits any electronic PHI on behalf of the Plan, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the appointed Security Official any security incident of which it becomes aware and it will implement reasonable and appropriate security measures for electronic PHI to ensure that the adequate separation provisions of Section 12.7 are satisfied.

Section 13.05 Workforce of the Plan. The Plan has designated a Privacy and Security Official – (please contact the Plan Administrator for the name and address of such official). The Privacy and Security Official is the privacy and security fiduciary responsible for the Plan's compliance with the HIPAA Privacy and Security Rules. Compliance includes ensuring that appropriate administrative, physical and technical procedures and safeguards are in place to protect PHI and to reasonably and appropriately protect the integrity, confidentiality and availability of any electronic PHI that the Employer creates, receives, maintains or transmit on behalf of the Plan. This also includes ensuring that certain members of the Employer's Workforce comply with, are trained in and appropriately handle PHI and electronic PHI under the HIPAA Privacy and Security Rules, and understand the sanctions for HIPAA violations.

Certain employees of the Employer whose duties include administrative and management functions on behalf of the Plan also are considered part of the Workforce of the Plan and thus

privacy and security fiduciaries of the Plan. Their access to PHI is limited to the minimum necessary information needed to perform administrative functions on behalf of the Plan, including using or disclosing summary health information for the purpose of obtaining premium bids (including bids in connection with the placement of stop loss coverage) or making decisions to modify, amend or terminate the Plan, or enrollment or disenrollment information about participants. Please contact the Privacy Official for a complete listing of the designated employees who serve as members of the workforce with access to PHI or electronic PHI.

Section 13.06 Adequate Separation between the Plan and Employer. The Employer shall allow access to PHI received from the Plan only to those employees who have been specifically designated by Employer as employees authorized to access PHI pursuant to the Plan's HIPAA Privacy and Security Policies and Procedures.

No other persons shall have access to PHI. These employees who have authorized access to PHI only shall use and disclose PHI to the extent necessary to perform the plan administration functions that Employer performs for the Plan. These employees generally may not use or disclose PHI for purposes of payment, operation or other administrative functions of the Employer's non-group health benefit plans (e.g. disability, life insurance, workers compensation, supplemental plans etc.) or of any other non-plan activity such as employment related decisions without individual authorization. The Employer will ensure that the adequate separation between the Plan and Employer is supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

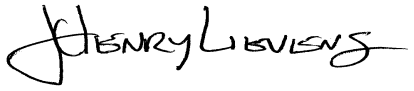
Section 13.07 Violations of Privacy or Security Rules. If the Employer becomes aware of violations of these HIPAA privacy or security rules, it shall arrange for the HIPAA Privacy or Security Officer appointed by The Employer to consult with the person who has violated the privacy or security rules with respect to his or her obligations under the privacy or security rules. A person who violates these privacy or security rules may be subject to discipline up to and including discharge. The Employer also shall comply with any notice requirements regarding breach of Unsecured PHI, as set forth in the Employer's HIPAA Privacy and Security Policies and Procedures.

Section 13.08 Individual Rights. Participants can learn more about these HIPAA Privacy and Security laws or their legal rights regarding their medical information by reviewing a copy of the Plan's Notice of Privacy Practice that has been furnished to Participants and is available upon request by contacting the Administrator.

EXECUTION PAGE

In Witness Whereof, the County of Monroe, Michigan, through its Board of Commissioners, has caused this Plan to be restated effective as of June 7, 2016, and, hereby agrees to the provisions of this Plan.

BOARD OF COMMISSIONERS FOR THE COUNTY OF MONROE, MICHIGAN



Dated: June 8, 2016

By: J. Henry Lievens,
Its: Chairman, Board of Commissioners

The Administrator, by signing below, hereby accepts the Plan and its positions, and agrees to all of the obligations, responsibilities and duties imposed upon the Administrator under this Plan

ADMINISTRATOR OF THE COUNTY OF MONROE, MICHIGAN

Dated: June 8, 2016

By: Michael Bosanac
Its: Administrator/Chief Financial Officer

APPENDIX A
TO THE
MONROE COUNTY
RETIREE HEALTH CARE PLAN

SCHEDULED BENEFITS FOR 2016

The Benefits Guide will set forth the coverage available for the Plan Year. Participants will receive the same health care benefits, including but not limited to, the cost sharing requirements, that is provided to active employees of the Employer until such Participant becomes eligible for Medicare. Upon Medicare eligibility, the Participant is required to timely enroll in both Medicare Parts A and B. If a Participant does not timely enroll, Medicare may not approve the application either for some period or not at all. It is the Participant's sole responsibility to consult with the local Social Security office and obtain details regarding Medicare. For these purposes, the Plan will assume that all individuals who are eligible for Medicare are actually enrolled in Parts A and B. As a result, a Participant's failure to apply for Medicare when eligible could leave the Participant without primary coverage for certain medical expenses. Participants who are Medicare eligible will receive the United American Medicare Supplemental Plan F with a $100 deductible, which option will have the same prescription drug benefits received by the Employer's active employees.

The monthly illustrated premiums/fully insured premium cost for coverage under these plans shall be paid as follows:

a) **Pre-Medicare (Illustrated Premium):** The Employer shall pay the difference between the participants cost sharing based on coverage and 100% of the monthly illustrated premiums cost for single coverage under the Plan for the Retiree only. The Administrator shall have the sole discretion to determine the monthly illustrated premium cost for these purposes.

b) **Medicare (Fully Insured):** The Employer shall pay 100% of the monthly premium cost for single coverage under the Plan for a Retiree only.

c) **Spouse & Dependent Coverage:** The Employer also shall pay 50% of the monthly illustrated premium for a Retiree's Eligible Dependent; provided, however, that the Employer shall pay (i) an additional 2.27% of an Eligible Dependent's monthly illustrated premium/fully insured premium for each year of Credited Service in excess of eight (8) years of Credited Service earned by the Retiree under the Retirement System or (ii) 100% of the Eligible Dependent's monthly illustrated premium/fully insured premium if the Retiree is credited with 30 or more years of Credited Service under the Retirement System.

APPENDIX B
TO THE
MONROE COUNTY
RETIREE HEALTH CARE PLAN

EMPLOYEE CONTRIBUTIONS

Required Employee Contributions During Active Employment (only required of those classes of Employees who may become eligible to participate in the Plan upon retirement):

Employee Classification	Amount of Employee Contribution (Percentage of annual Compensation)*
TPOAM General	3.0% of Compensation
TPOAM – Probate Court	3.0% of Compensation
TPOAM – District Court	3.0% of Compensation
POAM - Deputies	3.0% of Compensation
POAM – Assistant Prosecutors	3.0% of Compensation
POAM - Corrections	3.0% of Compensation
POLC – Communication Specialist	3.0% of Compensation
POLC Communication Supervisors	3.0% of Compensation
UAW Friend of Court	3.0% of Compensation
UAW – Youth Center Supervisors	3.0% of Compensation
UAW – Probation Officers	3.0% of Compensation
UAW – County Agency	3.0% of Compensation
Steelworkers – Youth Centers	3.0% of Compensation
Michigan Nurses Association	3.0% of Compensation
COAM Corrections Supervisors	3.0% of Compensation
COAM District Court	3.0% of Compensation
COAM - Command Officers.	3.0% of Compensation
Non Bargained For Employees	3.0% of Compensation

* Annual Compensation is defined as the annual base wages paid to an employee and excludes special pay, overtime, call in and any other premium wages.

TO THE EXTENT THAT THESE APPENDICES CONTRADICTS THE TERMS OF A VALID COLLECTIVE BARGAINING AGREEMENT, THE TERMS OF THE COLLECTIVE BARGAINING AGREEMENT SHALL CONTROL FOR THAT UNIT OF EMPLOYEES.

APPENDIX C
TO THE
MONROE COUNTY
RETIREE HEALTH CARE PLAN

RESOLUTION TO AMEND THE MONROE COUNTY RETIREE HEALTH CARE PLAN AS IT PERTAINS TO JUDGES

WHEREAS, in December, 1999, the Michigan Judges Retirement System ("MJRS") (MCL 38.2100 et seq) was amended by the Michigan State Legislature to provide that only Circuit, Probate and District Judges who first became Judges before March 31, 1997 would be entitled to pension benefits under the State's defined benefit plan and that Judges appointed/elected after that date would be eligible only for the State's defined contribution plan; and

WHEREAS, the MJRS and Section 706 of the Michigan Judges Retirement Act ("JRA") requires that Judges appointed or elected after March 31, 1997 are no longer eligible for membership in the Monroe County Employees Retirement System and will participate in the Tier 2 plan based upon 100% of their judicial salary. (MCL 38.2656(3)(a)); and

WHEREAS, Section 3.01, Article III, Benefit Eligibility, of the Monroe County Retiree Health Care Plan, initially effective January 1, 1996, amended and restated effective October 12, 2004, states that to be eligible to receive health care coverage during any Plan Year (in retirement), an individual must: (a) be a Retiree, who has enrolled in the Plan; (b) have been employed by the County in a full time capacity prior to October 28, 2003; and be a Retiree who retires from the County and immediately commences payments under the Monroe County Employees Retirement System and simultaneously requests benefits to commence under the Monroe County Retiree Health Care Plan; and

WHEREAS, the State Legislature's amendment of the MJRS (MCL 38.2100 et seq), which impacts pension benefits for Judges hired on or after March 31, 1997, without the County

amending the Monroe County Retiree Health Care Plan, left the issue of Retiree Health Care for current and future Judges in question; and

WHEREAS, specifically, three (3) sitting Judges in Monroe County; Judge Mark S. Braunlich, Judge Jack Vitale, and Judge Michael A. Weipert, were previously informed that they are included as employees eligible for Retiree Health Care, although they do not participate in the Monroe County Retirement Plan and, as such, may not under the eligibility provisions as written for the Monroe County Retiree Health Care Plan be eligible for Retiree Healthcare unless granted eligibility by this Resolution; and

WHEREAS, Judge Jack Vitale, who became a District Court Judge on January 1, 1999, and has continued so, has been contributing three (3) percent for Retiree Health Care through payroll deduction each payday since 1999, and has never been advised that he would NOT have Retiree Health Care upon his retirement; and further Judge Vitale will not have any Pension Benefits through Monroe County, which conflicts with the eligibility provisions of the Monroe County Retiree Health Care Plan; and

WHEREAS, Judge Michael A. Weipert, who first was the elected Monroe County Prosecutor from January 1, 2001, up until he became Circuit Court Judge on January 1, 2005, and has continued so, has been contributing three (3) percent for Retiree Health Care through payroll deduction each payday since he first became prosecutor in 2001, and has never been advised that he would NOT have Retiree Health Care upon his retirement; and further Judge Weipert will not have any Pension Benefits through Monroe County, which conflicts with the eligibility provisions of the Monroe County Retiree Health Care Plan; and

WHEREAS, Judge Mark S. Braunlich, who had worked as Monroe County Assistant Prosecutor from June 27, 1983 to July 7, 1986, and then returned to employment with Monroe County as County Legal Advisor from May 10, 1989 through December 31, 2002, up until he became District Court Judge on January 1, 2003, and has continued so, has been considered as a participant in the Retiree Health Care Plan, although not contributing due to his status dating back to 1989, at which time he was grandfathered into the non-contributing status for Retiree

Health Care as other employees hired during that time frame, and further has never been advised the he would NOT have Retiree Health Care upon his retirement; and further Judge Braunlich, although no longer currently earning retirement credits under the Monroe County Retirement Plan, is eligible for a deferred vested pension benefit due to his prior non-judicial service in Monroe County; and further that this deferred vested pension benefit does not meet the eligibility provisions of the Retiree Health Care Plan; and

WHEREAS, Monroe County Policy 442, Retiree Health Care Plan and Retiree Health Care Fund, states that employees hired on or after October 28, 2003 shall not be eligible for Retiree Health Care, and further that Judges Braunlich, Vitale, and Weipert were hired into a Monroe County position prior to October 28, 2003; and

WHEREAS, it has come to the attention of the Board of Commissioners that this Resolution should address Retiree Health Care for Judges Braunlich, Vitale, and Weipert, and further that the issue of Retiree Health Care for Future Judges should herein be addressed; and

NOW THEREFORE, IT IS HEREBY RESOLVED, that the Monroe County Board of Commissioners hereby approves eligibility for Retiree Health Care for Judge Mark S. Braunlich, Judge Jack Vitale, and Judge Michael A. Weipert as an exception to the current Monroe County Retiree Health Care Plan and directs that an appropriate amendment be made to the Monroe County Retiree Health Care Plan to provide Judges Braunlich, Vitale, and Weipert with Retiree Health Care upon their retirements; and

BE IT FURTHER RESOLVED, the Monroe County Board of Commissioners directs that the Monroe County Retiree Health Care Plan be further amended and restated to address the appointment and/or election of future Judges and their eligibility or ineligibility for Retiree Health Care as stated below:

1. Newly elected or appointed Judges who transition directly from other Monroe County positions, where they have been participating in the Monroe County Retirement Plan, and have vested under the terms of the Monroe County Retirement Plan, and where there is no break in service from the last day as a

County Employee until the first day as a newly elected or appointed Judge in the Circuit, Probate or District Courts, and provided further they were hired or elected in their prior Monroe County position prior to October 28, 2003, shall be eligible for retiree health care. In those cases where collective bargaining groups have negotiated a date different than October 28, 2003, after which new hires are not eligible for retiree health care benefits, the collectively bargained date shall control in determining eligibility for retiree health care for a newly elected or appointed Judge who transitions directly from another Monroe County position.

2. Newly elected or appointed Judges who have no prior Monroe County employment, or who have had a break in service from prior Monroe County employment shall be considered as new hires and fall under Monroe County Policy 442, Retiree Health Care Plan and Retiree Health Care Fund, which states that employees hired on or after October 28, 2003 shall not be eligible for retiree health care benefits.

(Adopted/NOT Adopted) by the Monroe County Board of Commissioners at a regular meeting held at the Monroe County Board Chambers, Monroe County Courthouse, Monroe County, Michigan, by a vote of a majority of the membership of the Board, on the 28th day of September, 2010.

Resolution offered by Commissioner Lievens, supported by Commissioner Fowler.

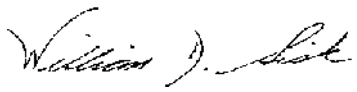
A Roll Call Vote Was Taken As Follows:

YES: Lievens, Zorn, Mentel, Sisk, Oley, Fowler, Velliquette, Frederick

NO: None

ABSTAIN: None

The Resolution Was Declared Adopted.



William D. Sisk, Chairman
Monroe County Board of Commissioners

ATTEST:

Vickie Koczman, Deputy Clerk
Monroe County Board of Commissioners

PDG/blc
COUNTY\Resolution Retiree Healthcare -- Judges.final

RESOLUTION TO AUTHORIZE THE RESTATEMENT OF THE MONROE COUNTY, MICHIGAN RETIREE HEALTH CARE PLAN

RESOLVED, the Monroe County Board of Commissioners, County of Monroe, State of Michigan, hereby adopts the Resolution for the Monroe County Retiree Health Care Plan, and the Board of Commissioners hereby delegates the Administrator/Chief Financial Officer to amend and restate the Monroe County Retiree Health Care Plan to incorporate any plan design changes approved by the Board of Commissioners and as outlined in Appendix A and B to the Monroe County Retiree Health Care Plan.

RESOLVED, that the Board of Commissioners, on September 28, 2010, approved a Resolution to Amend the Monroe County Retiree Health Care Plan as it Pertains to Judges but that in prior Restatements of the Monroe County Retiree Health Care Plan, this Resolution was not included as an Appendix to the Restated Plan.

RESOLVED, that the Board of Commissioners directs that the Resolution to Amend the Monroe County Retiree Health Care Plan as it Pertains to Judges be included in the Restated Retiree Health Care Plan as Appendix C, so that it is consistent in the administration of the Plan and not recorded as a separate Resolution outside of the Restated Retiree Health Care Plan.

Resolution dated June 7, 2016.

Motion made by Commissioner Hoffman and supported by Commissioner Brant to approve and adopt the Amendments to the Monroe County, Michigan Retiree Health Care Trust Agreement.

Commissioners Voting For: Commissioner Hoffman, Commissioner Brant, Commissioner Potratz, Commissioner Donahue, Commissioner Turner, Commissioner Oley, Commissioner Wilmoth, Commissioner Ellsworth and Commissioner Lievens.

Commissioners Voting Against: None

Motion carried.