County of Jackson
120 W. Michigan Ave.
Jackson, MI 49201
(517) 788-4335

BOARD OF COMMISSIONERS

Clifford E. Herl, District 1
David F. Lutchka, District 2
Carl Rice, Jr., District 3
Philip S. Duckham III, District 4
Julie Alexander, District 5
James C. Videto, District 6
James E. Shotwell, Jr., District 7
Gail W. Mahoney, District 8
Jonathan T. Williams, District 9
Patricia A. Smith, District 10
Michael J. Way, District 11
David K. Elwell, District 12

ELECTED OFFICIALS

Amanda Riska, Clerk
Steven Rand, Sheriff
Mindy Reilly, Register of Deeds
Karen Coffman, Treasurer
Geoffrey Snyder, Drain Commissioner
Hank Zavislak, Prosecuting Attorney

COUNTY STAFF

Michael Overton, Administrator/Controller
Adam Brown, Deputy Administrator
Charles Adkins, Circuit Court Administrator
Tammy Bates, District Court Administrator
Andy Crisenbery, Friend of the Court
Gerard Cyrocki, Finance Officer
Connie Frey, IT Director
Brandon Ransom, Parks Director
Teresa Hawkins, Youth Center Director
TBD, Equalization Director
Crystal Dixon, Human Resources Director
Dr. John Maino, Medical Director
Kent Maurer, Airport Manager
Ric Scheele, Director-Fleet & Facilities Opns.
Matt Shane, MSU Ext.-District Coordinator
Marce Wandell, Department on Aging Director
Dave Welihan, Veterans Affairs Officer
Ted Westmeier, Health Officer

County Commission Agenda
October 18, 2011

Order of Business:

1. Call to Order
2. Invocation
3. Pledge of Allegiance
4. Roll Call
5. Approval of Agenda
6. Awards and Recognitions
7. Communications and Petitions
8. Special Orders/Public Hearing(s)
9. Public Comment
10. Special Meetings of Standing Committees
11. Minutes
12. Consent Agenda
13. Standing Committees
    - A. Policy
    - B. County Affairs & Agencies
    - C. Human Services
    - D. Personnel & Finance
14. Unfinished Business
15. New Business
16. Public Comment
17. Commissioner Comment
18. Closed Session
19. Adjournment

Public Comment

Any person desiring to speak on a matter to the Board of Commissioners may do so under the Public Comment items near the beginning and end of the meeting. Please state your name and use the microphone. Please note that the Commission allocates a maximum of five minutes per individual at the beginning of the meeting and three minutes per individual at the end of the meeting for this purpose.

Consent Agenda

Items on the Consent Agenda are items generally routine in nature that have passed a Standing Committee and will be enacted by one motion and one vote. There will be no separate discussion on these items. Any Commissioner may remove an item from the Consent Agenda and it will be considered by separate motion at the proper place during the meeting.

Standing Committees

The Board of Commissioners operates under a Standing Committee system with the following Committees: Policy, County Affairs & Agencies, Human Services, Personnel & Finance. All departments of the County coordinate their business through one of the Standing Committees. The Committees then forward their recommendations to the Board of Commissioners.

Closed Session

The Board of Commissioners is permitted under the Open Meetings Act to go into Closed Session to discuss labor contracts, purchase of property, and certain employee matters if requested by the employee. A two-thirds vote of the Commission is required to go into Closed Session.

"Your interest in your County Government is appreciated"

AGENDA
JACKSON COUNTY BOARD OF COMMISSIONERS BOARD MEETING
ANNUAL MEETING
October 18, 2011
7:00 p.m.
County Commission Chambers

Mission Statement: *Jackson County Government, in cooperation with the community and local governmental units, strives through a planned process to deliver quality services that address public needs.*

1. **CALL TO ORDER** – *by Chairman Steve Shotwell*

2. **INVOCATION** – *by Commissioner Cliff Herl*

3. **PLEDGE OF ALLEGIANCE** – *by Chairman Steve Shotwell*

4. **ROLL CALL** – *County Clerk Amanda Riska*

5. **APPROVAL OF AGENDA**

6. **AWARDS & RECOGNITIONS**

   A. **Proclamation Honoring Hanover Township's 175 Years of Government Service**

   Attachments:
   *Proclamation Honoring Hanover Township's 175 Years of Government Service

7. **COMMUNICATIONS/PETITIONS** – None.

8. **SPECIAL ORDERS/PUBLIC HEARINGS**

7:10 pm A. **Brownfield Plan – 3535 Francis Street, Summit Township**

   Attachments:
   *Brownfield Plan – 3535 Francis Street, Summit Township
   *Public Notice
   *Resolution (10-11.34)

7:11 pm B. **Brownfield Plan – 1721 Probert Road, Summit Township**

   Attachments:
   *Brownfield Plan – 1721 Probert Road, Summit Township
   *Public Notice
   *Resolution (10-11.35)

9. **PUBLIC COMMENTS**

10. **SPECIAL MEETINGS OF STANDING COMMITTEES**

11. **MINUTES** - Minutes of the 9/20/11Regular Meeting of the Jackson County Board of Commissioners

Attachments:
*9/20/11 Regular Meeting Minutes

12. **CONSENT AGENDA** ***(Roll Call)***

A. **County Policy**

1. **Revised/New Policies**

a. **Administrative Policy 5160** (revised)
b. **Board Rule 4045** (new)

Attachments:
*Policies 5160, 4045

B. **County Affairs & Agencies**

2. **Airport**

a. **Donation of Concrete Materials and Installation Labor by R. W. Mercer Company for Aviation Heritage Park**

Attachments:
*Memo from Airport Manager and attachments

b. **Resolution (10-11.33) Authorizing the County Board of Commissioners Chair, James E. Shotwell, Jr., to Sign MDOT Contract #3011-0525 (Federal Project #B-26-0051-3011 for Preliminary Engineering Runway 7-25 and Paint Markings for Runway 6-24**

Attachments:
*Resolution (10-11.33)
*Memo from Airport Manager and MDOT Grant

3. **Equalization - Apportionment Report**

Attachments:
*Apportionment Report

4. **Friend of the Court Reorganization**

Attachments:
*Memo from Friend of the Court
*Reorganization Cost Analysis

5. **Drain Commission 2010 Annual Report**

   Attachments:
   *Drain Commission 2010 Annual Report

C. **Human Services** – None.

D. **Personnel & Finance**

6. **Resolution (10-11.31) Adopting Amended and Restated Health Plan**

   Attachments:
   *Resolution (10-11.31)
   *Memo from Human Resources regarding Resolution (10-11.31)
   *Amended and Restated Health Plan and attachments

7. **Approve Service contract Between Jackson County Employees' Retirement System and Jackson County, Michigan**

   Attachments:
   *Memo from Administrator/Controller
   *Service Contract

8. **Waive Personnel Policy 3100 to Allow for the Administrator/Controller to Conduct the Recruitment and Selection of the County Equalization Director with the Board of Commissioners Ratifying the Selection**

   Attachments:
   *Memo from Administrator/Controller

9. **Budget Adjustments**

   a. **Register of Deeds**
   b. **Department on Aging**

   Attachments:
   *Memo from Register of Deeds
   *Department on Aging Budget Adjustments

E. **Other Business**

10. **Claims dated 9/1/11 – 9/30/11**

    Attachments: None.

13. **STANDING COMMITTEES**

A. **County Policy – *Commissioner Dave Elwell*** – None.

B. **County Affairs & Agencies – *Commissioner Dave Lutchka***

1. **Appointments**

a. **Board of County Canvassers** – two public members, terms to 10/2015 (one Republic and one Democratic member)
b. **Department of Human Services**, one public member, term to 10/2014
c. **Land Bank Authority** – one commissioner member, term to 10/2015

Attachments:
*Board Appointments
*Applications

C. **Human Services – *Commissioner Jon Williams*** - None.

D. **Personnel and Finance – *Commissioner Jim Videto*** – None.

14. **UNFINISHED BUSINESS** – None.

15. **NEW BUSINESS**

Roll Call A. **Resolution (10-11.34) Approving a Brownfield Plan by the County of Jackson Pursuant to and in Accordance with the Provisions of Act 381 of the Public Acts of the State of Michigan of 1996, as Amended – 3535 Francis Street, Summit Township**

Attachments:
*Resolution (10-11.34)
*Brownfield Plan – 3535 Francis Street, Summit Township
*Public Notice

Roll Call B. **Resolution (10-11.35) Approving a Brownfield Plan by the County of Jackson Pursuant to and in Accordance with the Provisions of Act 381 of the Public Acts of the State of Michigan of 1996, as Amended – 1721 Probert Road, Summit Township**

Attachments:
*Resolution (10-11.35)
*Brownfield Plan – 1721 Probert Road, Summit Township
*Public Notice

16. **PUBLIC COMMENTS**

17. **COMMISSIONER COMMENTS**

18. **CLOSED SESSION**

A. **Union Negotiations Parameters**

Attachments: None.

19. **ADJOURNMENT**

Jackson County Proclamation

Whereas, the Hanover Township will be celebrating 175 years of governmental service to their residents on October 23, 2011; and

Whereas, Hanover Township has worked collaboratively with other units of government and community partners to renovate the Hanover Horton School House to be functional as a Township Office Building ; and

Whereas, Hanover Township has improved the building to cut the utility costs in half; and

Whereas, Hanover Township received community buy-in and participation in this project; and

Whereas, this accomplishment was done in the midst of turbulent economic times; and

Whereas, Hanover Township has pursued and been successful at many other forms of intergovernmental collaboration.

Now Therefore Be It Resolved, that I, James E. Shotwell, Jr., Chairman, Jackson County Board of Commissioners, do proclaim support and accolades for the Hanover Township Government in the successful renovation of their new facility and in celebrating 175 years of governmental service to their residents.

James E. Shotwell, Jr.
Chairman, Jackson County Board of Commissioners
September 12, 2011

JACKSON COUNTY, MICHIGAN
BROWNFIELD REDEVELOPMENT AUTHORITY

BROWNFIELD PLAN
FOR A SITE AT

3535 FRANCIS STREET
SUMMIT TOWNSHIP, MICHIGAN

AUGUST 25, 2011

Prepared for:

Jackson County Brownfield Redevelopment Authority
One Jackson Square, Suite 1100
Jackson, Michigan 49201

Prepared with the assistance of:

ENVIROLOGIC TECHNOLOGIES, INC.
2960 Interstate Parkway
Kalamazoo, Michigan 49048(269) 342-1100

Recommended for Approval by the Brownfield Redevelopment Authority on:_____
Approved by the County Commission on: _____

TABLE OF CONTENTS

LIST OF TABLES

ATTACHMENTS

BROWNFIELD PLAN

3535 FRANCIS STREET
SUMMIT TOWNSHIP, MICHIGAN

I. GENERAL DEFINITIONS AS USED IN THIS PLAN

1996 PA 381 Sec. 2

(a) "Additional response activities" means response activities identified as part of a brownfield plan that are in addition to baseline environmental assessment activities and due care activities for an eligible property.

(b) "Authority" means a brownfield redevelopment authority created under this act.

(c) "Baseline environmental assessment" means that term as defined in Section 20101 of the Natural Resources and Environmental Protection Act (NREPA), 1994 PA 451, MCL 324.20101.

(d) "Baseline environmental assessment activities" means those response activities identified as part of a brownfield plan that are necessary to complete a baseline environmental assessment for an eligible property in the brownfield plan.

(e) "Blighted" means property that meets any of the following criteria as determined by the governing body:

(i) Has been declared a public nuisance in accordance with a local housing, building, plumbing, fire, or other related code or ordinance.

(ii) Is an attractive nuisance to children because of physical condition, use, or occupancy.

(iii) Is a fire hazard or is otherwise dangerous to the safety of persons or property.

(iv) Has had the utilities, plumbing, heating, or sewerage permanently disconnected, destroyed, removed, or rendered ineffective so that the property is unfit for its intended use.

(v) Is tax reverted property owned by a qualified local governmental unit, by a county, or by this state. The sale, lease, or transfer of tax reverted property by a qualified local governmental unit, county, or this state after the property's inclusion in a brownfield plan shall not result in the loss to the property of the status as blighted property for purposes of this act.

(vi) Is property owned or under the control of a land bank fast track authority under the Land Bank Fast Track Act, whether or not located within a qualified local governmental

unit. Property included within a brownfield plan prior to the date it meets the requirements of this subdivision to be eligible property shall be considered to become eligible property as of the date the property is determined to have been or becomes qualified as, or is combined with, other eligible property. The sale, lease, or transfer of the property by a land bank fast track authority after the property's inclusion in a brownfield plan shall not result in the loss to the property of the status as blighted property for purposes of this act.

(vii) Has substantial subsurface demolition debris buried on site so that the property is unfit for its intended use.

(f) "Board" means the governing body of an authority.

(g) "Brownfield plan" means a plan that meets the requirements of Section 13 and is adopted under Section 14.

(h) "Captured taxable value" means the amount in one year by which the current taxable value of an eligible property subject to a brownfield plan, including the taxable value or assessed value, as appropriate, of the property for which specific taxes are paid in lieu of property taxes, exceeds the initial taxable value of that eligible property. The state tax commission shall prescribe the method for calculating captured taxable value.

(i) "Chief executive officer" means the mayor of a city, the village manager of a village, the township supervisor of a township, or the county executive of a county or, if the county does not have an elected county executive, the chairperson of the county board of commissioners.

(j) "Department" means the Department of Environmental Quality.

(k) "Due care activities" means those response activities identified as part of a brownfield plan that are necessary to allow the owner or operator of an eligible property in the plan to comply with the requirements of Section 20107a of NREPA, 1994 PA 451, MCL 324.20107a.

(l) "Economic opportunity zone" means one or more parcels of property that meet all of the following:

(i) That together are 40 or more acres in size.

(ii) That contain a manufacturing facility that consists of 500,000 or more square feet.

(iii) That are located in a municipality that has a population of 30,000 or less and that is contiguous to a qualified local governmental unit.

(m) "Eligible activities" or "eligible activity" means one or more of the following:

(i) Baseline environmental assessment activities.

(ii) Due care activities.

(iii) Additional response activities.

(iv) For eligible activities on eligible property that was used or is currently used for commercial, industrial, or residential purposes that is in a qualified local governmental unit, that is owned or under the control of a land bank fast track authority, or that is located in an economic opportunity zone, and is a facility, functionally obsolete, or blighted, and except for purposes of Section 38d of former 1975 PA 228, the following additional activities:

(A) Infrastructure improvements that directly benefit eligible property.

(B) Demolition of structures that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(C) Lead or asbestos abatement.

(D) Site preparation that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(E) Assistance to a land bank fast track authority in clearing or quieting title to, or selling or otherwise conveying, property owned or under the control of a and bank fast track authority or the acquisition of property by the land bank fast track authority if the acquisition of the property is for economic development purposes.

(F) Assistance to a qualified local governmental unit or authority in clearing or quieting title to, or selling or otherwise conveying, property owned or under the control of a qualified local governmental unit or authority or the acquisition of property by a qualified local governmental unit or authority if the acquisition of the property is for economic development purposes.

(v) Relocation of public buildings or operations for economic development purposes.

(vi) For eligible activities on eligible property that is a qualified facility that is not located in a qualified local governmental unit and that is a facility, functionally obsolete, or blighted, the following additional activities:

(A) Infrastructure improvements that directly benefit eligible property.

(B) Demolition of structures that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(C) Lead or asbestos abatement.

(D) Site preparation that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(vii) For eligible activities on eligible property that is not located in a qualified local governmental unit and that is a facility, functionally obsolete, or blighted, the following additional activities:

(A) Demolition of structures that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(B) Lead or asbestos abatement.

(viii) Reasonable costs of developing and preparing brownfield plans and work plans.

(ix) For property that is not located in a qualified local governmental unit and that is a facility, functionally obsolete, or blighted, that is a former mill that has not been used for industrial purposes for the immediately preceding 2 years, that is located along a river that is a federal superfund site listed under the Comprehensive EnvironmentalResponse, Compensation, and Liability Act (CERCLA) of 1980, 42 USC 9601 to 9675, and that is located in a city with a population of less than 10,000 persons, the following additional activities:

(A) Infrastructure improvements that directly benefit the property.

(B) Demolition of structures that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(C) Lead or asbestos abatement.

(D) Site preparation that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(x) For eligible activities on eligible property that is located north of the 45th parallel, that is a facility, functionally obsolete, or blighted, and the owner or operator of which makes new capital investment of $250,000,000.00 or more in this state, the following additional activities:

(A) Demolition of structures that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(B) Lead or asbestos abatement.

(xi) Reasonable costs of environmental insurance.

(n) Except as otherwise provided in this subdivision, "eligible property" means property for which eligible activities are identified under a brownfield plan that was used or is currently used for commercial, industrial, public, or residential purposes, including personal property located on the property, to the extent included in the brownfield plan, and that is one or more of the following:

(i) Is in a qualified local governmental unit and is a facility, functionally obsolete, or blighted and includes parcels that are adjacent or contiguous to that property if the development of the adjacent and contiguous parcels is estimated to increase the captured taxable value of that property.

(ii) Is not in a qualified local governmental unit and is a facility, and includes parcels that are adjacent or contiguous to that property if the development of the adjacent and contiguous parcels is estimated to increase the captured taxable value of that property.

(iii) Is tax reverted property owned or under the control of a land bank fast track authority.

(iv) Is not in a qualified local governmental unit, is a qualified facility, and is a facility, functionally obsolete, or blighted, if the eligible activities on the property are limited to the eligible activities identified in subdivision (m)(vi).

(v) Is not in a qualified local governmental unit and is a facility, functionally obsolete, or blighted, if the eligible activities on the property are limited to the eligible activities identified in subdivision (m)(vii).

(vi) Is not in a qualified local governmental unit and is a facility, functionally obsolete, or blighted, if the eligible activities on the property are limited to the eligible activities identified in subdivision (m)(ix).

(vii) Is located north of the 45th parallel, is a facility, functionally obsolete, or blighted, and the owner or operator makes new capital investment of $250,000,000.00 or more in this state. Eligible property does not include qualified agricultural property exempt under Section 7ee of the general property tax act, 1893 PA 206, MCL 211.7ee, from the tax levied by a local school district for school operating purposes to the extent provided under Section 1211 of the revised school code, 1976 PA 451, MCL 380.1211.

(viii) Is a transit-oriented development.

(ix) Is a transit-oriented facility.

(o) "Environmental insurance" means liability insurance for environmental contamination and cleanup that is not otherwise required by state or federal law.

(p) "Facility" means that term as defined in Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(q) "Fiscal year" means the fiscal year of the authority.

(r) "Functionally obsolete" means that the property is unable to be used to adequately perform the function for which it was intended due to a substantial loss in value resulting from factors such as overcapacity, changes in technology, deficiencies or superadequacies in design, or other similar factors that affect the property itself or the property's relationship with other surrounding property.

(s) "Governing body" means the elected body having legislative powers of a municipality creating an authority under this act.

(t) "Infrastructure improvements" means a street, road, sidewalk, parking facility, pedestrian mall, alley, bridge, sewer, sewage treatment plant, property designed to reduce, eliminate, or prevent the spread of identified soil or groundwater contamination, drainage system, waterway, waterline, water storage facility, rail line, utility line or pipeline, transit-oriented development, transit-oriented facility, or other similar or related structure or improvement, together with necessary easements for the structure or improvement, owned or used by a public agency or functionally connected to similar or supporting property owned or used by a public agency, or designed and dedicated to use by, for the benefit of, or for the protection of the health, welfare, or safety of the public generally, whether or not used by a single business entity, provided that any road, street, or bridge shall be continuously open to public access and that other property shall be located in public easements or rights-of-way and sized to accommodate reasonably foreseeable development of eligible property in adjoining areas.

(u) "Initial taxable value" means the taxable value of an eligible property identified in and subject to a brownfield plan at the time the resolution adding that eligible property in the brownfield plan is adopted, as shown either by the most recent assessment roll for which equalization has been completed at the time the resolution is adopted or, if provided by the brownfield plan, by the next assessment roll for which equalization will be completed following the date the resolution adding that eligible property in the brownfield plan is adopted. Property exempt from taxation at the time the initial taxable value is determined shall be included with the initial taxable value of zero. Property for which a specific tax is paid in lieu of property tax shall not be considered exempt from taxation. The state tax commission shall prescribe the method for calculating the initial taxable value of property for which a specific tax was paid in lieu of property tax.

(v) "Land bank fast track authority" means an authority created under the Land Bank Fast Track Act, 2003 PA 258, MCL 124.751 to 124.774.

(w) "Local taxes" means all taxes levied other than taxes levied for school operating purposes.

(x) "Municipality" means all of the following:

(i) A city.

(ii) A village.

(iii) A township in those areas of the township that are outside of a village.

(iv) A township in those areas of the township that are in a village upon the concurrence by resolution of the village in which the zone would be located.

(v) A county.

(y) "Owned or under the control of" means that a land bank fast track authority has one or more of the following:

(i) An ownership interest in the property.

(ii) A tax lien on the property.

(iii) A tax deed to the property.

(iv) A contract with this state or a political subdivision of this state to enforce a lien on the property.

(v) A right to collect delinquent taxes, penalties, or interest on the property.

(vi) The ability to exercise its authority over the property.

(z) "Qualified facility" means a landfill facility area of 140 or more contiguous acres that is located in a city and that contains a landfill, a material recycling facility, and an asphalt plant that are no longer in operation.

(aa) "Qualified local governmental unit" means that term as defined in the Obsolete Property Rehabilitation Act, 2000 PA 146, MCL 125.2781 to 125.2797.

(bb) "Qualified taxpayer" means that term as defined in Sections 38d and 38g of former 1975 PA 228, or Section 437 of the Michigan Business Tax Act, 2007 PA 36, MCL 208.1437.

(cc) "Response activity" means that term as defined in Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(dd) "Specific taxes" means a tax levied under 1974 PA 198, MCL 207.551 to 207.572; the Commercial Redevelopment act, 1978 PA 255, MCL 207.651 to 207.668; the Enterprise Zone Act, 1985 PA 224, MCL 125.2101 to 125.2123; 1953 PA 189, MCL 211.181 to 211.182; the Technology Park Development Act, 1984 PA 385, MCL 207.701 to 207.718; the Obsolete Property Rehabilitation Act, 2000 PA 146, MCL 125.2781 to 125.2797; the Neighborhood Enterprise Zone Act, 1992 PA 147, MCL 207.771 to 207.786; the Commercial Rehabilitation Act, 2005 PA 210, MCL 207.841 to 207.856; or that portion of the tax levied under the Tax Reverted Clean Title Act, 2003

PA 260, MCL 211.1021 to 211.1026, that is not required to be distributed to a land bank fast track authority.

(ee) "Tax increment revenues" means the amount of ad valorem property taxes and specific taxes attributable to the application of the levy of all taxing jurisdictions upon the captured taxable value of each parcel of eligible property subject to a brownfield plan and personal property located on that property. Tax increment revenues exclude ad valorem property taxes specifically levied for the payment of principal of and interest on either obligations approved by the electors or obligations pledging the unlimited taxing power of the local governmental unit, and specific taxes attributable to those ad valorem property taxes. Tax increment revenues attributable to eligible property also exclude the amount of ad valorem property taxes or specific taxes captured by a downtown development authority, tax increment finance authority, or local development finance authority if those taxes were captured by these other authorities on the date that eligible property became subject to a brownfield plan under this act.

(ff) "Taxable value" means the value determined under Section 27a of the General Property Tax Act, 1893 PA 206, MCL 211.27a.

(gg) "Taxes levied for school operating purposes" means all of the following:

(i) The taxes levied by a local school district for operating purposes.

(ii) The taxes levied under the State Education Tax Act, 1993 PA 331, MCL 211.901 to 211.906.

(iii) That portion of specific taxes attributable to taxes described under subparagraphs (i) and (ii).

(hh) "Transit-oriented development" means infrastructure improvements that are located within 1/2 mile of a transit station or transit-oriented facility that promotes transit ridership or passenger rail use as determined by the board and approved by the municipality in which it is located.

(ii) "Transit-oriented facility" means a facility that houses a transit station in a manner that promotes transit ridership or passenger rail use.

(jj) "Work plan" means a plan that describes each individual activity to be conducted to complete eligible activities and the associated costs of each individual activity.

(kk) "Zone" means, for an authority established before June 6, 2000, a brownfield redevelopment zone designated under this act.

II. ELIGIBLE PROPERTIES

3535 FRANCIS STREET
SUMMIT TOWNSHIP
JACKSON COUNTY, MICHIGAN

Introduction

The property is a single parcel of land located at 3535 Francis Street in Summit Township. The property is occupied by a former automotive dealership building.

The subject property consists of a single parcel of land with a tax identification number of 000-13-14-326-093-00. The legal description, obtained from the Summit Township Assessing Department, is as follows:

> *BEG AT THE CEN OF SEC 14 TH W 824.51 FT ALG E&W 1/4 LN TH S 0DEG 38'E 59.53 FT TO A PT FOR PL OF BEG OF THIS DESCN TH S 00DEG 38'E 329.16 FT TH S 89 DEG 22'W 400 FT TO THE ELY LN OF FRANCIS ST TH NELY 334.59 FT ON THE ARC OF A 2340 FT RADIUS CURVE TO THE LEFT (THE CORD OF WH BEARS N 9 DEG 26'35" E 334.29 FT) TH N 89 DEG 22' E 341.51 FT TO BEG SEC 14 T3S R1W*

The property has been acquired by Mr. Karl Jennings. The building will be extensively remodeled to develop The Healing Farewell Center – a next-generation funeral home providing healing support services to support families in their loss experience. The remodeling effort will include removal of the showroom for creation of a new façade and covered entryway, remodeling of offices and conversion of the former repair shop into a chapel. Total project investment anticipated, excluding property acquisition costs, is $750,000.

Basis of Eligibility

The property is an "eligible property" based on the designation of the property as "functionally obsolete." The property has been evaluated by the Summit Township Assessor, a Level 3 Assessor, and determined to meet the definition of "functionally obsolete" as defined in PA 381 of 1996. A copy of the determination is provided in Attachment D. The basis upon which the property was deemed functionally obsolete includes the age of the building (45+ years) and its ability to be converted for its intended use or other highest and best uses. According to the Township Assessor, "*the building is of low cost construction in average condition for structure including roof. In current condition, functionality for use as a funeral home would require major renovation.*

Building has functional obsolescence with respect to existing automobile service area. Functionality of existing service garage area is inadequate and would require extensive upgrades for use in a funeral home purpose. The physical functional updates may not be economically feasible".

The Plan

(a) A description of the costs of the plan intended to be paid for with tax increment revenues (Section 13(1)(a))

This Brownfield Plan anticipates acquisition of the property and redevelopment of the site as a funeral home and healing support center. This Plan anticipates an investment in real and personal property of $750,000 in the property.

Potential MDEQ and MEGA costs eligible for reimbursement under this Plan include the following:

- Costs of Preparing this Brownfield Plan ($2,500)
- Costs of Environmental Assessment Activities ($22,750)
- Authority expenses in adoption/implementation of the Brownfield Plan ($2,500)
- Contingencies (15%)

The cost of preparing this Brownfield Plan is estimated at $2,500. This cost is being borne by the Jackson County Brownfield Redevelopment Authority. Additional costs (estimated at $2,500) may be borne by the Authority for publication costs of public hearing notices and other eligible Authority administrative activities.

The Authority has also funded environmental assessment activities at the property including a Phase I and II Environmental Site Assessment. The total cost for environmental assessment activities is $19,750.

Upon full reimbursement for these *actual* eligible costs, the tax increment will be captured for placement in the Local Site Remediation Revolving Fund (LSSRF) for five full years.

This Brownfield Plan anticipates the capture of personal property taxes and local taxes.

Adoption of this Brownfield Plan will allow the purchaser/developer to pursue a Brownfield Redevelopment Tax Credit if they so choose.

This Plan does not intend to pay for interest expense.

(b) A brief summary of the eligible activities that are proposed for each eligible property (Section 13(1)(b))

Eligible activities that will be or have been completed at this site include baseline environmental assessment activities (Phase I and II Environmental Site Assessment, geophysical survey and inspection for underground storage tanks), preparation of the Brownfield Plan, and eligible Authority expenses. Refer to Table 1.

(c) An estimate of the captured taxable value and tax increment revenues for each year of the plan from each parcel of eligible property. (Section 13(1)(c))

Refer to Table 2.

(d) The method by which the costs of the plan will be financed, including a description of any advances made or anticipated to be made for the costs of the plan from the municipality. (Section 13(1)(d))

Costs for development of the Environmental Site Assessments and Brownfield Plan were financed by the Jackson County Brownfield Redevelopment Authority utilizing a U.S. EPA Brownfield Assessment Grant. No advances are anticipated. Table 5 provides the estimated schedule for repayment to the Jackson County Brownfield Redevelopment Authority.

(e) The maximum amount of note or bonded indebtedness to be incurred, if any. (Section 13(1)(e))

The Authority has no plans to incur indebtedness at this time, though such plans could be made in the future, if appropriate to support development of this site.

(f) The duration of the Brownfield Plan, which shall not exceed the lesser of the period authorized under Subsections (4) and (5) or 30 years. (Section 13(1)(f))

This Plan anticipates that the investment in the property will occur in 2011-2012. The County intends to implement the Plan the tax year following private investment on the property (i.e., anticipates initiating this Plan in 2012). This Plan will then remain in place until the eligible activities have been fully reimbursed or 30 years, whichever occurs sooner.

Table 1

Summary of Eligible Costs to be Reimbursed by Brownfield Plan

3535 Francis Street
Summit Township, Michigan

MDEQ Eligible Activities		**Estimated Cost**
BEA Activities	County BRA	$ 22,750.00
Due Care Activities		
Additional Response Activities		
Brownfield Plan	County BRA	$ 2,500.00
Total MDEQ Eligible Activities		$ 25,250.00
Contingencies (15%)		$ 3,787.50
Financing Costs		**$ -**
TOTAL MDNRE ELIGIBLE COSTS AND CONTINGENCIES		**$ 29,037.50**
MEGA Eligible Activities		
Total MEGA Eligible Activity Costs		$ -
Contingencies (15%)		$ -
Financing Costs		
TOTAL MEGA ELIGIBLE COSTS AND CONTINGENCIES		**$ -**
Authority Expense	County BRA	**$ 2,500.00**
TOTAL BROWNFIELD PLAN ELIGIBLE COSTS		**$ 31,537.50**
TOTAL REIMBURSEMENT TO DEVELOPER		
TOTAL REIMBURSEMENT TO COUNTY BRA		**$ 31,537.50**
TOTAL REIMBURSEMENT TO LSRRF		**$ 20,327.30**

Table 2

Estimate of Total Captured Incremental Taxes

3535 Francis Street
Summit Township, Michigan

Parcel 000-13-14-326-093-00 Real and Personal Property

Year	Annual Total Millage†	Initial Taxable Value (Real and Personal Property)	Tax Revenues from Initial Taxable Value	Estimated Future Taxable Value	Estimated Future Tax Revenues	Incremental Tax Revenues	Available for Capture
2012	18.3216	$ 77,800.00	$ 1,425.42	$ 280,000.00	$ 5,130.05	$ 3,704.63	$ 3,704.63
2013	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2014	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2015	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2016	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2017	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2018	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2019	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2020	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2021	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2022	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2023	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2024	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63
2025	18.3216	$ 77,800.00	1,425.42	$ 280,000.00	5,130.05	3,704.63	$ 3,704.63

† - Does not include school or debt millages, based on millages from 2010

(g) An estimate of the impact of tax increment financing on the revenues of all taxing jurisdictions in which the eligible property is located. (Section 13(1)(g))

Refer to Tables 3, 4 and 5.

(h) A legal description of each parcel of eligible property to which the plan applies, a map showing the location and dimensions of each eligible property, a statement of the characteristics that qualify the property as eligible property and a statement of whether personal property is included as part of the eligible property. (Section 13(1)(h))

The subject property consists of a single parcel of land with a tax identification number of 000-13-14-326-093-00. The legal description, obtained from the Summit Township Assessing Department, is as follows:

> *BEG AT THE CEN OF SEC 14 TH W 824.51 FT ALG E&W 1/4 LN TH S 0DEG 38'E 59.53 FT TO A PT FOR PL OF BEG OF THIS DESCN TH S 00DEG 38'E 329.16 FT TH S 89 DEG 22'W 400 FT TO THE ELY LN OF FRANCIS ST TH NELY 334.59 FT ON THE ARC OF A 2340 FT RADIUS CURVE TO THE LEFT (THE CORD OF WH BEARS N 9 DEG 26'35" E 334.29 FT) TH N 89 DEG 22' E 341.51 FT TO BEG SEC 14 T3S R1W*

A map showing the location of the property is included in Attachment A.

The site has been determined to be "functionally obsolete" and is thus an "eligible property".

Personal property will be included as part of the eligible property.

(i) Estimates of the number of persons residing on each eligible property to which the plan applies and the number of families and individuals to be displaced. (Section 13(1)(i))

No residences exist on the property.

(j) A plan for establishing priority for the relocation of persons displaced by implementation of the plan. (Section 13(1)(j))

Not applicable.

(k) Provision for the costs of relocating persons displaced by implementation of the plan. (Section 13(1)(k))

Not applicable.

(l) A strategy for compliance with 1972 PA 227, MCL 213.321 to 213.332. (Section 13(1)(l))

Not applicable.

(m) A description of proposed use of the local site remediation revolving fund. (Section 13(1)(m))

The Brownfield Redevelopment Authority's Local Site Remediation Revolving Fund (LSRRF) will capture five full years of the tax increment after the eligible activities have been reimbursed.

(n) Other material that the authority or governing body considers pertinent. (Section 13(1)(n))

Not applicable.

Table 3

Estimate of Annual Captured Incremental Taxes for Each Affected Taxing Jurisdiction
(Real and Personal Property)

3535 Francis Street
Summit Township, Michigan

Parcel 000-13-14-326-093-00

Taxing Jurisdiction		Township	County	Library	JCC	ISD	School Debt 1992	State Ed	School Operating	Total
Millage		1.8168	5.9909	1.2593	1.1446	8.11	6.35	6	17.4174	48.089
Initial Taxable Value	$ 77,800.00	$ 141.35	$ 466.09	$ 97.97	$ 89.05	$ 630.96	$ 494.03	$ 466.80	$ 1,355.07	$ 3,741.32
Future Taxable Value	$ 280,000.00	$ 508.70	$ 1,677.45	$ 352.60	$ 320.49	$ 2,270.80	$ 1,778.00	$ 1,680.00	$ 4,876.87	$ 13,464.92
Captured Taxable Value	$ 202,200.00	$ 367.36	$ 1,211.36	$ 254.63	$ 231.44	$ 1,639.84				$ 3,704.63

Plan does not include capture of school or debt millages
*Based on millages from 2010 taxes

Total Millages	48.0890
Total Non-School Millages	18.3216
Total School Millages	29.7674
Total Captured Millages	41.7390
Total Annual Tax Liability	$ 13,464.92
Total Annual Capturable Tax Increment	$ 3,704.63
Total School Tax Increment Capturable	$ -
Total Non-School Tax Increment Capturable	$ 3,704.63

Table 4

Captured Taxable Value and Tax Increment Revenue by Year and Aggregate for Each Taxing Jurisdiction
3535 Francis Street
Summit Township, Michigan

Parcel 000-13-14-326-093-00 Real and Personal Property

Year	Captured Taxable Value	Township	County	Library	JCC	ISD	School Debt 1992	State Ed	School Operating	Total
		1.8168	5.9909	1.2593	1.1446	8.11	6.35	6	17.4174	48.089
2012	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2013	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2014	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2015	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2016	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2017	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2018	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2019	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2020	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2021	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2022	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2023	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2024	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
2025	$ 202,200.00	367.36	1,211.36	254.63	231.44	1,639.84				3,704.63
TOTAL CAPTURED TAXES		$ 5,143.00	$ 16,959.04	$ 3,564.83	$ 3,240.13	$ 22,957.79	$ -	$ -	$ -	$ 51,864.79

Table 5

Reimbursement Schedule

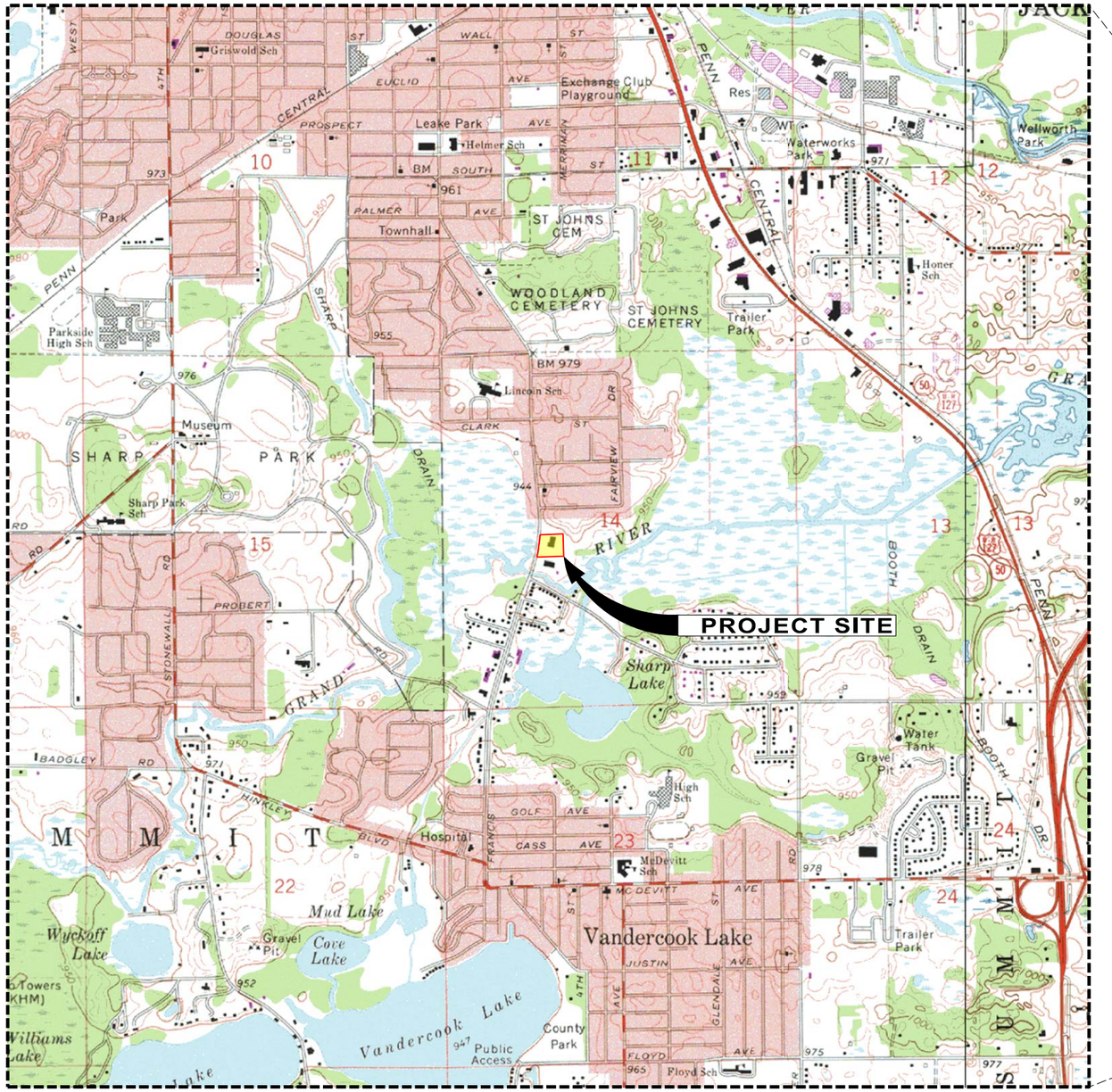
3535 Francis Street
Summit Township, Michigan

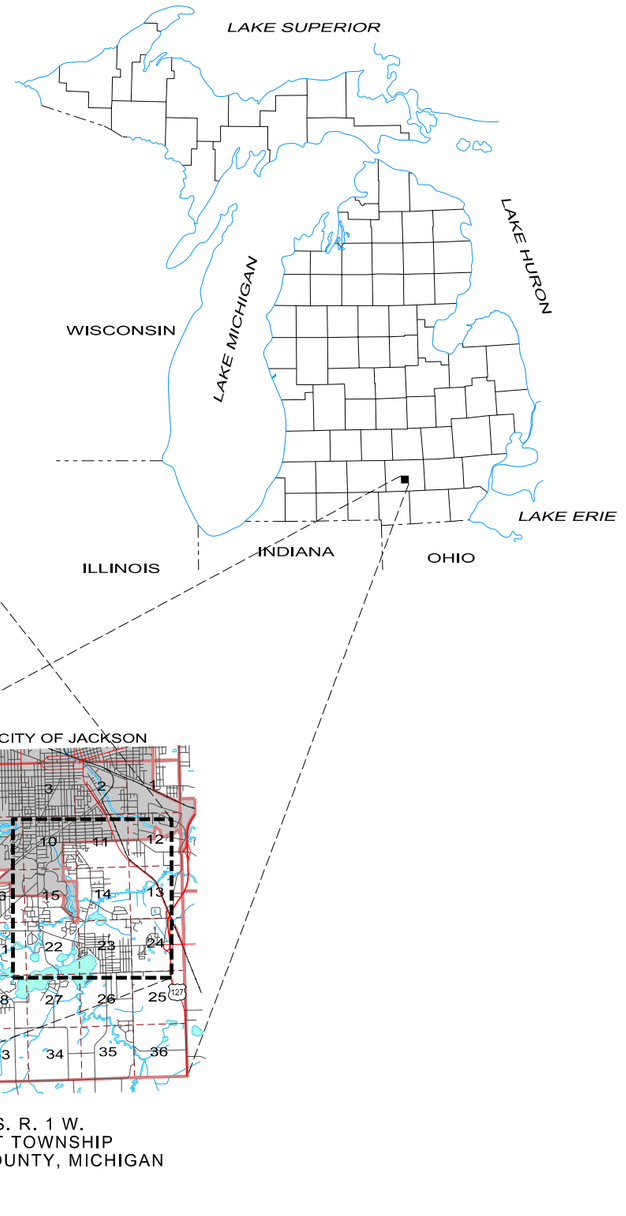
Year		Incremental Taxes Captured	Reimbursement to Developer		Reimbursement to County BRA		Local Site Remediation Revolving Fund
			Annual	Aggregate	Annual	Aggregate	
2012	School Incremental Tax Captured	$ -			$ -		
	Non-School Incremental Tax Captured	$ 3,704.63			$ 3,704.63		
	Total Incremental Tax Captured	$ 3,704.63				$ 3,704.63	
2013	School Incremental Tax Captured	$ -			$ -		
	Non-School Incremental Tax Captured	$ 3,704.63			$ 3,704.63		
	Total Incremental Tax Captured	$ 3,704.63				$ 7,409.26	
2014	School Incremental Tax Captured	$ -			$ -		
	Non-School Incremental Tax Captured	$ 3,704.63			$ 3,704.63		
	Total Incremental Tax Captured	$ 3,704.63				$ 11,113.88	
2015	School Incremental Tax Captured	$ -					
	Non-School Incremental Tax Captured	$ 3,704.63			$ 3,704.63		
	Total Incremental Tax Captured	$ 3,704.63				$ 14,818.51	
2016	School Incremental Tax Captured	$ -					
	Non-School Incremental Tax Captured	$ 3,704.63			$ 3,704.63		
	Total Incremental Tax Captured	$ 3,704.63				$ 18,523.14	
2017	School Incremental Tax Captured	$ -					
	Non-School Incremental Tax Captured	$ 3,704.63			$ 3,704.63		
	Total Incremental Tax Captured	$ 3,704.63				$ 22,227.77	
2018	School Incremental Tax Captured	$ -					
	Non-School Incremental Tax Captured	$ 3,704.63			$ 3,704.63		
	Total Incremental Tax Captured	$ 3,704.63				$ 25,932.39	
2019	School Incremental Tax Captured*	$ -					
	Non-School Incremental Tax Captured	$ 3,704.63			$ 3,704.63		
	Total Incremental Tax Captured	$ 3,704.63				$ 29,637.02	
2020	School Incremental Tax Captured	$ -					
	Non-School Incremental Tax Captured	$ 3,704.63			$ 1,900.48		$ 1,804.15
	Total Incremental Tax Captured	$ 3,704.63				$ 31,537.50	
2021	Non-School Incremental Tax Captured	$ 3,704.63					$ 3,704.63
2022	Non-School Incremental Tax Captured	$ 3,704.63					$ 3,704.63
2023	Non-School Incremental Tax Captured	$ 3,704.63					$ 3,704.63
2024	Non-School Incremental Tax Captured	$ 3,704.63					$ 3,704.63
2025	Non-School Incremental Tax Captured	$ 3,704.63					$ 3,704.63
Totals				$ -		$ 31,537.50	$ 20,327.30

ATTACHMENT A

FIGURES

Location Map: USGS Topographic Map
Site Plans





SOURCE: JACKSON SOUTH AND MICHIGAN CENTER, MICHIGAN USGS 7.5 MINUTE TOPOGRAPHIC QUADRANGLE MAPS
MAPTECH© U.S. TERRAIN SERIES™ ®MAPTECH©, INC. 606-433-8500

N

0 500 1000 2000 4000

SCALE 1" = 2000'

envirologic
environmental consulting + services
2960 INTERSTATE PARKWAY
KALAMAZOO, MICHIGAN 49048
PH: (269) 342-1100 FAX: (269) 342-4945

FORMER JENSEN LINCOLN MERCURY

3535 FRANCIS STREET
JACKSON, MICHIGAN 49203

LOCATION MAP

PROJECT NO.
110033

FIGURE No.
1

110033.JCBRAU File: 110033_Site_Plan.dgn Model: Location Map

LEGEND

GEOPROBE® SOIL BORING LOCATION

N

SCALE 1" = 60'

0 10 20 30 60 120

NOTE: AERIAL PHOTOGRAPHY: 2007 COLOR ORTHOPHOTO, OBTAINED FROM THE JACKSON COUNTY ON LINE GIS VIEWER.

NOTE:
THIS IS NOT A PROPERTY BOUNDARY SURVEY, PROPERTY BOUNDARIES SHOWN ON THIS MAP ARE BASED ON AVAILABLE FURNISHED INFORMATION AND ARE APPROXIMATE ONLY AND SHOULD NOT BE USED TO ESTABLISH PROPERTY BOUNDARY LOCATION IN THE FIELD.

FORMER JENSEN LINCOLN MERCURY

3535 FRANCIS STREET
JACKSON, MICHIGAN 49203

SITE PLAN

envirologic
environmental consulting + services
2960 INTERSTATE PARKWAY
KALAMAZOO, MICHIGAN 49048
PH: (269) 342-1100 FAX: (269) 342-4945

PROJECT NO.
110033

FIGURE No.
2

ATTACHMENT B

NOTICE OF PUBLIC HEARING

ATTACHMENT C

NOTICE TO TAXING JURISDICTIONS

ATTACHMENT D

RESOLUTION APPROVING A BROWNFIELD PLAN

DETERMINATION OF FUNCTIONAL OBSOLESCENCE

SUMMIT TOWNSHIP
2121 FERGUSON RD
JACKSON, MI. 49203

August, 16 2011

Dear Mr. James Dunn:

I, Brian Small testify to the following:

1. I am employed by Township of Summit and have held the position of Assessor for one year and the title of Deputy Assessor for nine years prior to being the Assessor.
2. I am a certified Level 3 Assessor and have held that certification since 2008.
3. I am familiar with the property located at 3535 Francis St.
4. This affidavit is given to confirm that the site qualifies as "Functionally Obsolete Property" as that term is defined under MCL 125.2652(r). The following facts form the basis of my expert opinion:
    a. Building was originally constructed for Automobile sales and service with actual age of 45+ years.
    b. The building is of low cost construction in average condition for structure including roof. In current condition functionality for use as a funeral home would require major renovation.
    c. Building has functional obsolescence with respect to existing automobile service area (garage).
    d. Functionality of existing service garage area is inadequate and would require extensive upgrades for use in a funeral home purpose. The physical functional updates may not be economically feasible.
    e. Highest and Best use based on current zoning, types of businesses in surrounding area would be retail/service.

Sincerely,
Brian Small
Township of Summit Assessor

NOTICE OF PUBLIC HEARING

THE BROWNFIELD REDEVELOPMENT AUTHORITY
OF JACKSON COUNTY

REGARDING INCLUSION INTO THE COUNTY'S BROWNFIELD PLAN
FOR PROPERTY LOCATED AT
3535 FRANCIS STREET, JACKSON, MI
LOCATED WITHIN
SUMMIT TOWNSHIP, IN THE
COUNTY OF JACKSON, MICHIGAN

TO ALL INTERESTED PERSONS IN THE COUNTY OF JACKSON

PLEASE TAKE NOTICE that the County Commissioners of the County of Jackson, Michigan, will hold a Public Hearing on Tuesday, the 18th day of October, 2011, at approximately 7:10 p.m., Eastern Daylight time in the Commissioners Chambers within the County Tower Building, 120 W. Michigan Avenue, Jackson, Michigan, to receive public comment on an amendment to the County's Brownfield Redevelopment Plan to include therein portions of 3535 Francis Street. The parcels are legally described as:

Property Number: 000-13-14-326-093-00:
BEG AT THE CEN OF SEC 14 TH W 824.51 FT ALG E&W ¼ LN TH S 0 DEG 38'E 59.53 FT TO A PT FOR PL OF BEG OF THIS DESCN TH S 00 DEG 38'E 329.16 FT TH S 89 DEG 22'W 400 FT TO THE ELY LN OF FRANCIS ST TH NELY 334.59 FT ON THE ARC OF A 2340 FT RADIUS CURVE TO THE LEFT (THE CORD OF WH BEARS N 9 DEG 26'35" E 334.29 FT) TH N 89 DEG 22'E 341.51 FT TO BEG SEC 14 T3S R1W

The property consists of a single parcel of land with approximately 2.83 acres, more or less and is commonly described as 3535 Francis Street, Jackson, Michigan 49203 (former automobile dealership).

The Brownfield Plan, which includes a site map, is available for public inspection at the County Brownfield Redevelopment Authority office, located at One Jackson Square, 11th Floor, Jackson, Michigan, which can be obtained via email by request to dkelly@enterprisegroup.org. All aspects of the plan are open for discussion at the public hearing.

FURTHER INFORMATION may be obtained from the Brownfield Redevelopment Authority of Jackson County at (517) 788-4458. THIS NOTICE is given by order of the County Board of the County of Jackson, Michigan.

Amanda Riska, Clerk
County of Jackson

JACKSON COUNTY, MICHIGAN

RESOLUTION (10-11.34)
APPROVING A BROWNFIELD PLAN
BY THE COUNTY OF JACKSON
PURSUANT TO AND IN ACCORDANCE WITH
THE PROVISIONS OF ACT 381 OF THE PUBLIC ACTS
OF THE STATE OF MICHIGAN OF 1996, AS AMENDED

At a regular meeting of the Board of Commissioners of Jackson County, Michigan, held in the County Tower Building located at 120 W. Michigan Ave., Jackson, Michigan, on the 18th day of October 2011, at 7:00 p.m.

PRESENT:

ABSENT:

MOTION BY:

SUPPORTED BY:

WHEREAS, the Jackson County Board of Commissioners, pursuant to and in accordance with the provisions of the Brownfield Redevelopment Financing Act, being Act 381 of the Public Acts of the State of Michigan of 1996, as amended (the "Act"), have formally resolved to participate in the Brownfield Redevelopment Authority (BRA) of Jackson County (the "Authority") and have designated that all related activities shall proceed through the BRA; and

WHEREAS, the Authority, pursuant to and in accordance with Section 13 of the Act, has reviewed, adopted and recommended for approval by the Jackson County Board of Commissioners, the Brownfield plan (the "Plan") attached hereto, to be carried out within Summit Township, relating to the redevelopment project proposed by Farewell Healing Center. located at 3535 Francis Street in Summit Township, (the "Site"), as more particularly described and shown in Figures 1 & 2 and Attachment "A" contained within the attached Plan; and

WHEREAS, the Jackson County Board of Commissioners and the County's taxing entities has reviewed the Plan, and have been provided a reasonable opportunity to express their views and recommendations regarding the Plan and in accordance with Sections 13 (13) of the Act; and

WHEREAS, the Jackson County Board of Commissioners has made the following determinations and findings:

A. The Plan constitutes a public purpose under the Act;

B. The Plan meets all of the requirements for a Brownfield plan set forth in Section 13 of the Act;

C. The proposed method of financing the costs of the eligible activities, as described in the Plan, is feasible and will not require the Authority to arrange the financing;

D. The costs of the eligible activities proposed in the Plan are reasonable and necessary to carry out the purposes of the Act;

E. School taxes will not be captured in accordance with Plan; and

WHEREAS, as a result of its review of the Plan, the Jackson County Board of Commissioners concurs with approval of the Plan.

NOW, THEREFORE, BE IT RESOLVED THAT:

1. **Plan Approved**. Pursuant to the authority vested in the Jackson County Board of Commissioners by the Act, the Plan is hereby approved in the form attached to this Resolution.

2. **Severability**. Should any section, clause or phrase of this Resolution be declared by the courts to be invalid, the same shall not affect the validity of this Resolution as a whole nor any part thereof other than the part so declared to be invalid.

3. **Repeals**. All resolutions or parts of resolutions in conflict with any of the provisions of this Resolution are hereby repealed.

AYES:

NAYES:

ABSTAINED:

RESOLUTION DECLARED ADOPTED.

STATE OF MICHIGAN)
COUNTY OF JACKSON) ss:

I, the undersigned, the fully qualified Clerk of Jackson County, State of Michigan, do hereby certify that the foregoing is a true and complete copy of a resolution adopted by the County Board of Commissioners of Jackson County at a regular meeting held on the 18th day of October, 2011, the original of which resolution is on file in my office.

IN WITNESS WHEREOF, I have hereunto set my official signature this ____ day of _____, 2011.

_____
Amanda Riska, Jackson County Clerk

JACKSON COUNTY, MICHIGAN
BROWNFIELD REDEVELOPMENT AUTHORITY

BROWNFIELD PLAN
FOR A SITE AT

STONE VILLAGE
1721 PROBERT ROAD
SUMMIT TOWNSHIP, MICHIGAN

AUGUST 25, 2011

Prepared for:

Jackson County Brownfield Redevelopment Authority
One Jackson Square, Suite 1100
Jackson, Michigan 49201

Prepared with the assistance of:

ENVIROLOGIC TECHNOLOGIES, INC.
2960 Interstate Parkway
Kalamazoo, MI 49048 (269) 342-1100

Recommended for Approval by the Brownfield Redevelopment Authority on:_____
Approved by the County Commission on: _____

TABLE OF CONTENTS

LIST OF TABLES

ATTACHMENTS

BROWNFIELD PLAN

STONE VILLAGE
1721 PROBERT ROAD
SUMMIT TOWNSHIP, MICHIGAN

I. GENERAL DEFINITIONS AS USED IN THIS PLAN

1996 PA 381 Sec. 2

(a) "Additional response activities" means response activities identified as part of a brownfield plan that are in addition to baseline environmental assessment activities and due care activities for an eligible property.

(b) "Authority" means a brownfield redevelopment authority created under this act.

(c) "Baseline environmental assessment" means that term as defined in Section 20101 of the Natural Resources and Environmental Protection Act (NREPA), 1994 PA 451, MCL 324.20101.

(d) "Baseline environmental assessment activities" means those response activities identified as part of a brownfield plan that are necessary to complete a baseline environmental assessment for an eligible property in the brownfield plan.

(e) "Blighted" means property that meets any of the following criteria as determined by the governing body:

(i) Has been declared a public nuisance in accordance with a local housing, building, plumbing, fire, or other related code or ordinance.

(ii) Is an attractive nuisance to children because of physical condition, use, or occupancy.

(iii) Is a fire hazard or is otherwise dangerous to the safety of persons or property.

(iv) Has had the utilities, plumbing, heating, or sewerage permanently disconnected, destroyed, removed, or rendered ineffective so that the property is unfit for its intended use.

(v) Is tax reverted property owned by a qualified local governmental unit, by a county, or by this state. The sale, lease, or transfer of tax reverted property by a qualified local governmental unit, county, or this state after the property's inclusion in a brownfield plan shall not result in the loss to the property of the status as blighted property for purposes of this act.

(vi) Is property owned or under the control of a land bank fast track authority under the Land Bank Fast Track Act, whether or not located within a qualified local governmental unit. Property included within a brownfield plan prior to the date it meets the requirements of this subdivision to be eligible property shall be considered to become eligible property as of the date the property is determined to have been or becomes qualified as, or is combined with, other eligible property. The sale, lease, or transfer of the property by a land bank fast track authority after the property's inclusion in a brownfield plan shall not result in the loss to the property of the status as blighted property for purposes of this act.

(vii) Has substantial subsurface demolition debris buried on site so that the property is unfit for its intended use.

(f) "Board" means the governing body of an authority.

(g) "Brownfield plan" means a plan that meets the requirements of Section 13 and is adopted under Section 14.

(h) "Captured taxable value" means the amount in 1 year by which the current taxable value of an eligible property subject to a brownfield plan, including the taxable value or assessed value, as appropriate, of the property for which specific taxes are paid in lieu of property taxes, exceeds the initial taxable value of that eligible property. The state tax commission shall prescribe the method for calculating captured taxable value.

(i) "Chief executive officer" means the mayor of a city, the village manager of a village, the township supervisor of a township, or the county executive of a county or, if the county does not have an elected county executive, the chairperson of the county board of commissioners.

(j) "Department" means the Department of Environmental Quality.

(k) "Due care activities" means those response activities identified as part of a brownfield plan that are necessary to allow the owner or operator of an eligible property in the plan to comply with the requirements of Section 20107a of NREPA, 1994 PA 451, MCL 324.20107a.

(l) "Economic opportunity zone" means one or more parcels of property that meet all of the following:

(i) That together are 40 or more acres in size.

(ii) That contain a manufacturing facility that consists of 500,000 or more square feet.

(iii) That are located in a municipality that has a population of 30,000 or less and that is contiguous to a qualified local governmental unit.

(m) "Eligible activities" or "eligible activity" means one or more of the following:

(i) Baseline environmental assessment activities.

(ii) Due care activities.

(iii) Additional response activities.

(iv) For eligible activities on eligible property that was used or is currently used for commercial, industrial, or residential purposes that is in a qualified local governmental unit, that is owned or under the control of a land bank fast track authority, or that is located in an economic opportunity zone, and is a facility, functionally obsolete, or blighted, and except for purposes of Section 38d of former 1975 PA 228, the following additional activities:

(A) Infrastructure improvements that directly benefit eligible property.

(B) Demolition of structures that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(C) Lead or asbestos abatement.

(D) Site preparation that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(E) Assistance to a land bank fast track authority in clearing or quieting title to, or selling or otherwise conveying, property owned or under the control of a land bank fast track authority or the acquisition of property by the land bank fast track authority if the acquisition of the property is for economic development purposes.

(F) Assistance to a qualified local governmental unit or authority in clearing or quieting title to, or selling or otherwise conveying, property owned or under the control of a qualified local governmental unit or authority or the acquisition of property by a qualified local governmental unit or authority if the acquisition of the property is for economic development purposes.

(v) Relocation of public buildings or operations for economic development purposes.

(vi) For eligible activities on eligible property that is a qualified facility that is not located in a qualified local governmental unit and that is a facility, functionally obsolete, or blighted, the following additional activities:

(A) Infrastructure improvements that directly benefit eligible property.

(B) Demolition of structures that is not response activity under Section 20101 of NREPA, 1994 PA 451, MCL 324.20101.

(C) Lead or asbestos abatement.

(D) Site preparation that is not response activity under Section 20101 of the NREPA, 1994 PA 451, MCL 324.20101.

(vii) For eligible activities on eligible property that is not located in a qualified local governmental unit and that is a facility, functionally obsolete, or blighted, the following additional activities:

(A) Demolition of structures that is not response activity under Section 20101 of the NREPA, 1994 PA 451, MCL 324.20101.

(B) Lead or asbestos abatement.

(viii) Reasonable costs of developing and preparing brownfield plans and work plans.

(ix) For property that is not located in a qualified local governmental unit and that is a facility, functionally obsolete, or blighted, that is a former mill that has not been used for industrial purposes for the immediately preceding two years, that is located along a river that is a federal superfund site listed under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, 42 USC 9601 to 9675, and that is located in a city with a population of less than 10,000 persons, the following additional activities:

(A) Infrastructure improvements that directly benefit the property.

(B) Demolition of structures that is not response activity under Section 20101 of the NREPA, 1994 PA 451, MCL 324.20101.

(C) Lead or asbestos abatement.

(D) Site preparation that is not response activity under Section 20101 of the NREPA, 1994 PA 451, MCL 324.20101.

(x) For eligible activities on eligible property that is located north of the 45th parallel, that is a facility, functionally obsolete, or blighted, and the owner or operator of which makes new capital investment of $250,000,000.00 or more in this state, the following additional activities:

(A) Demolition of structures that is not response activity under Section 20101 of the NREPA, 1994 PA 451, MCL 324.20101.

(B) Lead or asbestos abatement.

(xi) Reasonable costs of environmental insurance.

(n) Except as otherwise provided in this subdivision, "eligible property" means property for which eligible activities are identified under a brownfield plan that was used or is currently used for commercial, industrial, public, or residential purposes, including personal property located on the property, to the extent included in the brownfield plan, and that is one or more of the following:

(i) Is in a qualified local governmental unit and is a facility, functionally obsolete, or blighted and includes parcels that are adjacent or contiguous to that property if the development of the adjacent and contiguous parcels is estimated to increase the captured taxable value of that property.

(ii) Is not in a qualified local governmental unit and is a facility, and includes parcels that are adjacent or contiguous to that property if the development of the adjacent and contiguous parcels is estimated to increase the captured taxable value of that property.

(iii) Is tax reverted property owned or under the control of a land bank fast track authority.

(iv) Is not in a qualified local governmental unit, is a qualified facility, and is a facility, functionally obsolete, or blighted, if the eligible activities on the property are limited to the eligible activities identified in subdivision (m)(vi).

(v) Is not in a qualified local governmental unit and is a facility, functionally obsolete, or blighted, if the eligible activities on the property are limited to the eligible activities identified in subdivision (m)(vii).

(vi) Is not in a qualified local governmental unit and is a facility, functionally obsolete, or blighted, if the eligible activities on the property are limited to the eligible activities identified in subdivision (m)(ix).

(vii) Is located north of the 45th parallel, is a facility, functionally obsolete, or blighted, and the owner or operator makes new capital investment of $250,000,000.00 or more in this state. Eligible property does not include qualified agricultural property exempt under Section 7ee of the General Property Tax Aact, 1893 PA 206, MCL 211.7ee, from the tax levied by a local school district for school operating purposes to the extent provided under Section 1211 of the Revised School code, 1976 PA 451, MCL 380.1211.

(viii) Is a transit-oriented development.

(ix) Is a transit-oriented facility.

(o) "Environmental insurance" means liability insurance for environmental contamination and cleanup that is not otherwise required by state or federal law.

(p) "Facility" means that term as defined in Section 20101 of the NREPA, 1994 PA 451, MCL 324.20101.

(q) "Fiscal year" means the fiscal year of the authority.

(r) "Functionally obsolete" means that the property is unable to be used to adequately perform the function for which it was intended due to a substantial loss in value resulting from factors such as overcapacity, changes in technology, deficiencies or superadequacies in design, or other similar factors that affect the property itself or the property's relationship with other surrounding property.

(s) "Governing body" means the elected body having legislative powers of a municipality creating an authority under this act.

(t) "Infrastructure improvements" means a street, road, sidewalk, parking facility, pedestrian mall, alley, bridge, sewer, sewage treatment plant, property designed to reduce, eliminate, or prevent the spread of identified soil or groundwater contamination, drainage system, waterway, waterline, water storage facility, rail line, utility line or pipeline, transit-oriented development, transit-oriented facility, or other similar or related structure or improvement, together with necessary easements for the structure or improvement, owned or used by a public agency or functionally connected to similar or supporting property owned or used by a public agency, or designed and dedicated to use by, for the benefit of, or for the protection of the health, welfare, or safety of the public generally, whether or not used by a single business entity, provided that any road, street, or bridge shall be continuously open to public access and that other property shall be located in public easements or rights-of-way and sized to accommodate reasonably foreseeable development of eligible property in adjoining areas.

(u) "Initial taxable value" means the taxable value of an eligible property identified in and subject to a brownfield plan at the time the resolution adding that eligible property in the brownfield plan is adopted, as shown either by the most recent assessment roll for which equalization has been completed at the time the resolution is adopted or, if provided by the brownfield plan, by the next assessment roll for which equalization will be completed following the date the resolution adding that eligible property in the brownfield plan is adopted. Property exempt from taxation at the time the initial taxable value is determined shall be included with the initial taxable value of zero. Property for which a specific tax is paid in lieu of property tax shall not be considered exempt from taxation. The state tax commission shall prescribe the method for calculating the initial taxable value of property for which a specific tax was paid in lieu of property tax.

(v) "Land bank fast track authority" means an authority created under the Land Bank Fast Track Act, 2003 PA 258, MCL 124.751 to 124.774.

(w) "Local taxes" means all taxes levied other than taxes levied for school operating purposes.

(x) "Municipality" means all of the following:

(i) A city.

(ii) A village.

(iii) A township in those areas of the township that are outside of a village.

(iv) A township in those areas of the township that are in a village upon the concurrence by resolution of the village in which the zone would be located.

(v) A county.

(y) "Owned or under the control of" means that a land bank fast track authority has one or more of the following:

(i) An ownership interest in the property.

(ii) A tax lien on the property.

(iii) A tax deed to the property.

(iv) A contract with this state or a political subdivision of this state to enforce a lien on the property.

(v) A right to collect delinquent taxes, penalties, or interest on the property.

(vi) The ability to exercise its authority over the property.

(z) "Qualified facility" means a landfill facility area of 140 or more contiguous acres that is located in a city and that contains a landfill, a material recycling facility, and an asphalt plant that are no longer in operation.

(aa) "Qualified local governmental unit" means that term as defined in the Obsolete Property Rehabilitation Act, 2000 PA 146, MCL 125.2781 to 125.2797.

(bb) "Qualified taxpayer" means that term as defined in Sections 38d and 38g of former 1975 PA 228, or Section 437 of the Michigan Business Tax Act, 2007 PA 36, MCL 208.1437.

(cc) "Response activity" means that term as defined in Section 20101 of the NREPA, 1994 PA 451, MCL 324.20101.

(dd) "Specific taxes" means a tax levied under 1974 PA 198, MCL 207.551 to 207.572; the Commercial Redevelopment Aact, 1978 PA 255, MCL 207.651 to 207.668; the Enterprise Zone Act, 1985 PA 224, MCL 125.2101 to 125.2123; 1953 PA 189, MCL 211.181 to 211.182; the Technology Park Development Act, 1984 PA 385, MCL 207.701 to 207.718; the Obsolete Property Rehabilitation Act, 2000 PA 146, MCL 125.2781 to 125.2797; the Neighborhood Enterprise zone act, 1992 PA 147, MCL 207.771 to 207.786; the Commercial Rehabilitation Act, 2005 PA 210, MCL 207.841 to 207.856; or that portion of the tax levied under the Tax Reverted Clean Title Act, 2003

PA 260, MCL 211.1021 to 211.1026, that is not required to be distributed to a land bank fast track authority.

(ee) "Tax increment revenues" means the amount of ad valorem property taxes and specific taxes attributable to the application of the levy of all taxing jurisdictions upon the captured taxable value of each parcel of eligible property subject to a brownfield plan and personal property located on that property. Tax increment revenues exclude ad valorem property taxes specifically levied for the payment of principal of and interest on either obligations approved by the electors or obligations pledging the unlimited taxing power of the local governmental unit, and specific taxes attributable to those ad valorem property taxes. Tax increment revenues attributable to eligible property also exclude the amount of ad valorem property taxes or specific taxes captured by a downtown development authority, tax increment finance authority, or local development finance authority if those taxes were captured by these other authorities on the date that eligible property became subject to a brownfield plan under this act.

(ff) "Taxable value" means the value determined under Section 27a of the General Property Tax Act, 1893 PA 206, MCL 211.27a.

(gg) "Taxes levied for school operating purposes" means all of the following:

(i) The taxes levied by a local school district for operating purposes.

(ii) The taxes levied under the state education tax act, 1993 PA 331, MCL 211.901 to 211.906.

(iii) That portion of specific taxes attributable to taxes described under subparagraphs (i) and (ii).

(hh) "Transit-oriented development" means infrastructure improvements that are located within 1/2 mile of a transit station or transit-oriented facility that promotes transit ridership or passenger rail use as determined by the board and approved by the municipality in which it is located.

(ii) "Transit-oriented facility" means a facility that houses a transit station in a manner that promotes transit ridership or passenger rail use.

(jj) "Work plan" means a plan that describes each individual activity to be conducted to complete eligible activities and the associated costs of each individual activity.

(kk) "Zone" means, for an authority established before June 6, 2000, a brownfield redevelopment zone designated under this act.

II. ELIGIBLE PROPERTIES

STONE VILLAGE
1721 PROBERT ROAD
SUMMIT TOWNSHIP
JACKSON COUNTY, MICHIGAN

Introduction

The property is a single parcel of land located at 1721 Probert Road in Summit Township. The subject property consists of an approximately three acre parcel with a tax identification number of 000-13-15-451-046-16.

The property is a single parcel of land. The property appears to have first been developed in the 1880s with construction of stone barns on the property as part of the original agricultural operation known as Bennett Farm. The Bennett Family owned the site until the early 1900s. The Probert Family acquired the property by 1911 and continued to farm the surrounding lands and use the barns on site for livestock and storage. In the mid-1940s, the property was sold to the Beaman Family who used portions of the property as art galleries, a theatre and residences. At about this time a large portion of the buildings were used or leased for industrial purposes. Manufacturers operating at the site included Jaxon Wire Products, owned by Thomas Beaman. Other manufacturers who operated on the site included Coyler Products (1946-1947), Wid-Lee Machine and Tool (1949), Hy-Air Products (1949 – 1951), Main and Co. (1955), and Trident Corp. (1955), none apparently lasting more than a few years. Jaxon Wire Products continued to operate at the site until 1982.

The buildings that Jaxon Wire operated in are dilapidated with significant roof damage, water intrusion and other factors that have caused the buildings to decay. Asbestos-containing materials were identified on the property including a significant amount of thermal system insulation. In the basement, much of this insulation had come loose from steam pipes and had fallen onto the ground. Trench drains have been cut into the floor to convey steam, water and wastewater piping. Electrical systems are outdated and no longer working in portions of the building. The property is an “eligible property” based on the designation of the property as “functionally obsolete”. The property has been evaluated by the Summit Township Assessor, a Level 3 Assessor, and determined to meet the definition of “functionally obsolete” as defined in PA 381 of 1996. A copy of the determination is provided in Attachment D.

The property has been acquired by Bennett Holdings, LLC who intends to make significant improvements to the property to make the buildings suitable for residential condominiums. The anticipated investment is $600,000 to $1,000,000 to create three to four condominiums. It is not yet known if these condominiums will be used as principal residences or not.

The subject property consists of a single parcel of land with a tax identification number of 000-13-14-326-093-00. The legal description, obtained from the Summit Township Assessing Department, is as follows:

> *BEG AT S 1/4 POST OF SEC 15 TH N 773.96 FT (RECORD 774.76 FT) ALG N&S 1/4 LN TH S89DEG00'46''E 334.47 FT (RECORD 334.55 FT) TO POB TH CONTINUING S89DEG00'46''E 96.60 FT TH N00DEG01'37''W46.10 FT TH S89DEG58'37''E 44.94 FT TH N42DEG28'51''E 59.21 FT TH N00DEG01'37''W 156 FT TH N89DEG57'37''E 212.67 FT TH S00DEG02'43''E 449.84 FT TH S89DEG56'07''W 352.76 FT TH TH N00DEG02'31''W 180.99 FT TH N89DEG59'21''W 41.56 FT TH N00DEG01'22''E 25 FT TO BEG SEC 15 T3S R1W - 2.99A SPLIT ON 09/13/2004 FROM 000-13-15-451-046-01, 000-13-15-451-046-10 AND ENTIRE 000-13-15-451-046-06; SPLIT ON 3/28/2007 FROM 000-13-15-451-046-15; SPLIT ON 3/28/2007 FROM 000-13-15-451-046-15*

Basis of Eligibility

The property is an "eligible property" based on the designation of the property as "functionally obsolete". The property has been evaluated by the Summit Township Assessor, a Level 3 Assessor, and determined to meet the definition of "functionally obsolete" as defined in PA 381 of 1996. A copy of the determination is provided in Attachment D. The basis upon which the property was deemed functionally obsolete includes the fact that the building was constructed for agricultural barns and later adapted to manufacturing. According to the Assessor's Affidavit "*the building has functional obsolescence with respect to roof structure being in poor condition (shingle, underlayment, and trusses will need to be replaced). Repair of the roof structure may not be economically feasible. In current condition, functionality for use as residential housing, the existing plumbing, electrical, interior would require major renovation and may not be economically feasible. Highest and Best use based on current zoning, types of businesses in surrounding area, would be residential.*"

THE PLAN

(a) A description of the costs of the plan intended to be paid for with tax increment revenues (Section 13(1)(a))

This Brownfield Plan anticipates acquisition of the property and redevelopment of the site as for residential condominiums. This Plan anticipates an investment in real and personal property of $600,000 to $1,000,000 in the property.

The Jackson County Brownfield Redevelopment Authority conducted an environmental assessment and asbestos survey of the property in order to spur redevelopment of the property. This Plan is intended to reimburse the Authority for these costs.

MDEQ costs eligible for reimbursement under this Plan include the following:

- Cost of Preparing this Brownfield Plan ($2,500)
- Costs of Environmental Assessment Activities ($7,700)
- Authority expenses in adoption/implementation of the Brownfield Plan ($5,000)
- Contingencies (15%)

The cost of preparing this Brownfield Plan is estimated at $2,500. This cost is being borne by the Jackson County Brownfield Redevelopment Authority. Additional costs (estimated at $5,000) may be borne by the Authority for publication costs of public hearing notices and other eligible Authority administrative activities. The Authority has also funded environmental assessment activities at the property including a Phase I and II Environmental Site Assessment and asbestos survey. The total cost for baseline environmental assessment activities is $7,700.

Upon full reimbursement for these *actual* eligible costs, the tax increment will be captured for placement in the Local Site Remediation Revolving Fund (LSSRF) for five full years. This Brownfield Plan anticipates the capture of personal property taxes and local taxes.

This Plan does not intend to pay for interest expense.

(b) A brief summary of the eligible activities that are proposed for each eligible property (Section 13(1)(b))

Eligible activities that will be or have been completed at this site include baseline environmental assessment activities (Phase I and II Environmental Site Assessment, asbestos survey), preparation of the Brownfield Plan, and eligible Authority expenses. Refer to Table 1.

(c) An estimate of the captured taxable value and tax increment revenues for each year of the plan from each parcel of eligible property. (Section 13(1)(c))

Refer to Table 2.

(d) The method by which the costs of the plan will be financed, including a description of any advances made or anticipated to be made for the costs of the plan from the municipality. (Section 13(1)(d))

Costs for development of the Environmental Site Assessments and Brownfield Plan were financed by the Jackson County Brownfield Redevelopment Authority utilizing a U.S. EPA Brownfield Assessment Grant. No advances are anticipated. Table 5 provides the estimated schedule for repayment to the Jackson County Brownfield Redevelopment Authority.

(e) The maximum amount of note or bonded indebtedness to be incurred, if any. (Section 13(1)(e))

The Authority has no plans to incur indebtedness at this time, though such plans could be made in the future, if appropriate to support development of this site.

(f) The duration of the Brownfield Plan, which shall not exceed the lesser of the period authorized under Subsections (4) and (5) or 30 years. (Section 13(1)(f))

This Plan anticipates that the investment in the property will occur over the next several years. The County intends to implement the Plan immediately (i.e., anticipates initiating this Plan in 2012). This Plan will then remain in place until the eligible activities have been fully reimbursed or

30 years, whichever occurs sooner. This is a phased project. This Plan presumes that the project will be completed over a period of four years and thus assumes that the taxable value will increase incrementally over that period of time.

Table 1

Summary of Eligible Costs to be Reimbursed by Brownfield Plan

1721 Probert Road
Summit Township, Michigan

MDEQ Eligible Activities*		**Estimated Cost**	
BEA Activities	County BRA	$	7,700.00
Due Care Activities			
Additional Response Activities			
Brownfield Plan	County BRA	$	2,500.00
Total MDEQ Eligible Activities		$	10,200.00
Contingencies (15%)		$	1,530.00
Financing Costs		**$**	**-**
TOTAL MDNRE ELIGIBLE COSTS AND CONTINGENCIES		**$**	**11,730.00**
MEGA Eligible Activities			
Total MEGA Eligible Activity Costs		$	-
Contingencies (15%)		$	-
Financing Costs			
TOTAL MEGA ELIGIBLE COSTS AND CONTINGENCIES		**$**	**-**
Authority Expense	County BRA	**$**	**5,000.00**
TOTAL BROWNFIELD PLAN ELIGIBLE COSTS		**$**	**16,730.00**
TOTAL REIMBURSEMENT TO DEVELOPER			
TOTAL REIMBURSEMENT TO COUNTY BRA		**$**	**16,730.00**
TOTAL REIMBURSEMENT TO LSRRF		**$**	**22,192.33**

Table 2

Estimate of Total Captured Incremental Taxes

1721 Probert Road
Summit Township, Michigan

Parcel 000-13-14-326-093-00 Real and Personal Property

Year	Annual Total Millage†	% Completion	Initial Taxable Value (Real and Personal Property)	Tax Revenues from Initial Taxable Value	Estimated Future Taxable Value	Estimated Future Tax Revenues	Incremental Tax Revenues	Available for Capture
2012	18.3216	0.2500	$ 63,956.00	$ 1,171.78	$ 75,000.00	$ 1,374.12	$ 202.34	$ 202.34
2013	18.3216	0.5000	$ 63,956.00	1,171.78	$ 150,000.00	2,748.24	1,576.46	$ 1,576.46
2014	18.3216	0.7500	$ 63,956.00	1,171.78	$ 225,000.00	4,122.36	2,950.58	$ 2,950.58
2015	18.3216	1.0000	$ 63,956.00	1,171.78	$ 300,000.00	5,496.48	4,324.70	$ 4,324.70
2016	18.3216	1.0000	$ 63,956.00	1,171.78	$ 300,000.00	5,496.48	4,324.70	$ 4,324.70
2017	18.3216	1.0000	$ 63,956.00	1,171.78	$ 300,000.00	5,496.48	4,324.70	$ 4,324.70
2018	18.3216	1.0000	$ 63,956.00	1,171.78	$ 300,000.00	5,496.48	4,324.70	$ 4,324.70
2019	18.3216	1.0000	$ 63,956.00	1,171.78	$ 300,000.00	5,496.48	4,324.70	$ 4,324.70
2020	18.3216	1.0000	$ 63,956.00	1,171.78	$ 300,000.00	5,496.48	4,324.70	$ 4,324.70

† - Does not include school or debt millages, based on millages from Winter 2010 and Summer 2011

(g) An estimate of the impact of tax increment financing on the revenues of all taxing jurisdictions in which the eligible property is located. (Section 13(1)(g))

Refer to Tables 3, 4 and 5.

(h) A legal description of each parcel of eligible property to which the plan applies, a map showing the location and dimensions of each eligible property, a statement of the characteristics that qualify the property as eligible property and a statement of whether personal property is included as part of the eligible property. (Section 13(1)(h))

The subject property consists of a single parcel of land with a tax identification number of 000-13-14-326-093-00. The legal description, obtained from the Summit Township Assessing Department, is as follows:

> *BEG AT S 1/4 POST OF SEC 15 TH N 773.96 FT (RECORD 774.76 FT) ALG N&S 1/4 LN TH S89DEG00'46''E 334.47 FT (RECORD 334.55 FT) TO POB TH CONTINUING S89DEG00'46''E 96.60 FT TH N00DEG01'37''W46.10 FT TH S89DEG58'37''E 44.94 FT TH N42DEG28'51''E 59.21 FT TH N00DEG01'37''W 156 FT TH N89DEG57'37''E 212.67 FT TH S00DEG02'43''E 449.84 FT TH S89DEG56'07''W 352.76 FT TH TH N00DEG02'31''W 180.99 FT TH N89DEG59'21''W 41.56 FT TH N00DEG01'22''E 25 FT TO BEG SEC 15 T3S R1W - 2.99A SPLIT ON 09/13/2004 FROM 000-13-15-451-046-01, 000-13-15-451-046-10 AND ENTIRE 000-13-15-451-046-06; SPLIT ON 3/28/2007 FROM 000-13-15-451-046-15; SPLIT ON 3/28/2007 FROM 000-13-15-451-046-15*

A map showing the location of the property is included in Attachment A.

The site has been determined to be “functionally obsolete” and is thus an “eligible property”.

Personal property will be included as part of the eligible property.

(i) Estimates of the number of persons residing on each eligible property to which the plan applies and the number of families and individuals to be displaced. (Section 13(1)(i))

One residence currently exists on the property with a single family. No families or persons will be displaced by the project.

(j) A plan for establishing priority for the relocation of persons displaced by implementation of the plan. (Section 13(1)(j))

Not applicable.

(k) Provision for the costs of relocating persons displaced by implementation of the plan. (Section 13(1)(k))

Not applicable.

(l) A strategy for compliance with 1972 PA 227, MCL 213.321 to 213.332. (Section 13(1)(l))

Not applicable.

(m) A description of proposed use of the local site remediation revolving fund. (Section 13(1)(m))

The Brownfield Redevelopment Authority's Local Site Remediation Revolving Fund (LSRRF) will capture five full years of the tax increment after the eligible activities have been reimbursed.

(n) Other material that the authority or governing body considers pertinent. (Section 13(1)(n))

At this time, it is not known if the future condominiums will meet the principal residence exemption from the School Operating Tax. Regardless, all eligible activities completed at the property were completed prior to adoption of the Brownfield Plan and thus only the local tax increment will be captured.

Table 3

Estimate of Annual Captured Incremental Taxes for Each Affected Taxing Jurisdiction
(Real and Personal Property)
After full development

Stone Village
1721 Probert Road
Summit Township, Michigan

Parcel 000-13-14-326-093-00

Taxing Jurisdiction		Township	Med Care	Library	Jail	Senior Svcs	Police Fire	ISD	School Debt 2004	School Debt 2010	State Ed	School Operating	JP Oper Pub Rec	Comm College	County	Total
Millage		0.8168	0.1398	1.2593	0.4851	0.2473	1	8.11	2.4	0.65	6	18	0.2	1.1446	5.1187	45.5716
Initial Taxable Value	$ 63,956.00	$ 52.24	$ 8.94	$ 80.54	$ 31.03	$ 15.82	$ 63.96	$ 518.68	$ 153.49	$ 41.57	$ 383.74	$ 1,151.21	$ 12.79	$ 73.20	$ 327.37	$ 2,914.58
Future Taxable Value	$ 300,000.00	$ 245.04	$ 41.94	$ 377.79	$ 145.53	$ 74.19	$ 300.00	$ 2,433.00	$ 720.00	$ 195.00	$ 1,800.00	$ 5,400.00	$ 60.00	$ 343.38	$ 1,535.61	$ 13,671.48
Captured Taxable Value	$ 236,044.00	$ 192.80	$ 33.00	$ 297.25	$ 114.50	$ 58.37	$ 236.04	$ 1,914.32						$ 270.18	$ 1,208.24	$ 4,324.70

Plan does not include capture of school or debt millages
*Based on millages from Winter 2010 taxes and Summer 2011 taxes

Total Millages	45.5716
Total Non-School Millages	18.3216
Total School Millages	27.2500
Total Captured Millages	44.9216
Total Annual Tax Liability	$ 13,671.48
Total Annual Capturable Tax Increment	$ 4,324.70
Total School Tax Increment Capturable	$ -
Total Non-School Tax Increment Capturable	$ 4,324.70

Table 4

Captured Taxable Value and Tax Increment Revenue by Year and Aggregate for Each Taxing Jurisdiction
1721 Probert Road
Summit Township, Michigan

Parcel 000-13-14-326-093-00 Real and Personal Property

Year	Captured Taxable Value	Township	Med Care	Library	Jail	Senior Svcs	Police Fire	ISD	School Debt 2004	School Debt 2010	State Ed	School Operating	JP Oper Pub Rec	Comm College	County	Total
		0.8168	0.1398	1.2593	0.4851	0.2473	1	8.11	2.4	0.65	6	18	0.2	1.1446	5.1187	45.5716
2012	$ 11,044.00	9.02	1.54	13.91	5.36	2.73	11.04	89.57						12.64	56.53	202.34
2013	$ 86,044.00	70.28	12.03	108.36	41.74	21.28	86.04	697.82						98.49	440.43	1,576.46
2014	$ 161,044.00	131.54	22.51	202.80	78.12	39.83	161.04	1,306.07						184.33	824.34	2,950.58
2015	$ 236,044.00	192.80	33.00	297.25	114.50	58.37	236.04	1,914.32						270.18	1,208.24	4,324.70
2016	$ 236,044.00	192.80	33.00	297.25	114.50	58.37	236.04	1,914.32						270.18	1,208.24	4,324.70
2017	$ 236,044.00	192.80	33.00	297.25	114.50	58.37	236.04	1,914.32						270.18	1,208.24	4,324.70
2018	$ 236,044.00	192.80	33.00	297.25	114.50	58.37	236.04	1,914.32						270.18	1,208.24	4,324.70
2019	$ 236,044.00	192.80	33.00	297.25	114.50	58.37	236.04	1,914.32						270.18	1,208.24	4,324.70
2020	$ 236,044.00	192.80	33.00	297.25	114.50	58.37	236.04	1,914.32						270.18	1,208.24	4,324.70
TOTAL CAPTURED TAXES		$ 1,367.65	$ 234.08	$ 2,108.57	$ 812.25	$ 414.08	$ 1,674.40	$ 13,579.35	$ -	$ -	$ -	$ -	$ -	$ 1,916.51	$ 8,570.73	$ 30,677.61

Table 5

Reimbursement Schedule

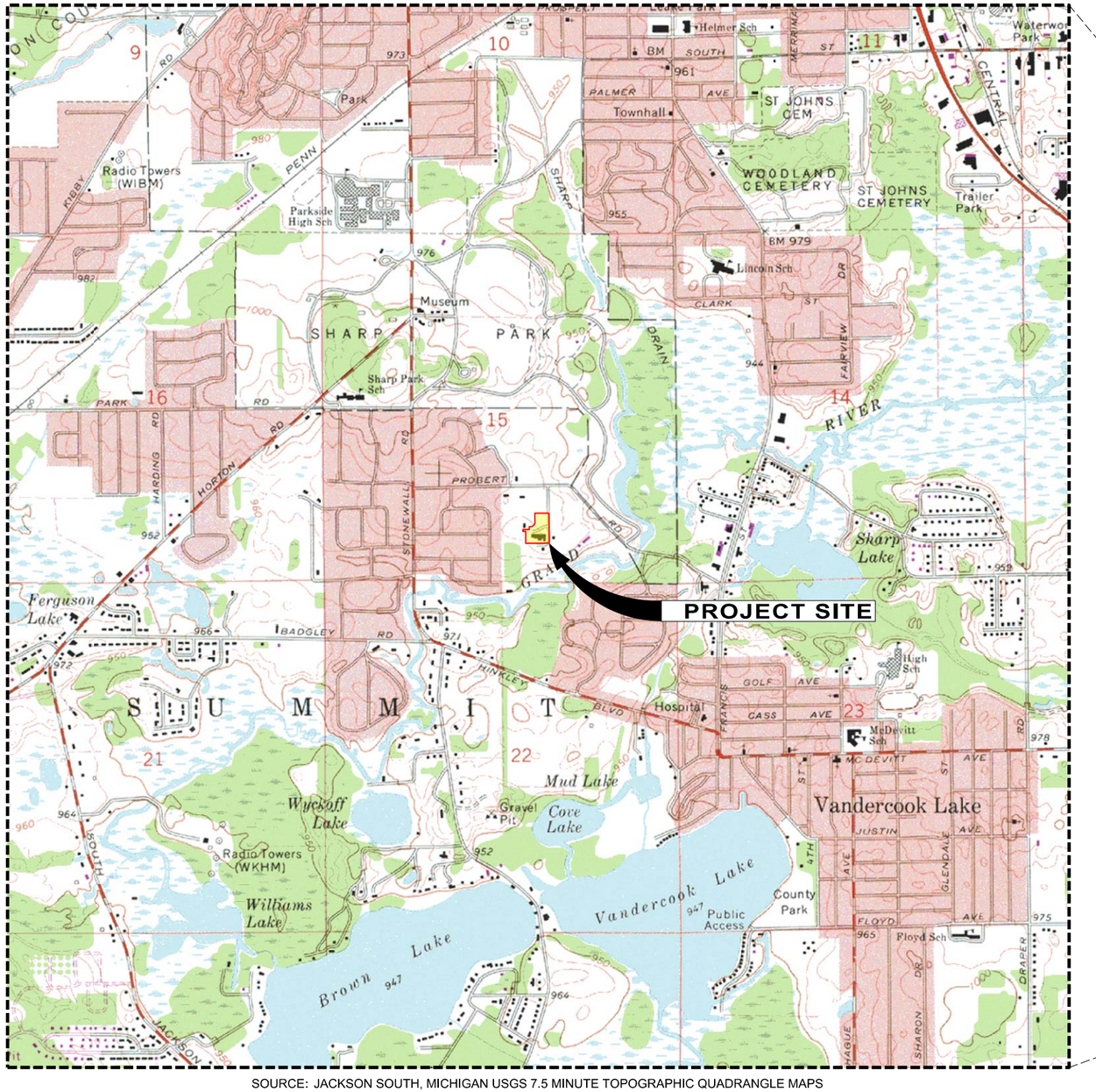
1721 Probert Road
Summit Township, Michigan

Year		Incremental Taxes Captured	Reimbursement to Developer		Reimbursement to County BRA		Local Site Remediation Revolving Fund
			Annual	Aggregate	Annual	Aggregate	
2012	School Incremental Tax Captured	$ -			$ -		
	Non-School Incremental Tax Captured	$ 4,324.70			$ 4,324.70		
	Total Incremental Tax Captured	$ 4,324.70				$ 4,324.70	
2013	School Incremental Tax Captured	$ -			$ -		
	Non-School Incremental Tax Captured	$ 4,324.70			$ 4,324.70		
	Total Incremental Tax Captured	$ 4,324.70				$ 8,649.41	
2014	School Incremental Tax Captured	$ -			$ -		
	Non-School Incremental Tax Captured	$ 4,324.70			$ 4,324.70		
	Total Incremental Tax Captured	$ 4,324.70				$ 12,974.11	
2015	School Incremental Tax Captured	$ -			$ -		
	Non-School Incremental Tax Captured	$ 4,324.70			$ 3,755.89		$ 568.82
	Total Incremental Tax Captured	$ 4,324.70				$ 16,730.00	
2016	School Incremental Tax Captured	$ -					$ -
	Non-School Incremental Tax Captured	$ 4,324.70					$ 4,324.70
	Total Incremental Tax Captured	$ 4,324.70					
2017	School Incremental Tax Captured	$ -					$ -
	Non-School Incremental Tax Captured	$ 4,324.70					$ 4,324.70
	Total Incremental Tax Captured	$ 4,324.70					
2018	School Incremental Tax Captured	$ -					$ -
	Non-School Incremental Tax Captured	$ 4,324.70					$ 4,324.70
	Total Incremental Tax Captured	$ 4,324.70					
2019	School Incremental Tax Captured*	$ -					$ -
	Non-School Incremental Tax Captured	$ 4,324.70					$ 4,324.70
	Total Incremental Tax Captured	$ 4,324.70					
2020	School Incremental Tax Captured	$ -					
	Non-School Incremental Tax Captured	$ 4,324.70					$ 4,324.70
	Total Incremental Tax Captured	$ 4,324.70					
Totals				$ -		$ 16,730.00	$ 22,192.33

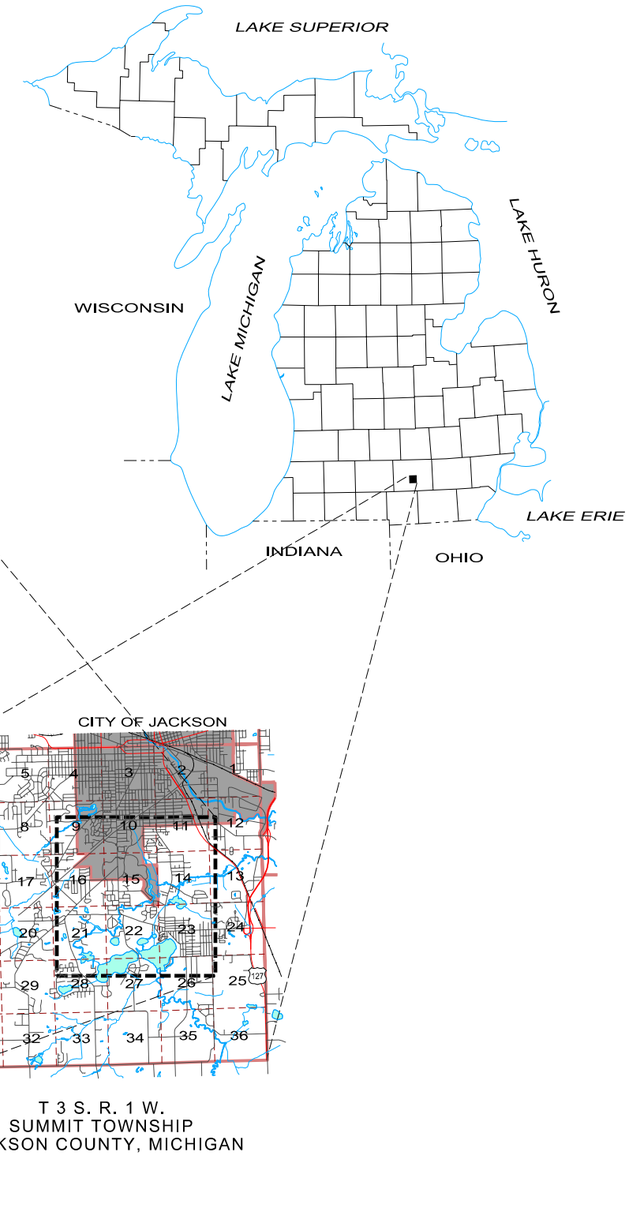
ATTACHMENT A

FIGURES

Location Map: USGS Topographic Map
Site Plans



SOURCE: JACKSON SOUTH, MICHIGAN USGS 7.5 MINUTE TOPOGRAPHIC QUADRANGLE MAPS
MAPTECH© U.S. TERRAIN SERIES™ ®MAPTECH©, INC. 606-433-8500



T 3 S. R. 1 W.
SUMMIT TOWNSHIP
JACKSON COUNTY, MICHIGAN

N

0 500 1000 2000 4000

SCALE 1" = 2000'

envirologic
environmental consulting + services
2960 INTERSTATE PARKWAY
KALAMAZOO, MICHIGAN 49048
PH: (269) 342-1100 FAX: (269) 342-4945

BENNETT HOLDINGS LLC

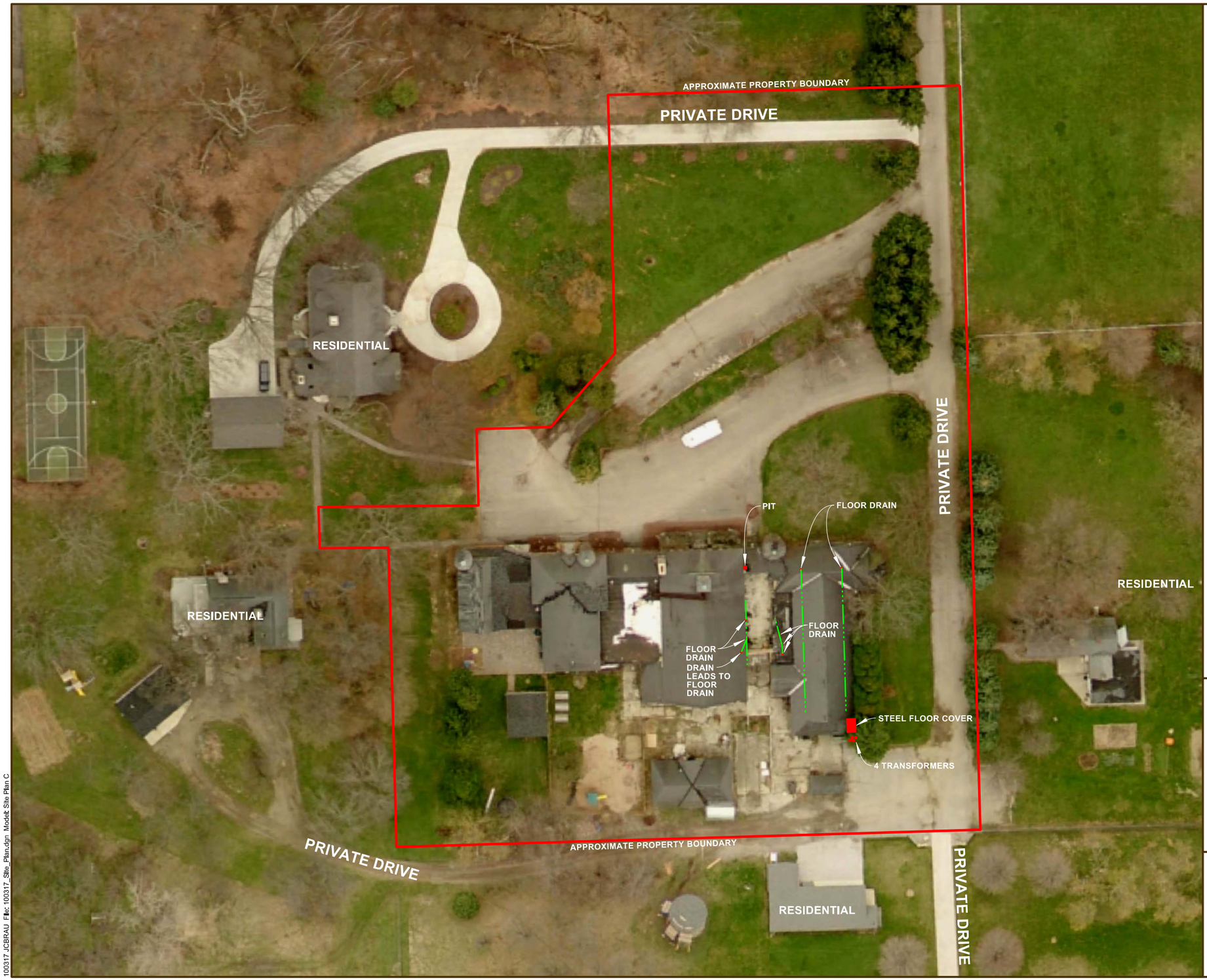
1721 PROBERT ROAD
JACKSON, MICHIGAN 49203

LOCATION MAP

PROJECT NO.
100317

FIGURE No.
1

100317 JCBRAU File: 100317_Site_Plan.dgn Model: Location Map



N

SCALE 1" = 60'

0 10 20 30 60 120

NOTE: AERIAL PHOTOGRAPHY: 2007 COLOR ORTHOPHOTO, OBTAINED FROM THE JACKSON COUNTY ON LINE GIS VIEWER.

NOTE:
THIS IS NOT A PROPERTY BOUNDARY SURVEY, PROPERTY BOUNDARIES SHOWN ON THIS MAP ARE BASED ON AVAILABLE FURNISHED INFORMATION AND ARE APPROXIMATE ONLY AND SHOULD NOT BE USED TO ESTABLISH PROPERTY BOUNDARY LOCATION IN THE FIELD.

BENNETT HOLDINGS LLC

1721 PROBERT ROAD
JACKSON, MICHIGAN 49203

SITE PLAN

envirologic
environmental consulting + services
2960 INTERSTATE PARKWAY
KALAMAZOO, MICHIGAN 49048
PH: (269) 342-1100 FAX: (269) 342-4945

PROJECT NO.
100317

FIGURE No.
2

ATTACHMENT B

NOTICE OF PUBLIC HEARING

ATTACHMENT C

NOTICE TO TAXING JURISDICTIONS

ATTACHMENT D

RESOLUTION APPROVING A BROWNFIELD PLAN

DETERMINATION OF FUNCTIONAL OBSOLESCENCE

SUMMIT TOWNSHIP
2121 FERGUSON RD
JACKSON, MI. 49203

August, 22 2011

Dear Mr. James Dunn:

I, Brian Small testify to the following:

1. I am employed by Township of Summit and have held the position of Assessor for one year and the title of Deputy Assessor for nine years prior to being the Assessor.
2. I am a certified Level 3 Assessor and have held that certification since 2008.
3. I am familiar with the property located at 1721 Probert Rd.
4. This affidavit is given to confirm that the site qualifies as "Functionally Obsolete Property" as that term is defined under MCL 125.2652(r). The following facts form the basis of my expert opinion:
    a. Building was originally constructed for agricultural use in the late 1800's and converted to manufacturing around the 1940's.
    b. Building has functional obsolescence with respect to roof structure being in poor condition (shingle, underlayment and trusses will need to be replaced) Repair of the roof structure may not be economically feasible.
    c. In current condition, functionality for use as residential housing, the existing plumbing, electrical, interior would require major renovation and may not be economically feasible.
    d. Highest and Best use based on current zoning, types of businesses in surrounding area would be residential.

Sincerely,
Brian Small
Township of Summit Assessor

NOTICE OF PUBLIC HEARING

THE BROWNFIELD REDEVELOPMENT AUTHORITY
OF JACKSON COUNTY

REGARDING INCLUSION INTO THE COUNTY'S BROWNFIELD PLAN
FOR PROPERTY LOCATED AT
1721 PROBERT ROAD, JACKSON, MI
LOCATED WITHIN
SUMMIT TOWNSHIP, IN THE
COUNTY OF JACKSON, MICHIGAN

TO ALL INTERESTED PERSONS IN THE COUNTY OF JACKSON

PLEASE TAKE NOTICE that the County Commissioners of the County of Jackson, Michigan, will hold a Public Hearing on Tuesday, the 18th day of October, 2011, at approximately 7:10 p.m., Eastern Daylight time in the Commissioners Chambers within the County Tower Building, 120 W. Michigan Avenue, Jackson, Michigan, to receive public comment on an amendment to the County's Brownfield Redevelopment Plan to include therein portions of 1721 Probert Road. The parcels are legally described as:

Property Number: 000-13-15-451-046-16:
BEG AT S ¼ POST OF SEC 15 TH N 773.96 FT (RECORD 774.76 FT) ALG N&S ¼ LN TH S89DEG00'46"E 334.47 FT (RECORD 334.55 FT) TO POB TH CONTINUING S89DEG00'46"E 96.60 FT TH N00DEG01'37" W 46.10 FT TH S89DEG58'37"E 44.94 FT TH N42DEG28'51"E 59.21 FT TH N00DEG01'37"W 156 FT TH N89DEG57'37"E 212.67 FT TH S00DEG02'43"E 449.84 FT TH S89DEG56'07"W 352.76 FT TH N00DEG02'31"W 180.99 FT TH N89DEG59'21"W 41.56 FT TH N00DEG01'22"E 25 FT TO BEG SEC 15 T3S R1W – 2.99A SPLIT ON 09/13/2004 FROM 000-13-15-451-046-01, 000-13-15-451-046-10 AND ENTIRE 000-13-15-451-046-06; SPLIT ON 3/28/2007 FROM 000-13-15-451-046-15; SPLIT ON 3/28/2007 FROM 000-13-15-451-046-15.

The property consists of a single parcel of land with approximately 3 acres, more or less and is commonly described as 1721 Probert Road, Jackson, Michigan 49203 (also known as Stone Village).

The Brownfield Plan, which includes a site map, is available for public inspection at the County Brownfield Redevelopment Authority office, located at One Jackson Square, 11th Floor, Jackson, Michigan, which can be obtained via email by request to dkelly@enterprisegroup.org. All aspects of the plan are open for discussion at the public hearing.

FURTHER INFORMATION may be obtained from the Brownfield Redevelopment Authority of Jackson County at (517) 788-4458. THIS NOTICE is given by order of the County Board of the County of Jackson, Michigan.

Amanda Riska, Clerk
County of Jackson

JACKSON COUNTY, MICHIGAN

RESOLUTION (10-11.35)
APPROVING A BROWNFIELD PLAN
BY THE COUNTY OF JACKSON
PURSUANT TO AND IN ACCORDANCE WITH
THE PROVISIONS OF ACT 381 OF THE PUBLIC ACTS
OF THE STATE OF MICHIGAN OF 1996, AS AMENDED

At a regular meeting of the Board of Commissioners of Jackson County, Michigan, held in the County Tower Building located at 120 W. Michigan Ave., Jackson, Michigan, on the 18th day of October 2011, at 7:00 p.m.

PRESENT:

ABSENT:

MOTION BY:

SUPPORTED BY:

WHEREAS, the Jackson County Board of Commissioners, pursuant to and in accordance with the provisions of the Brownfield Redevelopment Financing Act, being Act 381 of the Public Acts of the State of Michigan of 1996, as amended (the "Act"), have formally resolved to participate in the Brownfield Redevelopment Authority (BRA) of Jackson County (the "Authority") and have designated that all related activities shall proceed through the BRA; and

WHEREAS, the Authority, pursuant to and in accordance with Section 13 of the Act, has reviewed, adopted and recommended for approval by the Jackson County Board of Commissioners, the Brownfield plan (the "Plan") attached hereto, to be carried out within Summit Township, relating to the redevelopment project proposed by Bennett Holdings/Stone Village Condo Project, located at 1721 Probert Road in Summit Township, (the "Site"), as more particularly described and shown in Figures 1 & 2 and Attachment "A" contained within the attached Plan; and

WHEREAS, the Jackson County Board of Commissioners and the County's taxing entities has reviewed the Plan, and have been provided a reasonable opportunity to express their views and recommendations regarding the Plan and in accordance with Sections 13 (13) of the Act; and

WHEREAS, the Jackson County Board of Commissioners has made the following determinations and findings:

A. The Plan constitutes a public purpose under the Act;

B. The Plan meets all of the requirements for a Brownfield plan set forth in Section 13 of the Act;

C. The proposed method of financing the costs of the eligible activities, as described in the Plan, is feasible and will not require the Authority to arrange the financing;

D. The costs of the eligible activities proposed in the Plan are reasonable and necessary to carry out the purposes of the Act;

E. School taxes will not be captured in accordance with Plan; and

WHEREAS, as a result of its review of the Plan, the Jackson County Board of Commissioners concurs with approval of the Plan.

NOW, THEREFORE, BE IT RESOLVED THAT:

1. **Plan Approved**. Pursuant to the authority vested in the Jackson County Board of Commissioners by the Act, the Plan is hereby approved in the form attached to this Resolution.

2. **Severability**. Should any section, clause or phrase of this Resolution be declared by the courts to be invalid, the same shall not affect the validity of this Resolution as a whole nor any part thereof other than the part so declared to be invalid.

3. **Repeals**. All resolutions or parts of resolutions in conflict with any of the provisions of this Resolution are hereby repealed.

AYES:

NAYES:

ABSTAINED:

RESOLUTION DECLARED ADOPTED.

STATE OF MICHIGAN)
COUNTY OF JACKSON) ss:

I, the undersigned, the fully qualified Clerk of Jackson County, State of Michigan, do hereby certify that the foregoing is a true and complete copy of a resolution adopted by the County Board of Commissioners of Jackson County at a regular meeting held on the 18th day of October, 2011, the original of which resolution is on file in my office.

IN WITNESS WHEREOF, I have hereunto set my official signature this ____ day of _____, 2011.

_____
Amanda Riska, Jackson County Clerk

MINUTES
JACKSON COUNTY BOARD OF COMMISSIONERS BOARD MEETING
September 20, 2011
7:00 p.m.
County Commission Chambers

1. **CALL TO ORDER** – Chairman Steve Shotwell called the September 20, 2011 Board of Commissioners Meeting to order at 7:00 p.m.

2. **INVOCATION** – by Commissioner David Elwell

3. **PLEDGE OF ALLEGIANCE** – by Chairman Shotwell

4. **ROLL CALL** – County Clerk Amanda Riska

(12) Present. Commissioners Herl, Lutchka, Rice, Duckham, Alexander, Videto, Mahoney, Williams, Smith, Way, Elwell, and Shotwell.

5. **APPROVAL OF AGENDA**

Moved by Videto, supported by Mahoney for ***Approval of the Agenda.*** Motion carried unanimously.

6. **AWARDS & RECOGNITIONS** – None.

7. **COMMUNICATIONS/PETITIONS** – None.

8. **SPECIAL ORDERS/PUBLIC HEARINGS** – None.

9. **PUBLIC COMMENTS** – None.

10. **SPECIAL MEETINGS OF STANDING COMMITTEES** – None.

11. **MINUTES** – Minutes of the 8/23/11 Regular Meeting of the Jackson County Board of Commissioners

Moved by Mahoney, supported by Williams ***to Approve the Minutes of the 8/23/11 Regular Meeting of the Jackson County Board of Commissioners.*** Motion carried unanimously.

12. **CONSENT AGENDA**

Moved by Mahoney, supported by Way ***for Approval of the Consent Agenda.***
Roll Call: (12) Yeas. Motion carried unanimously.

A. County Policy – None.

B. County Affairs & Agencies

1. Resolution (09-11.28) Authorizing Property Acquisition for Runway #7-25 Safety Area Project – Eaton Aeroquip

C. Human Services

2. Initiation of Fees for Court Ordered Testing (COT)

3. Authorization for the Jackson County Health Department to Enter into the FY 2012 Comprehensive Agreement with the Michigan Department of Community Health

4. Region 2 Area Agency on Aging Annual Implementation Plan FY 2012

D. Personnel & Finance

5. Authorize a Loan from the Register of Deeds Automation Fund to the County in the Amount of $37,736 and to the Treasurer in the Amount of $42,152 and Approve the Purchase of Upgrades to the BS&A Software with the Associated Training and Hardware

6. Create Full-time Position of Senior Accountant to Provide Vital Financial Services for the County and the Unique Accounting/Grant Needs of the Health Department

7. Approve Resolution (09-11.29) Establishing the ICMA-Retirement Corporation 401 Defined Contribution Plan

8. Budget Adjustments

a. Health Department

E. Other Business

9. Claims dated 8/1/11 – 8/31/11

13. STANDING COMMITTEES

A. County Policy – Commissioner Dave Elwell – None.

B. County Affairs & Agencies – Commissioner Dave Lutchka – None.

C. Human Services – Commissioner Jon Williams

1. Resolution (09-11.30) Department of Human Services Board of Directors Requesting Use of Post-1998 MOE Funds for Payment to Replace the Faultily Constructed and Leaking (since January 2003) Roof of the Jackson County Medical Care Facility

Moved by Williams, supported by Mahoney, ***to Approve Resolution (09-11.30) Department of Human Services Board of Directors Requesting Use of Post-1998 MOE Funds for Payment to Replace the Faultily Constructed and Leaking (since January 2003) roof of the Jackson County Medical Care Facility.*** Roll Call: (12) Yeas. Motion carried unanimously.

D. Personnel and Finance – Commissioner Jim Videto – None.

14. UNFINISHED BUSINESS – None.

15. NEW BUSINESS – None.

16. PUBLIC COMMENTS – None.

17. COMMISSIONER COMMENTS

Commissioner Way thanked the Board for allowing him to attend the MAC Conference. After speaking with commissioners from other counties, he found that Jackson is ahead of the curve in many areas.

Commissioner Alexander also attended the MAC Conference and thanked the Board for allowing her to do so. She is very proud of Jackson County and what it has to offer.

Commissioner Mahoney asked for prayer for her son who just had surgery. She also thanked the Board for allowing her to attend a very successful Retirement Conference.

Chairman Shotwell also attended the Retirement Conference and found that Jackson County is one of the leaders in retirement programs. He appreciates the Board allowing him and Commissioner Mahoney to attend.

18. CLOSED SESSION – None.

19. ADJOURNMENT

Chairman Shotwell adjourned the September 20, 2011 Meeting of the Jackson County Board of Commissioners at 7:13 p.m.

James E. Shotwell – Chairman, Jackson County Board of Commissioners

Amanda L. Riska – County Clerk

COUNTY OF JACKSON
POLICY MANUAL

ADMINISTRATIVE **Policy No. 5160**

MATERIAL AND EQUIPMENT STORAGE AND/OR DISPOSAL

I. Policy

It is the policy of the Board of Commissioners that items of value are stored in a way that maximizes the lifespan of the county's investment and disposed of in a manner that maximizes the return. It is the policy of the Board of Commissioners that the cost and time dedicated to the disposal of equipment shall be proportional to the remaining value.

II. Procedure

A. Storage and/or disposal of Jackson County equipment and materials are~~is~~ the responsibility of the Fleet & Facilities Operations Department. County departments that have excess equipment or materials shall contact the Fleet & Facilities Operations Department for the appropriate forms and procedures.

B. The Fleet & Facilities Operations Department shall supply a disposal form to Department Heads and Elected Officials. The disposal form shall accommodate the following policies.

1. Items of significant value shall be disposed of in a manner that maximizes the remaining value.

2. Except where legally obligated, I~~L~~arge expenses shall not be incurred for the disposal of items with little remaining value. ~~except where legally obligated.~~

3. Other departments shall have the right~~s~~ to acquire property no longer needed by another department

C. The Fleet & Facilities Operations Director may authorize a Department Head or Elected Official to directly dispose of items with little value.

D. The Fleet & Facilities Operations Department shall maintain a copy of all disposal request forms. A copy of the disposal request form shall be provided to the Finance Officer and the Administrator/Controller's Office ~~. Special consideration may be given for the sale of stored items at the discretion of the Director of Fleet & Facilities Operations Manager and the Administrator/Controller.~~

Adopted 12/18/01
Reviewed: 3/16/10
Revised: 10/18/11

COUNTY OF JACKSON
POLICY MANUAL

BOARD RULES

POLICY NO. 4045

ARTICLE IV
AGENDA ITEM FORMAT

I. Policy

Requests by County Department Heads and Elected Officials to the County Board of Commissioners ~~should~~ shall cover the same basic content, in addition to other items deemed necessary by the Department Head or Elected Official, to enable Commissioners to make informed decisions.

II. Basic Elements – The agenda item must include the following elements for the Board of Commissioners to consider action.

A. Motion Requested by the Board of Commissioners

B. Background Information

C. Current Situation

D. Analysis

1. Strategic (required) – State how the proposed action relates to the Board's strategic priorities.

2. Financial (required) – Address what impact the requested action has on the county's approved budget.

3. Legal (required) – State the legal implications for the requested action. This section may also include policy limitations with the proposed action.

4. Timing (required) – Address why the issue must be acted upon now and what time frames are important to the decision making process.

5. Other (optional) – Any other pertinent analysis which may be helpful for the decision making process.

E. Alternatives to the Proposed Action

III. Template

The attached template is included for reference by Department Heads and Elected Officials. The template may be altered by the Administrator/Controller so long as it complies with the contents of the policy.

JXN

Jackson County Airport

3606 Wildwood Avenue Jackson, Michigan 49202
(517) 788-4225 FAX (517) 788-4682

September 23, 2011

TO: Michael Overton, Administrator/Controller

FROM: Kent Maurer, Airport Manager

RE: Donation of Concrete Materials and Installation Labor by R.W. Mercer Company for Aviation Heritage Park

Requested action: Agenda Item for County Board of Commissioners to Accept This Donation

Generated Income: Donation of concrete materials and labor for Aviation Heritage Park

Funding: Private

Background: Mr. Kirk Mercer of R.W. Mercer Company, Jackson, has offered to supply materials and labor for the "patio" area associated with the (William Maher) WWII monument to WWII aviators associated with the Civilian Pilot Training Program prior to WWII.

Recommendation: Accept the donation by consent or motion

Attachments: Letter to Airport Board

JXN

Jackson County Airport

3606 Wildwood Avenue Jackson, Michigan 49202
(517) 788-4225 FAX (517) 788-4682

August 3, 2011

TO: Airport Board Members

FROM: Kent Maurer, Airport Manager

RE: Aviation Heritage Park Donation

On August 2, 2011 I participated in a meeting Mr. Bill Maher and Mr. Kirk Mercer of the Mercer Company. Discussion occurred about the WWII monument project "The Aviator" with specific details about the concrete work and footing for the monument. Mr. Kirk Mercer offered to produce a landscape plan and install the concrete at no cost to the Airport. The design will be in keeping with the one the Airport Board and Advisory Council have previously approved.

I am writing to request Airport Board approval of this donation by the Mercer Company of Jackson, Michigan.

RESOLUTION (10-11.33)
AUTHORIZING THE COUNTY BOARD OF COMMISSIONERS
CHAIR, James E. Shotwell Jr. TO SIGN MDOT CONTRACT
#2011-0525 (FEDERAL PROJECT #B-26-0051-3011),
For Preliminary Engineering Runway 7-25
And Paint Markings for Runway 6-24

WHEREAS, The FAA has indicated that Runway 6-24 at the Jackson County Airport does not have required "safety areas" at the ends and approaches; and

WHEREAS, Because of FAA Runway Safety Requirements, a new Runway 7-25 will be constructed; and

WHEREAS, Preliminary engineering for Runway 7-25 is required and necessary so that a proper runway design can be completed; and

WHEREAS, Existing Runway 6-24 requires new paint markings in order to maintain FAA approval for the ILS system and to maintain a safe runway; and

WHEREAS, Grant funds in the amount of $300,000 were allocated by the Michigan Office of Aeronautics with an allocation of $285,000 Federal; $7,500 State and $7,500 Local match amounts are required for the referenced projects; and

WHEREAS, The Jackson County Board of Commissioners has legal authority to approve this resolution and sponsor contract; and

WHEREAS, James E. Shotwell, Jr., is the Chairman of the Jackson County Board of Commissioners and has authority to sign such resolution and contract; and

NOW, THEREFORE, BE IT RESOLVED, that the Jackson County Board of Commissioners approves of the referenced grant and contract authorizes James E. Shotwell Jr. to sign on behalf of the Jackson County Board of Commissioners.

_____
James E. Shotwell, Jr., Chairman
October 18, 2011

STATE OF MICHIGAN)
) ss.
COUNTY OF JACKSON)

I, Amanda Riska, the duly qualified and acting Clerk of the County of Jackson, Michigan, do hereby certify that the foregoing is a true and complete copy of a Resolution adopted by the County Board of Commissioners of the County of Jackson, State of Michigan, at a regular meeting held on October 18, 2011 at which meeting a quorum was present and remained throughout and that an original thereof is on file in the records of the County. I further certify that said meeting was conducted and public notice of said meeting was given pursuant to and in full compliance with the Open Meetings Act, being Act No. 267, Public Acts of Michigan, 1976, and that the minutes of said meeting were kept and will be or have been made available as required by said Act.

_____
Amanda Riska, County Clerk

Date: _____

JXN

Jackson County Airport

3606 Wildwood Avenue Jackson, Michigan 49202
(517) 788-4225 FAX (517) 788-4682

TO: Michael Overton, Administrator/Controller

FROM: Kent Maurer, Airport Manager

SUBJECT: MDOT-Grant for Preliminary Engineering of Runway 7-25 and Airfield Paint Marking of Runway 6-24

DATE: October 3, 2011

Motion Requested: Approve the Sponsor Contract with MDOT-Aeronautics and adopt the Resolution that supports the Sponsor Contract.

I. Background

The grant will fund preliminary engineering of future runway 7-25. The other part of this grant will fund paint markings on existing runway 6-24.

II. Current Situation

Preliminary engineering must be completed this year in order to eventually construct new runway 7-25. The paint markings on runway 6-24 have faded and require new paint.

III. Analysis

Federal share = $285,000.00 State share = $7,500 Local share = $7,500*

This item is being directly submitted to the County Commission prior to review by the Airport Board in order to expedite the approval process.

*Funding for local share is contained within the Runway Match Public Improvement budget

IV. Recommendation

Adopt the attached resolution and approve the sponsor contract.

Attachments: Draft resolution and Sponsor Contract excerpts

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF TRANSPORTATION
LANSING

KIRK T. STEUDLE
DIRECTOR

September 28, 2011

Kent Maurer, Airport Manager
Jackson County-Reynolds Field
3606 Wildwood Avenue
Jackson, Michigan 49202

Dear Mr. Maurer:

SUBJECT: Jackson County-Reynolds Field
Jackson, Michigan
Fed. Proj. No. F-26-0051-3011
MDOT Contract No. 2011-0525

Enclosed are the original and one copy of the above-described contract between your organization and the Michigan Department of Transportation. Please take time to read and understand this contract **(noting the special conditions in Appendix F)**. If this contract meets with your approval, please complete the following checklist:

____ **PLEASE DO NOT DATE THE CONTRACTS**. MDOT will date the contracts when they are executed. (A contract is **not** executed unless both parties have signed it.)

____ Secure the necessary signatures on both contracts.

____ **Include a certified resolution/authorization that specifically names the official(s) authorized to sign the contract**. One must be submitted even though you may have submitted one to us in the past.

_____ If applicable, please provide any credit documentation to the project manager as soon as possible.

____ Return both copies of the contract to my attention at the address below for execution by MDOT. In order to meet the scheduled project start date and/or timely processing of project costs, **please return the contract by October 12, 2011**. One fully executed contract will be forwarded to you.

If you have any questions, please call me at 517-335-9960.

Sincerely,

Anu Taneja, Contract Administrator
Office of Aeronautics

Enclosures
cc: Amanda Hopper
Neal Barncard
File

CONTRACT NO. 2011-0525
FEDERAL PROJECT NO. F-26-0051-3011
AGENDA: DAB

MICHIGAN DEPARTMENT OF TRANSPORTATION

JACKSON COUNTY BOARD OF COMMISSIONERS

CONTRACT FOR A FEDERAL/STATE/LOCAL

AIRPORT PROJECT

UNDER THE BLOCK GRANT PROGRAM

This Contract is made and entered into this date of _____ by and between the Michigan Department of Transportation, hereinafter referred to as the "DEPARTMENT," and Jackson County Board of Commissioners, hereinafter referred to as the "SPONSOR," for the purpose of fixing the rights and obligations of the parties in agreeing to the following undertaking at the Jackson County - Reynolds Field, whose associated city is Jackson, Michigan, such undertaking hereinafter referred to as the "PROJECT," estimated in detail in Exhibit 1, dated September 16, 2011, attached hereto and made a part hereof.

PROJECT DESCRIPTION: PRELIMINARY DESIGN FOR RUNWAY 7/25 AND AIRFIELD PAINT MARKING FOR RUNWAY 6/24.

WITNESSETH:

WHEREAS, the PROJECT is eligible for federal funding pursuant to the Airport and Airway Improvement Act of 1982, as amended, and/or the Aviation Safety and Noise Abatement Act of 1979; and

WHEREAS, the DEPARTMENT has received a block grant from the Federal Aviation Administration (FAA) for airport development projects; and

WHEREAS, the DEPARTMENT is responsible for the allocation and management of block grant funds pursuant to the above noted act;

NOW, THEREFORE, the parties agree:

1. The term "PROJECT COST," as herein used, is defined in Attachment(s) 1, attached hereto and made a part hereof. The PROJECT COST will also include administrative costs incurred by the DEPARTMENT in connection with the PROJECT. Administrative costs incurred by the SPONSOR are not eligible PROJECT COSTS.

THE SPONSOR WILL:

2. Enter into a contract with a consultant for each element of the PROJECT that requires expertise. The consultant will be selected in conformity with FAA Advisory Circular 150/5100-14. The DEPARTMENT will select the consultant for each element of the PROJECT involving preparation of environmental documentation. The SPONSOR will select the consultant for all other aspects of the PROJECT. All consultant contracts will be submitted to the DEPARTMENT for review and approval. Any such approvals will not be construed as a warranty of the consultant's qualifications, professional standing, ability to perform the work being subcontracted, or financial integrity. The SPONSOR will neither award a consultant contract nor authorize the consultant to proceed prior to receiving written approval of the contract from the DEPARTMENT. Any change to the consultant contract will require prior written approval from the DEPARTMENT. In the event that the consultant contract is terminated, the SPONSOR will give immediate written notice to the DEPARTMENT.

3. Make payment to the DEPARTMENT for the SPONSOR's share of the PROJECT COSTS within thirty (30) days of the billing date. The DEPARTMENT will not make payments for any PROJECT work prior to receipt of payment from the SPONSOR for the SPONSOR's share of that item of the PROJECT work.

   Eligible PROJECT COSTS that are paid by the SPONSOR may be submitted for credit toward the SPONSOR's share of the PROJECT COST provided that they are submitted within one hundred eighty (180) days of the date the costs were incurred or within one hundred eighty (180) days of the date of award of this Contract by the parties, whichever is later. Documentation of the PROJECT COST will include copies of the invoices on which the SPONSOR will write the amounts paid, the check numbers, the voucher numbers, and the dates of the checks. Each invoice will be signed by an official of the SPONSOR as proof of payment. The amount of the SPONSOR billing will be reduced by the amount of the eligible credit, based on documentation submitted, provided it is submitted prior to the date of the billing. Should it be determined that the SPONSOR has been given credit for payment of ineligible items of work, the SPONSOR will be billed an amount to insure that the SPONSOR share of PROJECT COSTS is covered.

   The SPONSOR pledges sufficient funds to meet its obligations under this Contract.

4. With regard to audits and record-keeping,

   a. The SPONSOR will establish and maintain accurate records, in accordance with generally accepted accounting principles, of all expenses incurred for which payment is sought or made under this Contract, said records to be hereinafter

referred to as the "RECORDS." Separate accounts will be established and maintained for all costs incurred under this Contract.

b. Audit and Inspection. The SPONSOR will comply with the Single Audit Act of 1984, as amended, including, but not limited to, the Single Audit Amendments of 1996 (31 U.S.C. 7501-7507) the OMB Circular A-133, as revised or amended, and the provisions of 1951 PA 51; MCL 247.660h; MSA 9.1097(10i), as applicable, that is in effect at the time of Contract award with regard to audits.

i. Agencies expending a total of Five Hundred Thousand Dollars ($500,000.00) or more in federal funds from one or more funding sources in their fiscal year will comply with the requirements of the federal Office of Management and Budget (OMB) Circular A-133, as revised or amended.

The SPONSOR will submit two (2) copies of:

- The Reporting Package
- The Data Collection Package
- The management letter to the SPONSOR, if one issued by the audit firm

The OMB Circular A-133 audit must be submitted to the address below in accordance with the time frame established in the circular, as revised or amended.

ii. Agencies expending less than Five Hundred Thousand Dollars ($500,000.00) in federal funds must submit a letter to the DEPARTMENT advising that a circular audit was not required. The letter will indicate the applicable fiscal year, the amount of federal funds spent, the name(s) of the DEPARTMENT federal programs, and the CFDA grant number(s). This information must also be submitted to the address below.

iii. Address: Michigan Department of Transportation
Office of Aeronautics
Attn: Aviation Services Division
2700 Port Lansing Road
Lansing, MI 48906-2060

iv. Agencies must also comply with applicable state laws and regulations relative to audit requirements.

v. Agencies will not charge audit costs to the DEPARTMENT's federal programs that are not in accordance with the aforementioned OMB Circular A-133 requirements.

vi. All agencies are subject to the federally-required monitoring activities, which may include limited scope reviews and other on-site monitoring.

vii. The federal award associated with this Contract is CFDA Airport Improvement Program number 20.106, Federal Project Number F-26-0051-3011, award year 2011, Federal Aviation Administration, Department of Transportation.

c. The SPONSOR will maintain the RECORDS for at least six (6) years from the date of final payment made by the DEPARTMENT under this Contract. In the event of a dispute with regard to allowable expenses or any other issue under this Contract, the SPONSOR will thereafter continue to maintain the RECORDS at least until that dispute has been finally decided and the time for all available challenges or appeals of that decision has expired.

d. The DEPARTMENT or its representative may inspect, copy, or audit the RECORDS at any reasonable time after giving reasonable notice.

e. If any part of the work is subcontracted, the SPONSOR will assure compliance with subsections (a), (b), (c), and (d) above for all subcontracted work.

5. Provide and will require its subcontractors to provide access by the DEPARTMENT or its representatives to all technical data, accounting records, reports, and documents pertaining to this Contract. Copies of technical data, reports, and other documents will be provided by the SPONSOR or its subcontractors to the DEPARTMENT upon request. The SPONSOR agrees to permit representatives of the DEPARTMENT to inspect the progress of all PROJECT work at any reasonable time. Such inspections are for the exclusive use of the DEPARTMENT and are not intended to relieve or negate any of the SPONSOR's obligations and duties contained in this Contract. All technical data, reports, and documents will be maintained for a period of six (6) years from the date of final payment.

6. The SPONSOR agrees to require all prime contractors to pay each subcontractor for the satisfactory completion of work associated with the subcontract no later than ten (10) calendar days from the receipt of each payment the prime contractor receives from the DEPARTMENT or SPONSOR. The prime contractor also is required to return retainage payments to each subcontractor within ten (10) calendar days after the subcontractor's work is satisfactorily completed. Any delay or postponement of payment from these time frames may occur only upon receipt of written approval from the DEPARTMENT. These requirements are also applicable to all sub-tier subcontractors and will be made a part of all subcontract agreements.

This prompt payment provision is a requirement of 49 CFR, Part 26, as amended, and does not confer third-party beneficiary right or other direct right to a subcontractor against the DEPARTMENT. This provision applies to both Disadvantaged Business Enterprise (DBE) and non-DBE subcontractors.

The SPONSOR further agrees that it will comply with 49 CFR, Part 26, as amended, and will report any and all DBE subcontractor payments to the DEPARTMENT semi-annually in the format set forth in Appendix G, dated July 2010, attached hereto and made a part hereof, or any other format acceptable to the DEPARTMENT.

7. In the performance of the PROJECT herein enumerated, by itself, by a subcontractor, or by anyone acting on its behalf, comply with any and all state, federal, and local applicable statutes, ordinances, and regulations. The SPONSOR further agrees to obtain all permits that are applicable to the entry into and the performance of this Contract.

   The SPONSOR agrees to comply with the Special Conditions set forth in Appendix F, attached hereto and made a part hereof.

   In addition, the SPONSOR agrees to accomplish the project in compliance with the FAA "Terms and Conditions of Accepting Airport Improvement Program Grants" signed on April 20, 2011.

THE DEPARTMENT WILL:

8. Bill the SPONSOR for the SPONSOR's share of the estimated PROJECT COST. The DEPARTMENT will bill the SPONSOR for the SPONSOR's share of additional estimated PROJECT COSTS for changes approved in accordance with Section 14 at the time of award of the amendment for approved work.

9. Upon receipt of payment request approved by the SPONSOR, make payment for eligible PROJECT COSTS. The DEPARTMENT will seek reimbursement from the FAA through the block grant issued to the DEPARTMENT for funds expended on eligible PROJECT COSTS.

   The DEPARTMENT will not make payments for any PROJECT work prior to receipt of payment from the SPONSOR for the SPONSOR's share of that item of PROJECT work.

10. Make final accounting to the SPONSOR upon completion of the PROJECT, payment of all PROJECT COSTS, and completion of necessary audits. Any excesses or deficiencies will be returned or billed to the SPONSOR.

IT IS FURTHER AGREED:

11. The PROJECT COST participation is estimated to be as shown below and as in the attached Exhibit 1. Exhibit 1 is to be considered an estimate. The actual DEPARTMENT, FAA, and SPONSOR shares of the PROJECT COST will be determined at the time of financial closure of the FAA grant.

Federal Share	$285,000.00
Maximum DEPARTMENT Share	$7,500.00
SPONSOR Share	$7,500.00
Estimated PROJECT COST	$300,000.00

12. The PROJECT COST will be met in part with federal funds granted to the DEPARTMENT by the FAA through the block grant program and in part with DEPARTMENT funds. Upon final settlement of cost, the federal funds will be applied to the federally-funded parts of this Contract at a rate not to exceed ninety-five percent (95%) up to and not to exceed the maximum federal obligations shown in Section 11 or as revised in a budget letter, as set forth in Section 14. Those parts beyond the federal funding maximum may be eligible for state funds at a rate not to exceed ninety percent (90%) up to and not to exceed the maximum DEPARTMENT obligation shown in Section 11.

For portions of the PROJECT where only DEPARTMENT and SPONSOR funds will be applied to the final settlement, DEPARTMENT funds will be at a rate not to exceed ninety percent (90%), and the total DEPARTMENT funds applied toward the PROJECT COST may be up to but will not exceed the maximum DEPARTMENT obligations shown in Section 11 or as revised in a budget letter, as set forth in Section 14. Any items of PROJECT COST not funded by FAA or DEPARTMENT funds will be the sole responsibility of the SPONSOR.

DEPARTMENT funds in this Contract made available through legislative appropriation are based on projected revenue estimates. The DEPARTMENT may reduce the amount of this Contract if the revenue actually received is insufficient to support the appropriation under which this Contract is made.

13. The SPONSOR agrees that the costs reported to the DEPARTMENT for this Contract will represent only those items that are properly chargeable in accordance with this Contract. The SPONSOR also certifies that it has read the Contract terms and has made itself aware of the applicable laws, regulations, and terms of this Contract that apply to the reporting of costs incurred under the terms of this Contract.

14. The PROJECT COST shown in Section 11 is the maximum obligation of DEPARTMENT and federal funds under this Contract. The maximum obligation of DEPARTMENT and federal funds may be adjusted to an amount less than the maximums shown in Section 11 through a budget letter issued by the DEPARTMENT. A budget letter will be used when updated cost estimates for the PROJECT reflect a change in the amount of funds needed to fund all PROJECT COSTS. The budget letter will be signed by the Administrator of Airports Division of the Office of Aeronautics.

A budget letter will also be used to add or delete work items from the PROJECT description, provided that the costs do not exceed the maximum obligations of Section 11. If the total amount of the PROJECT COST exceeds the maximum obligations shown

in Section 11, the PROJECT scope will have to be reduced or a written amendment to this Contract to provide additional funds will have to be awarded by the parties before the work is started.

15. In the event it is determined by the DEPARTMENT that there will be either insufficient funds or insufficient time to properly administer such funds for the entire PROJECT or portions thereof, the DEPARTMENT, prior to advertising or authorizing work performance, may cancel the PROJECT or any portion thereof by giving written notice to the SPONSOR. In the event this occurs, this Contract will be void and of no effect with respect to the canceled portion of the PROJECT. Any SPONSOR deposits on the canceled portion less PROJECT COST incurred on the canceled portions will be refunded following receipt of a letter from the SPONSOR requesting excess funds be returned or at the time of financial closure, whichever comes first.

16. In the event that an audit performed by or on behalf of the DEPARTMENT indicates an adjustment to the costs reported under this Contract or questions the allowability of an item of expense, the DEPARTMENT will promptly submit to the SPONSOR a Notice of Audit Results and a copy of the audit report, which may supplement or modify any tentative findings verbally communicated to the SPONSOR at the completion of an audit.

Within sixty (60) days after the date of the Notice of Audit Results, the SPONSOR will (a) respond in writing to the responsible Bureau of the DEPARTMENT indicating whether or not it concurs with the audit report, (b) clearly explain the nature and basis for any disagreement as to a disallowed item of expense, and (c) submit to the DEPARTMENT a written explanation as to any questioned or no opinion expressed item of expense, hereinafter referred to as the "RESPONSE." The RESPONSE will be clearly stated and will provide any supporting documentation necessary to resolve any disagreement or questioned or no opinion expressed item of expense. Where the documentation is voluminous, the SPONSOR may supply appropriate excerpts and make alternate arrangements to conveniently and reasonably make that documentation available for review by the DEPARTMENT. The RESPONSE will refer to and apply the language of the Contract. The SPONSOR agrees that failure to submit a RESPONSE within the sixty (60) day period constitutes agreement with any disallowance of an item of expense and authorizes the DEPARTMENT to finally disallow any items of questioned or no opinion expressed cost.

The DEPARTMENT will make its decision with regard to any Notice of Audit Results and RESPONSE within one hundred twenty (120) days after the date of the Notice of Audit Results. If the DEPARTMENT determines that an overpayment has been made to the SPONSOR, the SPONSOR will repay that amount to the DEPARTMENT or reach agreement with the DEPARTMENT on a repayment schedule within thirty (30) days after the date of an invoice from the DEPARTMENT. If the SPONSOR fails to repay the overpayment or reach agreement with the DEPARTMENT on a repayment schedule within the thirty (30) day period, the SPONSOR agrees that the DEPARTMENT will deduct all or a portion of the overpayment from any funds then or thereafter payable by the DEPARTMENT to the SPONSOR under this Contract or any other agreement or

payable to the SPONSOR under the terms of 1951 PA 51, as applicable. Interest will be assessed on any partial payments or repayment schedules based on the unpaid balance at the end of each month until the balance is paid in full. The assessment of interest will begin thirty (30) days from the date of the invoice. The rate of interest will be based on the Michigan Department of Treasury common cash funds interest earnings. The rate of interest will be reviewed annually by the DEPARTMENT and adjusted as necessary based on the Michigan Department of Treasury common cash funds interest earnings. The SPONSOR expressly consents to this withholding or offsetting of funds under those circumstances, reserving the right to file a lawsuit in the Court of Claims to contest the DEPARTMENT's decision only as to any item of expense the disallowance of which was disputed by the SPONSOR in a timely filed RESPONSE.

17. This Contract will be in effect from the date of award through twenty (20) years.

18. Failure on the part of the SPONSOR to comply with any of the conditions in this Contract may be considered cause for placing the SPONSOR in a state of noncompliance, thereby making the SPONSOR ineligible for future federal and/or state funds until such time as the noncompliance issues are resolved. In addition, this failure may constitute grounds for cancellation of the PROJECT and/or repayment of all grant amounts on a pro rata basis, if the PROJECT has begun. In this Section, pro rata means proration of the cost of the PROJECT over twenty (20) years, if the PROJECT has not yet begun.

19. Any approvals, acceptances, reviews, and inspections of any nature by the DEPARTMENT will not be construed as a warranty or assumption of liability on the part of the DEPARTMENT. It is expressly understood and agreed that any such approvals, acceptances, reviews, and inspections are for the sole and exclusive purposes of the DEPARTMENT, which is acting in a governmental capacity under this Contract, and that such approvals, acceptances, reviews, and inspections are a governmental function incidental to the PROJECT under this Contract.

    Any approvals, acceptances, reviews, and inspections by the DEPARTMENT will not relieve the SPONSOR of its obligations hereunder, nor are such approvals, acceptances, reviews, and inspections by the DEPARTMENT to be construed as a warranty as to the propriety of the SPONSOR's performance, but are undertaken for the sole use and information of the DEPARTMENT.

20. In connection with the performance of PROJECT work under this Contract, the parties (hereinafter in Appendix A referred to as the "contractor") agree to comply with the State of Michigan provisions for "Prohibition of Discrimination in State Contracts," as set forth in Appendix A, attached hereto and made a part hereof. The parties further covenant that they will comply with the Civil Rights Act of 1964, being P.L. 88-352, 78 Stat. 241, and the Regulations of the United States Department of Transportation (49 CFR, Part 21) issued pursuant to said Act, including Appendix B, attached hereto and made a part hereof, and will require similar covenants on the part of any contractor or subcontractor employed in the performance of this Contract.

The SPONSOR will carry out the applicable requirements of the DEPARTMENT's Disadvantaged Business Enterprise (DBE) program and 49 CFR Part 26, including, but not limited to, those requirements set forth in Appendix C, dated October 1, 2005, attached hereto and made a part hereof.

21. In accordance with 1980 PA 278; MCL 423.321 et seq; MSA 17.458(22), et seq, the SPONSOR, in the performance of this Contract, will not enter into a contract with a subcontractor, manufacturer, or supplier listed in the register maintained by the United States Department of Labor of employers who have been found in contempt of court by a federal court of appeals on not less than three (3) separate occasions involving different violations during the preceding seven (7) years for failure to correct an unfair labor practice, as prohibited by Section 8 of Chapter 372 of the national Labor Relations Act, 29 USC 158. The DEPARTMENT may void this Contract if the name of the SPONSOR or the name of a subcontractor, manufacturer, or supplier utilized by the SPONSOR in the performance of this Contract subsequently appears in the register during the performance period of this Contract.

22. With regard to claims based on goods or services that were used to meet the SPONSOR's obligation to the DEPARTMENT under this Contract, the SPONSOR hereby irrevocably assigns its right to pursue any claims for relief or causes of action for damages sustained by the State of Michigan or the DEPARTMENT due to any violation of 15 USC, Sections 1 - 15, and/or 1984 PA 274, MCL 445.771 - .788, excluding Section 4a, to the State of Michigan or the DEPARTMENT.

    The SPONSOR shall require any subcontractors to irrevocably assign their rights to pursue any claims for relief or causes of action for damages sustained by the State of Michigan or the DEPARTMENT with regard to claims based on goods or services that were used to meet the SPONSOR's obligation to the DEPARTMENT under this Contract due to any violation of 15 USC, Sections 1 - 15, and/or 1984 PA 274, MCL 445.771 - .788, excluding Section 4a, to the State of Michigan or the DEPARTMENT as a third-party beneficiary.

    The SPONSOR shall notify the DEPARTMENT if it becomes aware that an antitrust violation with regard to claims based on goods or services that were used to meet the SPONSOR's obligation to the DEPARTMENT under this Contract may have occurred or is threatened to occur. The SPONSOR shall also notify the DEPARTMENT if it becomes aware of any person's intent to commence, or of commencement of, an antitrust action with regard to claims based on goods or services that were used to meet the SPONSOR's obligation to the DEPARTMENT under this Contract.

23. In any instance of dispute and/or litigation concerning the PROJECT, the resolution thereof will be the sole responsibility of the party/parties to the contract that is/are the subject of the controversy. It is understood and agreed that any legal representation of the SPONSOR in any dispute and/or litigation will be the financial responsibility of the SPONSOR.

24. The DEPARTMENT and the FAA will not be subject to any obligations or liabilities by contractors of the SPONSOR or their subcontractors or any other person not a party to this Contract without its specific consent and notwithstanding its concurrence in or approval of the award of any contract or subcontract or the solicitation thereof.

25. Each party to this Contract will remain responsible for any claims arising out of that party's performance of this Contract as provided by this Contract or by law.

This Contract is not intended to increase or decrease either party's liability for or immunity from tort claims.

This Contract is not intended to nor will it be interpreted as giving either party a right of indemnification, either by Contract or at law, for claims arising out of the performance of this Contract.

26. In case of any discrepancies between the body of this Contract and any exhibit hereto, the body of the Contract will govern.

27. This Contract will become binding on the parties and of full force and effect upon signing by the duly authorized representatives of the SPONSOR and the DEPARTMENT and upon adoption of a resolution approving said Contract and authorizing the signature(s) thereto of the respective representative(s) of the SPONSOR, a certified copy of which resolution will be sent to the DEPARTMENT with this Contract, as applicable.

IN WITNESS WHEREOF, the parties have caused this Contract to be awarded.

JACKSON COUNTY BOARD OF COMMISSIONERS

By: _____

Title:

MICHIGAN DEPARTMENT OF TRANSPORTATION

By: _____

Title: Department Director

EXHIBIT 1

JACKSON COUNTY-REYNOLDS FIELD
JACKSON, MICHIGAN

Project No. F-26-0051-3011
Contract No. FM 38-01-C72 & C73

September 16, 2011

	Federal	State	Local	Total
ADMINISTRATION	$475	$12	$13	$500
DEPARTMENT-AERO	$475	$12	$13	$500
ENVIRONMENTAL	$0	$0	$0	$0
DESIGN	$265,525	$6,988	$6,987	$279,500
Preliminary design for runway 7/25 C72				
AERO - Design C72	$5,919	$156	$155	$6,230
CONSULTANT - Design C72	$259,606	$6,832	$6,832	$273,270
CONSTRUCTION	$19,000	$500	$500	$20,000
Airfield paint marking - runway 6/24 C73	$19,000	$500	$500	$20,000
CONTINGENCIES	$0	$0	$0	$0
Funding Contingency	$0	$0	$0	$0
TOTAL PROJECT BUDGET	**$285,000**	**$7,500**	**$7,500**	**$300,000**

MAC Transfer: 7/27/11

RESOLUTION ( )
AUTHORIZING THE COUNTY BOARD OF COMMISSIONERS CHAIR, James E. Shotwell Jr. TO SIGN MDOT CONTRACT #2011-0525 (FEDERAL PROJECT #B-26-0051-3011), For Preliminary Engineering Runway 7-25 And Paint Markings for Runway 6-24

WHEREAS, The FAA has indicated that Runway 6-24 at the Jackson County Airport does not have required "safety areas" at the ends and approaches; and

WHEREAS, Because of FAA Runway Safety Requirements, a new Runway 7-25 will be constructed; and

WHEREAS, Preliminary engineering for Runway 7-25 is required and necessary so that a proper runway design can be completed; and

WHEREAS, Existing Runway 6-24 requires new paint markings in order to maintain FAA approval for the ILS system and to maintain a safe runway; and

WHEREAS, Grant funds in the amount of $300,000 were allocated by the Michigan Office of Aeronautics with an allocation of $285,000 Federal; $7,500 State and $7,500 Local match amounts are required for the referenced projects; and

WHEREAS, The Jackson County Board of Commissioners has legal authority to approve this resolution and sponsor contract; and

WHEREAS, James E. Shotwell, Jr., is the Chairman of the Jackson County Board of Commissioners and has authority to sign such resolution and contract; and

NOW, THEREFORE, BE IT RESOLVED, that the Jackson County Board of Commissioners approves of the referenced grant and contract authorizes James E. Shotwell Jr. to sign on behalf of the Jackson County Board of Commissioners.

_____
James E. Shotwell, Jr., Chairman
October 18, 2011

STATE OF MICHIGAN)
) ss.
COUNTY OF JACKSON)

I, Amanda Riska, the duly qualified and acting Clerk of the County of Jackson, Michigan, do hereby certify that the foregoing is a true and complete copy of a Resolution adopted by the County Board of Commissioners of the County of Jackson, State of Michigan, at a regular meeting held on October 18, 2011 at which meeting a quorum was present and remained throughout and that an original thereof is on file in the records of the County. I further certify that said meeting was conducted and public notice of said meeting was given pursuant to and in full compliance with the Open Meetings Act, being Act No. 267, Public Acts of Michigan, 1976, and that the minutes of said meeting were kept and will be or have been made available as required by said Act.

_____
Amanda Riska, County Clerk

Date: _____

Memorandum

To: Jackson County Board of Commissioners

From: JoAnna LaGow, Equalization Deputy Director

Date: 10/10/2011

Re: 2011 Apportionment Report

Attached please find the unsigned copy of the 2011 apportionment report. I, JoAnna LaGow fulfilled all the information provided in the 2011 apportionment report (L-4402.) Please note this report has not been signed due to the absence of a qualified Equalization Director.

Michigan Department of Treasury

1020 (Rev. 9-02)

Statement Showing Taxable Valuations and Mills Apportioned by the County Board of Commissioners of the County of JACKSON for the Year 2011

L - 4402

This report is issued under the authority of P.A. 282 of 1905. Filing of this report is mandatory. Failure to complete and file this report may result in a penalty of $100.

1 Taxing Gov. Authority	2 Taxable Valuation	Millages 3 Charter or Allocated	Millages Extra Voted 4 EV Operating	Millages Extra Voted 5 Bldg.Site/Debt	6 Purpose
State Education Tax	**4,046,282,739**	6.0000			(less Industrial Personal TV & Ren Zones)
County	**4,162,037,740**	5.1187	0.8722		Med Care 0.1398 Jail 0.4851 Sr Services 0.2473 minus ren zones
Townships:					
Blackman	506,600,516	0.8313	2.0000		Public Safety
Blackman ReZ	741,183				
Blackman Tool & Die Rez	929,107				
Columbia	339,931,024	0.7214	1.3853		0.9236 police & 0.4617 fire
Columbia Tool & Die Rez	1,986,763				
Concord	69,956,220	0.8322	0.9435		Roads
Grass Lake	207,471,521	0.7033	1.2294	0.2560	Fire/Fire Station Debt
Grass Lake Tool & Die Rez	485,646			0.2560	Fire Station Debt
Hanover	122,667,996	0.7711	1.0000		Fire
Henrietta	125,159,286	0.7818			
Leoni	382,545,735	0.7671			
Leoni RenZ	1,090,397				
Leoni Tool & Die RenZ	263,804				
Liberty	105,352,313	0.7603			
Napoleon	219,407,224	0.8042		1.1300	Township Hall Debt
Napoleon Tool & Die Rez	815,479			1.1300	Township Hall Debt
Norvell	121,278,704	0.7738	0.8289		fire
Parma	66,922,205	0.8404	1.7130		1.2160 fire & 0.4970 police
Pulaski	46,037,535	0.7388	1.4118		Fire
Rives	118,063,852	0.7758			
Sandstone	132,164,879	0.7929	1.7042		1.2042 fire & 0.50 police
Spring Arbor	190,880,067	0.8668	1.1000		Fire
Spring Arbor Tool & Die ReZ	1,395,703				
Springport	47,422,269	0.8386	4.5000		1.50 fire+ 3.00 police
Summit	599,663,939	0.8168	1.0000		Police & Fire
Summit Ren Zone	2,536,279				
Tompkins	70,625,672	0.9002			
Waterloo	104,110,674	0.8464	0.4261		Public Safety
	3,586,505,992				

Once Completed, mail to: Michigan Department of Treasury, State Tax Commission, Treasury Building, Lansing, Michigan 48922.

Continued on page 2

L-4402

Statement Showing Taxable Valuations and Mills Apportioned by the County Board of Commissioners of the County of JACKSON for the Year 2011

This report is issued under the authority of P.A. 282 of 1905. Filing of this report is mandatory. Failure to complete and file this report may result in a penalty of $100.

7 Taxing Gov. Authority	8 Taxable Valuation	9 Total Tax Rates	10 Dollars of Ad Valorem Taxes Levied
Cities:			
Jackson	585,776,109	14.8389	8,692,273.10
City of Jackson ReZ	102,222,637	0.9500	97,111.51
City Tool & Die RenZ	3,670,246	0.9500	3,486.73
	691,668,992		
Villages:			
Brooklyn	38,361,543	13.6051	521,912.63
Tool & Die Ren Zone	127,902	3.5500	454.05
Cement City	988,603	10.0000	9,886.03
Concord	21,818,068	14.8574	324,159.76
Grass Lake	28,347,290	7.7032	218,364.84
Hanover	7,247,236	8.3024	60,169.45
Parma	34,783,609	5.0750	176,526.82
Springport	9,249,062	15.9536	147,555.84
			1,459,029.42

CERTIFICATION

I hereby certify that this report is a true statement of the taxable valuation of each assessing district and of all ad valorem millages apportioned by the County Board of Commissioners of the

County of JACKSON for the year 2011

Signature of County Equalization Director

NOTARIZATION

Notary Public

JACKSON County, Michigan

STATE OF MICHIGAN

County of JACKSON } ss

Subscribed before me this _____

day of _____ *year* _____

My commission expires _____, _____

It is Important That All City ad Valorem Taxes Be Entered On This Sheet. County Board Of Commissioners Do Not Certify City Or Village Tax Rates. These Rates Are For Informational Purposes Only. List All Authorities On Page 3. List All School Districts on Page 4.

Continued on page 3

L-4402

Statement Showing Taxable Valuations and Mills Apportioned by the County Board of Commissioners of the County of JACKSON for the Year 2011

This report is issued under the authority of P.A. 282 of 1905. Filing of this report is mandatory. Failure to complete and file this report may result in a penalty of $100.

11 Taxing Gov. Authority	12 Taxable Valuation	13 Operating Tax Rates	14 Debt Tax Rates	
District Libraries:				
Jackson District Library	4,162,037,740	1.2593		*County's taxable value less ren zones*
Other Authorities:				
City of Jackson DDA	87,249,729	1.9996		
Jackson Transporation Authority	585,776,109	1.0000		*city less ren zones*
(City of Jackson only)				
Stockbridge Area Emergency	104,110,674	1.0994		
Services Authority				
(Waterloo Twp only)				

Use this sheet to list all authorities within the county such as; District Libraries, Fire Auth., DDA*, etc.
List All School Districts On Page 4.
*Only list the DDAs that levy their own millage under MCL 125.1662 Sec 12. Do not list DDAs that capture.

Continued on page 4

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Statement Showing Taxable Valuations and Mills Apportioned by the County Board of Commissioners of the County of JACKSON for the Year 2011

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						Millages			
1 All Property	Non Home-Stead	Comm. Pers.	2 School Districts Name and Code	3 List Each Township/City Where Located Separately	4 Taxable Valuation For Each Township/City	5 **ISD Only Allocated**	Extra Voted 6 Operating	7 Bldg.Site/Debt	8 County Use (Notes)
X			**ADDISON SCHOOLS 46020**	LIBERTY	206,121			2.9500	10 debt
	X			LIBERTY	50,053		18.0000		
		X		LIBERTY	0				
X			**ALBION SCHOOLS 13010**	CONCORD	3,985,838			2.6500	95 debt
	X			CONCORD	272,821		18.0000		
		X		CONCORD	1,890		6.0000		
X				PARMA	6,888,530			2.6500	95 debt
	X			PARMA	2,122,215		18.0000		
		X		PARMA	120,577		6.0000		
X			**CHELSEA SCHOOLS 81040**	GRASS LAKE	796,529			7.5000	7.00 debt & 0.50 sinking fund
	X			GRASS LAKE	18,594		18.0000		
		X		GRASS LAKE	0				
X				WATERLOO	35,649,351			7.5000	7.00 debt & 0.50 sinking fund
	X			WATERLOO	8,158,493		18.0000		
		X		WATERLOO	59,500		6.0000		
X			**CHELSEA/GRASS LAKE 1504**	GRASS LAKE	229,769			7.5000	7.00 debt & 0.50 sinking fund
	X			GRASS LAKE	144,347		18.0000		
		X		GRASS LAKE	0				
X			**COLUMBIA SCHOOLS 38040**	COLUMBIA	324,296,676			1.1200	1.12(98 debt)
	X			COLUMBIA	119,151,071		18.0000		
		X		COLUMBIA	4,953,425		6.0000		
X				COLUMBIA TOOL & DIE REZ	1,986,763			1.1200	1.12(98 debt)
X				LIBERTY	27,962,444			1.1200	1.12(98 debt)
	X			LIBERTY	5,000,627		18.0000		
		X		LIBERTY	390,800		6.0000		
X				NORVELL	85,814,790			1.1200	1.12(98 debt)
	X			NORVELL	32,884,467		18.0000		
		X		NORVELL	382,548		6.0000		

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X			CONCORD SCHOOLS 38080	CONCORD	57,554,373			2.9300	2002 debt
	X			CONCORD	11,224,677		18.0000		
		X		CONCORD	731,350		6.0000		
X				PARMA	2,390,498			2.9300	2002 debt
	X			PARMA	233,976		18.0000		
		X		PARMA	62		6.0000		
X				PULASKI	30,966,205			2.9300	2002 debt
	X			PULASKI	5,379,842		18.0000		
		X		PULASKI	152,430		6.0000		
X				HANOVER	3,802,033			2.9300	2002 debt
	X			HANOVER	543,773		18.0000		
		X		HANOVER	0				
X				SPRING ARBOR	36,482,030			2.9300	2002 debt
	X			SPRING ARBOR	4,701,639		18.0000		
		X		SPRING ARBOR	143,376		6.0000		
X			EAST JACKSON SCHOOLS 38090	BLACKMAN	37,355,492			6.4800	.44(96)+ 5.66(05)+ 0.38(09)
	X			BLACKMAN	23,882,548		18.0000		
		X		BLACKMAN	2,789,262		6.0000		
X				BLACKMAN REZ	741,183			6.4800	.44(96)+ 5.66(05)+ 0.38(09)
X				CITY OF JACKSON	202,550			6.4800	.44(96)+ 5.66(05)+ 0.38(09)
	X			CITY OF JACKSON	202,550		18.0000		
		X		CITY OF JACKSON	0				
X				HENRIETTA	3,416,084			6.4800	.44(96)+ 5.66(05)+ 0.38(09)
	X			HENRIETTA	530,390		18.0000		
		X		HENRIETTA	2,798		6.0000		
X				LEONI	169,416,950			6.4800	.44(96)+ 5.66(05)+ 0.38(09)
	X			LEONI	64,841,466		18.0000		
		X		LEONI	7,349,368		6.0000		
X				SUMMIT	674,074			6.4800	.44(96)+ 5.66(05)+ 0.38(09)
	X			SUMMIT	324,545		18.0000		
		X		SUMMIT	0				
X				WATERLOO	7,759,105			6.4800	.44(96)+ 5.66(05)+ 0.38(09)
	X			WATERLOO	4,795,442		18.0000		
		X		WATERLOO	91,600		6.0000		

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X			**GRASS LAKE SCHOOLS 38050**	GRASS LAKE	194,612,984			7.0000	5.05(00)+1.51(05)+0.44(10)
	X			GRASS LAKE	40,983,483		18.0000		
		X		GRASS LAKE	1,944,538		6.0000		
X				GRASS LAKE TOOL & DIE REZ	485,646			7.0000	5.05(00)+1.51(05)+0.44(10)
X				LEONI	26,212,206			7.0000	5.05(00)+1.51(05)+0.44(10)
	X			LEONI	4,599,915		18.0000		
		X		LEONI	408,021		6.0000		
X				WATERLOO	19,319,600			7.0000	5.05(00)+1.51(05)+0.44(10)
	X			WATERLOO	3,364,402		18.0000		
		X		WATERLOO	108,800		6.0000		
X			**HANOVER-HORTON 38100**	HANOVER	118,865,963			4.6000	2.60(95)+ 1.00(02) + 1.00 Sinking Fund
	X			HANOVER	26,431,643		18.0000		
		X		HANOVER	438,600		6.0000		
X				LIBERTY	75,428,924			4.6000	2.60(95)+ 1.00(02) + 1.00 Sinking Fund
	X			LIBERTY	14,960,958		18.0000		
		X		LIBERTY	589,000		6.0000		
X				PULASKI	9,362,516			4.6000	2.60(95)+ 1.00(02) + 1.00 Sinking Fund
	X			PULASKI	1,416,055		18.0000		
		X		PULASKI	17,740		6.0000		
X				SPRING ARBOR	785,429			4.6000	2.60(95)+ 1.00(02) + 1.00 Sinking Fund
	X			SPRING ARBOR	82,216		18.0000		
		X		SPRING ARBOR	0				
X				SUMMIT	5,763,762			4.6000	2.60(95)+ 1.00(02) + 1.00 Sinking Fund
	X			SUMMIT	709,311		18.0000		
		X		SUMMIT	0				
X			**HOMER SCHOOLS 13080**	PULASKI	1,387,153			7.0000	1.35(04)+5.65(11)
	X			PULASKI	95,704		18.0000		
		X		PULASKI	2,020		6.0000		

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X			**JACKSON PUBLIC 38170**	CITY OF JACKSON	685,231,911			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
	X			CITY OF JACKSON	405,705,352		18.0000		
		X		CITY OF JACKSON	29,639,700		6.0000		
X				CITY OF JACKSON REZ	105,892,883			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
X				BLACKMAN	96,389,438			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
	X			BLACKMAN	56,538,095		18.0000		
		X		BLACKMAN	9,164,406		6.0000		
X				BLACKMAN REZ	49,718			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
X				LIBERTY	909,689			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
	X			LIBERTY	320,869		18.0000		
		X		LIBERTY	188,400		6.0000		
X				NAPOLEON	5,294,627			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
	X			NAPOLEON	2,861,152		18.0000		
		X		NAPOLEON	72,080		6.0000		
X				NAPOLEON REZ	815,479			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
X				SUMMIT	500,413,381			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
	X			SUMMIT	122,819,510		18.0000		
		X		SUMMIT	9,069,400		6.0000		
X				SUMMIT REZ	2,536,279			3.2500	2.40(04d)+ 0.65(09d) + 0.20 rec fund
X			**JONESVILLE SCHOOLS 30030**	PULASKI	1,010,044			7.4700	5.43(99)+ 2.04(08)
	X			PULASKI	68,682		18.0000		
		X		PULASKI	330				
X			**LESLIE SCHOOLS 33100**	RIVES	15,358,414			7.3900	2.31(95 debt)+ 5.08(98 refin)
	X			RIVES	2,261,291		17.0617		
		X		RIVES	200		5.0617		
X				TOMPKINS	6,449,217			7.3900	2.31(95 debt)+ 5.08(98 refin)
	X			TOMPKINS	1,788,777		17.0617		
		X		TOMPKINS	42				
X			**LITCHFIELD SCHOOLS 30040**	PULAKSI	3,311,617			3.7000	96 debt 2.95 +-09 sinding fund 0.75
	X			PULAKSI	791,188		18.0000		
		X		PULAKSI	170		6.0000		

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X			**MANCHESTER SCHOOLS 81080**	GRASS LAKE	376,615			7.0000	
	X			GRASS LAKE	2,761		18.0000		
		X		GRASS LAKE	0				
X				NORVELL	1,866,125			7.0000	
	X			NORVELL	193,184		18.0000		
		X		NORVELL	0				
X			**MICHIGAN CENTER SCHOOLS 38120**	CITY OF JACKSON	4,661,664			0.7002	0.7002(11)
	X			CITY OF JACKSON	2,164,864		18.0000		
		X		CITY OF JACKSON	28,900		6.0000		
X				LEONI	186,894,125			0.7002	0.7002(11)
	X			LEONI	50,817,116		18.0000		
		X		LEONI	4,033,551		6.0000		
X				LEONI REZ	1,354,201				
X			**NAPOLEON SCHOOLS 38130**	COLUMBIA	17,621,111			2.7500	94 debt
	X			COLUMBIA	3,457,621		18.0000		
		X		COLUMBIA	13,850		6.0000		
X				GRASS LAKE	11,941,270			2.7500	94 debt
	X			GRASS LAKE	2,244,088		18.0000		
		X		GRASS LAKE	9,922		6.0000		
X				NAPOLEON	214,928,076			2.7500	94 debt
	X			NAPOLEON	47,748,110		18.0000		
		X		NAPOLEON	6,514,897		6.0000		
X				NORVELL	33,597,789			2.7500	94 debt
	X			NORVELL	8,776,781		18.0000		
		X		NORVELL	19,618		6.0000		
X			**NORTH ADAMS SCHOOLS 30050**	LIBERTY	845,135			2.3000	1.60 (90 debt)+ 0.70(09 sinking fund)
	X			LIBERTY	432,399		18.0000		
		X		LIBERTY	0				

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X			NORTHWEST SCHOOLS 38140	CITY OF JACKSON	1,572,867			1.0738	
	X			CITY OF JACKSON	1,455,067		18.0000		
		X		CITY OF JACKSON	117,800		6.0000		
X				BLACKMAN	320,807,235			1.0738	
	X			BLACKMAN	120,531,121		18.0000		
		X		BLACKMAN	31,699,255		6.0000		
X				HENRIETTA	89,942,532			1.0738	
	X			HENRIETTA	17,286,619		18.0000		
		X		HENRIETTA	587,880		6.0000		
X				RIVES	102,705,438			1.0738	
	X			RIVES	18,157,609		18.0000		
		X		RIVES	504,900		6.0000		
X				SANDSTONE	25,587,950			1.0738	
	X			SANDSTONE	2,033,423		18.0000		
		X		SANDSTONE	12,687		6.0000		
X				TOMPKINS	39,331,788			1.0738	
	X			TOMPKINS	8,565,337		18.0000		
		X		TOMPKINS	571,494		6.0000		
X			SPRINGPORT SCHOOLS 38150	PARMA	26,974,614			8.9500	1.5400 (03 debt) + 7.4100(05 debt)
	X			PARMA	5,054,523		18.0000		
		X		PARMA	420,690		6.0000		
X				SPRINGPORT	47,422,269			8.9500	1.5400 (03 debt) + 7.4100(05 debt)
	X			SPRINGPORT	10,146,178		18.0000		
		X		SPRINGPORT	761,600		6.0000		
X				TOMPKINS	20,578,485			8.9500	1.5400.(03 debt) + 7.4100(05 debt)
	X			TOMPKINS	4,034,503		18.0000		
		X		TOMPKINS	44,621		6.0000		

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X			**STOCKBRIDGE SCHOOL 33200**	HENRIETTA	31,800,670			3.9000	3.9(00 debt)
	X			HENRIETTA	4,374,095		18.0000		
		X		HENRIETTA	47,169		6.0000		
X				WATERLOO	41,382,618			3.9000	3.9(00 debt)
	X			WATERLOO	6,871,387		18.0000		
		X		WATERLOO	152,300		6.0000		
X			**VANDERCOOK LAKE 38020**	SUMMIT	95,082,927			6.5000	4.28(97 debt) + 2.22(07 debt)
	X			SUMMIT	25,911,657		17.9174		
		X		SUMMIT	1,843,700		5.9174		
X			**WESTERN SCHOOLS 38010**	BLACKMAN	53,718,641			5.2000	2002 debt
	X			BLACKMAN	37,499,571		18.0000		
		X		BLACKMAN	3,750,347		6.0000		
X				BLACKMAN TOOL & DIE REZ	929,107			5.2000	2002 debt
X				CONCORD	8,416,009			5.2000	2002 debt
	X			CONCORD	1,149,902		18.0000		
		X		CONCORD	29,030		6.0000		
X				PARMA	30,668,563			5.2000	2002 debt
	X			PARMA	7,419,872		18.0000		
		X		PARMA	792,437		6.0000		
X				SANDSTONE	106,576,929			5.2000	2002 debt
	X			SANDSTONE	22,562,017		18.0000		
		X		SANDSTONE	1,492,449		6.0000		
X				SPRING ARBOR	155,008,311			5.2000	2002 debt
	X			SPRING ARBOR	33,416,728		18.0000		
		X		SPRING ARBOR	2,785,680		6.0000		
X				SPRING ARBOR TOOL & DIE REZ	1,395,703			5.2000	2002 debt
X				SUMMIT	266,074			5.2000	2002 debt
	X			SUMMIT	266,074		18.0000		
		X		SUMMIT	0				
X				TOMPKINS	4,266,182			5.2000	2002 debt
	X			TOMPKINS	804,284		18.0000		
		X		TOMPKINS	0				

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X			JACKSON INTERMEDIATE	COLUMBIA SCHOOLS	438,073,910	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				COLUMBIA SCHOOLS TOOL & DIE REZ	1,986,763				
X				CONCORD SCHOOLS	131,195,139	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				EAST JACKSON SCHOOLS	218,824,255	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				EAST JACKSON SCHOOLS REZ	741,183				
X				GRASS LAKE SCHOOLS	240,144,790	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				GRASS LAKE TOOL & DIE REZ	485,646				
X				HANOVER-HORTON SCHOOLS	210,206,594	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				JACKSON PUBLIC	1,288,239,046	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				JACKSON PUBLIC CITY- REZ	105,892,883				
X				JACKSON PUBLIC - NAPOLEON TOOL & DIE	815,479				
X				JACKSON PUBLIC - SUMMIT REZ	2,536,279				
X				MICHIGAN CENTER SCHOOLS	191,555,789	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				MICHIGAN CENTER SCHOOLS - LEONI REZ	1,354,201				
X				NAPOLEON SCHOOLS	278,088,246	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				NORTHWEST SCHOOLS	579,947,810	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				SPRINGPORT SCHOOLS	94,975,368	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				VANDERCOOK SCHOOLS	95,082,927	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				WESTERN SCHOOLS	358,920,709	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X				WESTERN -BLACKMAN TOOL & DIE REZ	929,107				
X				WESTERN -SPRING ARBOR TOOL & DIE REZ	1,395,703				
X			TOTAL JACKSON ISD		4,125,254,583	0.3422	7.7678		2.1414 Voc Ed + 5.6264 Sp Ed
X			CALHOUN INTERMEDIATE	ALBION SCHOOLS	10,874,368	0.2519	5.9555		1.4538 Voc Ed + 4.50 Sp Ed
X				HOMER SCHOOLS	1,387,153	0.2519	5.9555		1.4538 Voc Ed + 4.50 Sp Ed
X			TOTAL CALHOUN ISD		12,261,521	0.2519	5.9555		1.4538 Voc Ed + 4.50 Sp Ed
X			HILLSDALE INTERMEDIATE	JONESVILLE SCHOOLS	1,010,044	0.2674	3.8918		0.8918 Voc Ed + 3.000 Sp Ed
X				LITCHFIELD SCHOOLS	3,311,617	0.2674	3.8918		0.8918 Voc Ed + 3.000 Sp Ed
X				NORTH ADAMS SCHOOLS	845,135	0.2674	3.8918		0.8918 Voc Ed + 3.000 Sp Ed
X			TOTAL HILLSDALE ISD		5,166,796	0.2674	3.8918		0.8918 Voc Ed + 3.000 Sp Ed

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X			INGHAM INTERMEDIATE	LESLIE SCHOOLS	21,807,631	0.1894	5.7987		1.2925 Voc Ed + 4.5062 Sp Ed
X				STOCKBRIDGE SCHOOLS	73,183,288	0.1894	5.7987		1.2925 Voc Ed + 4.5062 Sp Ed
X			TOTAL INGHAM ISD		94,990,919	0.1894	5.7987		1.2925 Voc Ed + 4.5062 Sp Ed
X			LENAWEE INTERMEDIATE	ADDISON SCHOOLS	206,121	0.2563	7.0233		2.9191 Voc Ed + 4.1042 Sp Ed
X			WASHTENAW INTERMEDIATE	CHELSEA SCHOOLS	36,675,649	0.0984	3.9745		3.8761 Sp Ed
X				MANCHESTER SCHOOLS	2,242,740	0.0984	3.9745		3.8761 Sp Ed
			TOTAL WASHTENAW ISD		38,918,389	0.0984	3.9745		3.8761 Sp Ed
X			JACKSON COMMUNITY COLLEGE	ENTIRE COUNTY	4,256,991,853		1.1446		
			less:	Blackman RenZ	741,183				
				Blackman Tool & Die RenZ	929,107				
				Columbia Tool & Die RenZ	1,986,763				
				Grass Lake Tool & Die RenZ	485,646				
				Leoni RenZ	1,090,397				
				Leoni Tool & Die RenZ	263,804				
				Napoleon Tool & Die RenZ	815,479				
				Spring Arbor Tool & Die RenZ	1,395,703				
				Summit RenZ	2,536,279				
				City of Jackson RenZ	102,222,637				
				City of Jackson Tool & Die RenZ	3,670,246				

JACKSON COUNTY FRIEND OF THE COURT
PROPOSED REORGANIZATION

To: Mike Overton, County Administrator/Controller
County Personnel and Finance Committee
County Board of Commissioners

From: Andy Crisenbery, Friend of the Court

cc: Adam Brown, Deputy Administrator/Controller
Charles Adkins, Circuit Court Administrator
Honorable John McBain, Chief Circuit Court Judge

Date: September 16, 2011

Subject: Proposed Reorganization

I. Background

A. Since the introduction of the Friend of the Court (FOC) "pay or stay" and "payment plan" programs, the FOC has observed a significant increase in the workload of the Support Services Unit (SSU). Currently, the SSU consists of five full-time equivalent (FTE) employees.

B. "Pay or stay" is an alternative jail sentencing program and is linked to the bench warrant arraignment process. When the Court orders a "pay or stay" jail sentence, payers must appear at the FOC by 4:00 p.m. each Friday for a fixed number of weeks and make their weekly payment or spend the weekend in jail. This program generates increased child support and produces significant cost savings for our local jail.

C. "Payment plans" are generally associated with our Wednesday support show cause hearing process and are linked to payers who do not have attachable income sources (i.e., self-employed, underground economy, etc.). Many of these payers are granted a court ordered exception that allows them to make their payments locally, instead of mailing them to the Michigan State Disbursement Unit (MiSDU) in Lansing. This increases the chance of child support being paid by this population.

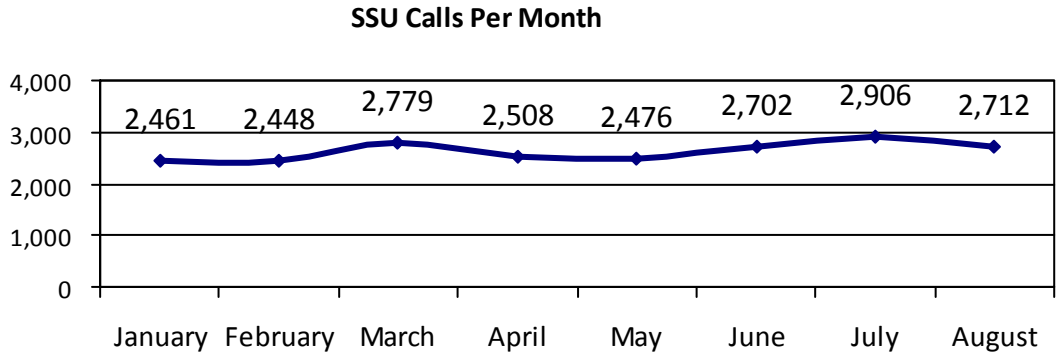
D. While "pay or stay" and "payment plans" are very successful, these programs make it difficult for the SSU to handle and cope with the increased workload, especially given the loss of one full-time SSU position that was eliminated in October 2009 as a part of a county-wide staffing reduction plan.

E. The following grid illustrates the contrast between the payments and monies the FOC expects to receipt locally in 2011 as compared to the past few years.

Category	**2008**	**2009**	**2010**	**2011 (Expected)**	**% Increase (2008 vs. 2011)**
Payments receipted locally	4,171	8,285	15,492	20,579	393%
Monies collected locally	$1,059,979	$1,024,658	$1,296,164	$1,636,746	54%

II. Current Situation

A. The SSU is also experiencing a sustained and sometimes increase in the number of phone calls they are handling monthly. Following are the call volumes noted since January 2011.



B. While the SSU has experienced a workload increase, our Imaging Department has noticed a significant workload decrease due to the implementation of the OnBase imaging system. Our Imaging Department currently consists of one full-time and one ¾ part-time Imaging Clerk.

III. Analysis

A. **Strategic** – The proposed re-organization supports the Jackson County Core Values of Responsiveness, by delivering customer-focused service that is accessible, user-friendly, respectful, and efficient.

B. **Financial/Service Level** - With the support of the Chief Circuit Court Judge (John McBain) and the Circuit Court Administrator (Charles Adkins), I am proposing an interdepartmental reorganization that will address the increased workload of the SSU and

accomplish the following without any additional costs to the County. Refer to the attached Excel spreadsheet for more details on the cost analysis.

1. Decrease the FTEs in our Imaging Department from 1.75 FTEs to one FTE,
2. Increase the number of FTEs in the SSU from 5 FTEs to 5.75 FTEs,
3. Upgrade the existing full-time Imaging Clerk position from a grade 3 to a grade 4 and add a cashier function to that position,
4. Create a system that will grant SSU representatives a one-week period of respite from the most demanding parts of their jobs every six weeks (i.e., phone calls, walk ins, etc.) by allowing them to focus exclusively on the cashier and imaging department functions,
5. Reduce the "wages-casual" expense line item (215143.705500) from $24,996 to $17,408,
6. Decrease the need to assign Enforcement, Accounting, and other FOC department employees to backup the SSU during staffing shortages,
7. Increase efficiencies with the receipting process,
8. Allow for better routing and handling of customer traffic, and
9. Decreases wait times for telephone and walk in traffic.

C. **Timing** – A vacancy in the imaging staff has provided an opportunity to restructure the organization without any movement of existing staff.

IV. **Recommendation** – In closing, I am asking for your full support of my proposed reorganization, and that you place this topic on a future agenda for the appropriate Board of Commissioners standing committee meetings.

Attachment: Proposed Reorganization Cost Analysis

JACKSON COUNTY FRIEND OF THE COURT REORGANIZATION PLAN
September 16, 2011

PRE-REORGANIZATION COST ANALYSIS

Position	Status	Grade	Position IV-D Billing %	IV-D Caseload %	Non IV-D Caseload %	Salary & Fringe	IV-D Caseload Costs (Pre-CRP)	Non-IV-D Caseload Costs	County Contribution (34%)
Imaging Clerk	Full-Time	3	100%	98.90%	1.10%	$47,074	$46,556	$518	$16,347
Imaging Clerk	3/4 Part-Time	3	100%	98.90%	1.10%	$20,264	$20,041	$223	$7,037
Support Services Rep. #1	Full-Time	6	100%	98.90%	1.10%	$48,914	$48,376	$538	$16,986
Support Services Rep. #2	Full-Time	6	100%	98.90%	1.10%	$48,914	$48,376	$538	$16,986
Support Services Rep. #3	Full-Time	6	100%	98.90%	1.10%	$46,379	$45,869	$510	$16,106
Support Services Rep. #4	Full-Time	6	100%	98.90%	1.10%	$46,379	$45,869	$510	$16,106
Support Services Rep. #5	Full-Time	6	90.96%	98.90%	1.10%	$46,379	$42,186	$4,193	$18,536
Casual Employee	Casual	6	100%	98.90%	1.10%	$7,588	$7,505	$83	$2,635
TOTAL						$311,891	$304,778	$7,113	$110,738

POST-REORGANIZATION COST ANALYSIS

Position		Grade	Position IV-D Billing %	IV-D Caseload %	Non IV-D Caseload %	Salary & Fringe	IV-D Caseload Costs (Pre-CRP)	Non-IV-D Caseload Costs	County Contribution (34%)
Imaging Clerk/Cashier **(New)***	Full-Time	4	100%	98.90%	1.10%	$49,276	$48,734	$542	$17,112
Support Services Rep. #1	Full-Time	6	100%	98.90%	1.10%	$48,914	$48,376	$538	$16,986
Support Services Rep. #2	Full-Time	6	100%	98.90%	1.10%	$48,914	$48,376	$538	$16,986
Support Services Rep. #3	Full-Time	6	100%	98.90%	1.10%	$46,379	$45,869	$510	$16,106
Support Services Rep. #4	Full-Time	6	100%	98.90%	1.10%	$46,379	$45,869	$510	$16,106
Support Services Rep. #5	Full-Time	6	90.96%	98.90%	1.10%	$46,379	$42,186	$4,193	$18,536
Support Services Rep. #6 **(New)**	3/4 Time	6	100%	98.90%	1.10%	$25,121	$24,845	$276	$8,724
TOTAL						$311,362	$304,255	$7,107	$110,554

Difference -$184

* This individual is planning on entering the drop, which would result in future cost savings of approximately $7,370.00 when she retires and is replaced by a new hire. After CRP, the net savings to the County would be an additional $2506.

ANNUAL REPORT
2010

Geoffrey W. Snyder
Jackson County Drain Commissioner

Geoffrey W. Snyder
COUNTY DRAIN COMMISSIONER
County Tower Building, Jackson, Michigan 49201
Mon.-Fri. 8-5, 517 / 788-4398

September 30, 2011

Honorable Board of Commissioners
County of Jackson
Jackson, Michigan

Dear Commissioners:

Complying with Section 31 of Chapter 2 of Act No. 40 of the Public Acts of 1956, as amended, I submit the Annual Report containing the financial statement of the Jackson County Drain Commissioner's Office for the fiscal year beginning January 1, 2010, and ending December 31, 2010.

I hereby certify that this report, identifying all special assessment districts within which work was performed during the fiscal year, and the financial statement of all districts are true and correct.

The report also contains information on: MS4/Watershed/NPDES Permit activities, and; Act 342 and Act 185 Sewer and Water projects that are administered by this Office, outside of the scope of Act 40.

Respectfully Submitted,

Geoffrey W. Snyder

Jackson County Drain Commission
2010 Annual Report

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Jackson County Drain Commission
2010 Annual Report

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DRAINAGE AND SANITARY SEWER DISTRICTS

Jackson County Drain Commission
2010 Annual Report

ACTIVE CONSTRUCTION
OR
MAINTENANCE WORK PERFORMED ON
COUNTY OR INTERCOUNTY DRAINS

The following county drains were in various stages of construction during the fiscal year:

ALLEN BRANCH OF THOMPSON LAKE DRAIN, Blackman Township

The grate on the drain was cleaned periodically as preventive maintenance.

BEVERLY HILLS DRAIN, Summit Township

Complaints were addressed at three properties within the drainage district. The drain was excavated around a catch basin, situated in the creek, to help the flow of water.

CASCADES VISTA DRAIN, Summit Township

Removed tree roots and vacuumed a catch basin at Dawn Street.

DECKER DRAIN, Leoni Township

The grate on the drain was cleaned periodically as preventive maintenance.

Active Construction or Maintenance
Work Performed on County or Intercounty
Drains (Continued)

GRAND RIVER NPDES PERMIT ACTIVITIES, Various counties and Townships

Portions of the Upper Grand River (UGR), and its tributary the Portage River, fail to meet water quality standards for dissolved oxygen, aquatic organisms (biota), and E. coli bacteria. As such, the State of Michigan has enacted Total Maximum Daily Load (TMDL) allocations, directing communities within these watersheds to reduce Stormwater pollutant loads, primarily sediment.

Jackson County, the City of Jackson, Leoni and Blackman Townships are regulated by the State of Michigan for their Stormwater discharges to the Grand River and its tributaries. These communities make up the Jackson Urban Area Storm Water Committee, and are charged with enacting policies and taking action to restore the river to meet state water quality standards. The communities, and their agencies, have teamed with other communities and organizations to conduct these activities under the umbrella of the Upper Grand River Watershed Alliance.

Stormwater Permit Compliance

- Revised and submitted new Storm Water Pollution Prevention Initiative (SWIPPI), illicit Discharge Elimination Plan (IDEP), Public Education Plan (PEP), and Public Involvement Plan (PIP) for Jackson County, the City of Jackson, and Blackman and Leoni Townships. All revised plans approved by MDEQ.
- Provided a series of five (5) webcasts on various aspects of improving Stormwater treatment and watershed management. The webcasts provide one means for municipal staff to meet annual training requirements for the NDPES Stormwater permits.
- The Jackson Urban Area Stormwater Committee and Upper Grand River Watershed Alliance met four (4) times during the year (January, August, October and December) in addition to the watershed planning workshops described below.

Active Construction or Maintenance
Work Performed on County or Intercounty
Drains (Continued)

GRAND RIVER NPDES PERMIT ACTIVITIES, continued

Watershed Planning

- Held five (5) public workshops (January - May) collecting information to revise/update the UGR Watershed Management Plan
- Thrity-three (33) different individuals participated, attendance at individual workshops ranged from 4-20
- Watershed Plan was amended to recommend that all new development incorporate the use of porous pavement and Stormwater treatment for first flush.

Grand River Expedition 2010

- Nine (9) planning meetings were held to work out logistics, identify sponsors, etc. for Grand River 2010 (GRE 2010); a 14 day, 225 mile paddling and education trip on the Grand River.
- Advertised and hosted local fundraiser at Bone Island Grille (raised $1,055).
- Raised over additional $6,500 in additional cash donations for the Jackson area.
- Sponsored a Grand River Art Exhibit at Art 634 as part of GRE 2010.
- Opening Ceremonies (Liberty Mill Pond), camping and band at Leoni Township Park, Upper Grand River Fest(City of Jackson Farmer's Market), and camping at Youth Haven Ranch were all Jackson County events held as part of the GRE 2010.
- The Grand Rapids Press published 17 days of articles on GRE 2010 and published a book about the event. Additional editorials and articles appeared in the Jackson Citizen Patriot, Lansing State Journal, Lansing City Pulse, Michigan State University's; the State News, Grand Haven Tribune, YouTube videos, etc.

Active Construction or Maintenance
Work Performed on County or Intercounty
Drains (Continued)

GRAND RIVER NPDES PERMIT ACTIVITIES, continued

Other Outreach and Education

- Continued Adopt-A-Stream volunteer monitoring program
- Educational display and materials provided at Jackson County Fair, and Jackson Area Outdoor Coalition Earth Day Event
- Continued to disseminate information about events and issues facing the Upper Grand River via the Upper Grand River Watershed Alliance website (www.upergrandriver.org)
- Advanced Drainage Systems (ADS) presented information about new Stormwater treatment technologies to the Jackson Urban Area Stormwater Committee.

Fundraising

- Worked with the Jackson County Conservation District to submit grand proposals for: a third round of Upper Grand River Implementation Project (UGRIP) funding.

HURD MARVIN DRAIN, Blackman Township

Excavated sediment from the upper pond and rebuilt the head wall at the R.A. Greene Park.

W.B. MINER DRAIN, Rives Township

Established a sedimentation basin between the end of the drain tile and the culvert beneath Territorial Road. A blowhole was repaired, and a tile replaced.

Active Construction or Maintenance
Work Performed on County or Intercounty
Drains (Continued)

NOON LATERAL OF THE MOE-BREWER DRAIN, Blackman Township

A Board of Determination hearing was held for the proposed lateral of the Moe-Brewer Drain.

MURRAY DRAIN, Blackman Township

A broken tile was repaired at intersection of Chrismac and M-50.

OLEARY DRAIN, Grass Lake Township

Five thousand three hundred lineal feet of open ditch was excavated.

TIMBER MEADOWS DRAIN, Summit Township

Three catch basins were vacuumed, and debris was disposed.

WATTS TILE DRAIN, Summit Township

A public hearing was held for the abandonment of the drain. Based upon testimony, it was determined that the drain should not be abandoned. A petition was also filed for the repair and relocation of the drain, however proved to be unqualified.

Active Construction or Maintenance
Work Performed on County or Intercounty
Drains (Continued)

WEST JACKSON IMPROVEMENT DISTRICT, Summit Township

Removed 19.1 lineal feet of 12" diameter concrete storm sewer and replaced it with 12" SDR 35 PVC with Fernco connections at both ends in front of 800 17th Street. This replacement took place from 54 feet to 75 feet upstream from the manhole in front of 724 17th Street. The sanitary sewer service to 800 17th Street was damaged during the excavating and repaired with 4 lineal feet of 6" diameter PVC pipe and two Ferncos.

The pipe was bedded with 6A stone. The heavy clay soils excavated from the trench were trucked off site. The trench was backfilled with compacted sand and topped with bituminous screenings.

Jackson County Drain Commission
2010 Annual Report

ACTIVE CONSTRUCTION
OR
MAINTENANCE WORK PERFORMED ON
SANITARY SEWER COLLECTION AND WATER DISTRIBUTION SYSTEMS

LAKE COLUMBIA SANITARY SEWER SYSTEM IMPROVEMENTS-EAST AND WEST SEGMENT ($ 11,000,000)

This project involved the construction of 49,400 lineal feet of pressure sewer around the east side of Lake Columbia and the installation of one submersible lift station. The project will provide service to 665 residential customers. The project was completed June 1, 2010, with approximately 80% of the homes connected.

LEONI REGIONAL UTILITY AUTHORITY, Blackman, Columbia, Leoni, Grass Lake, Napoleon, Liberty, Hanover, Norvell, Lyndon, Sylvan Townships, Brooklyn and Grass Lake Village

The Leoni Regional Sewer System formed an authority of the member communities. These include the Townships of Leoni, Grass Lake, Columbia, Napoleon, Norvell, Blackman, Lyndon, Cambridge, Liberty, Hanover, Sylvan and the Villages of Grass Lake and Brooklyn. The Authority is presently developing a "business plan" which will allow the "Authority" to undertake certain responsibilities that are presently being provided by Leoni Township. Additionally, the Authority is structuring itself to assume the day-to-day operation and maintenance responsibilities of the Waste Water Treatment Plant, the collection systems and the transmission systems. Active participation is taking place with the Lake LeAnn property Owner's Association and Somerset Township for the Lake LeAnn Sewer project.

Active Construction or Maintenance
Work Performed on Sanitary Sewer Collection
and Water Distribution Systems
(Continued)

PARMA VILLAGE SEWER LAGOON, Parma Township **($2,780,000)**

This project reconstructed the Parma Village Wastewater Disposal Facility by enlarging and lining the two sewer lagoons. Renovations to the existing wastewater treatment plant included removal of wastewater sludge from the existing lagoons, lining the existing lagoons, site piping, construction of a new effluent discharge, and appurtenant work. Completion of the project is projected for Spring 2010.

RIVES SANITARY SEWER SYSTEM (Collection System), Rives Township **($1,173,015.00)**

Approximately 6,600 lineal feet of 8" gravity sewer, 2,400 lineal feet of 2" pressure sewer, 3,000 lineal feet of 8" forcemain, was installed, in addition to the construction of one submersible type lift station, the installation of approximately 15 simplex grinder pumps on private property, sewer service lines, and related appurtenances in the Rives Junction area. The construction project was completed in the fall of 2010'. All but 13 property owners have connected to the system.

RIVES SANITARY SEWER SYSTEM (Transmission Main), Rives Township **($579,191.00)**

Approximately 17,500 lineal feet of 8" forcemain was installed with a portion being directionally drilled, sewer service lines were installed, 100 lineal feet of was directionally drilled under Norfolk Southern Railroad and related appurtenances in the Rives Junction Road right-of-way. Projected completion of the project is fall of 2010'.

Active Construction or Maintenance
Work Performed on Sanitary Sewer Collection
and Water Distribution Systems
(Continued)

ROUND/FARWELL LAKES SANITARY SEWER SYSTEM, Hanover/Liberty Townships ($3,900,000)

This project involved the construction of 51,000' of pressure sewer around Round and Farwell Lakes. The project serves 540 residential customers. The project was completed in December of 2010, with all of the customers achieving their connections this year.

SOUTHERN INTERCEPTOR-SEWER SYSTEM IMPROVEMENT: ($4,600,000)

This project involved the construction of approximately 77,000 feet of 12" and 16" forcemain from Round and Farwell Lakes, through Liberty and Columbia Townships, to the existing collection system near Clark Lake. The project also included installation of three lift stations and an equalization chamber near Clark Lake that will allow additional capacity to be used in the Clark Lake interceptor. The project was completed in the fall of 2010. The abandonment of the Ocean Beach lift Station will was accomplished in 2010'.

VINEYARD LAKE SANITARY SEWER SYSTEM IMPROVEMENTS, Norvell and Columbia Township ($6,100,000)

This project involved the construction of 67,000 feet of pressure sewer around Vineyard Lake and the installation of two submersible lift stations. The project provides service to 652 residential costumers. The construction of this project was substantially completed on February 25, 2005, with all property owners being connected to the collection/transmission system in 2010'.

Proposed drain/public works projects, for which estimates of cost for construction were prepared, and which are awaiting petition filing, Board of Determination action, Judicial or Administrative Processing.

Noon Lateral of the Moe-Brewer Drain	Blackman Township
Pleasant Lake Sanitary Sewer	Henrietta Township
Lake LeAnn Sanitary Sewer	Somerset Township

CONDOMINIUM REVIEW AND APPROVAL

Two (2) condominiums were reviewed, by this office, as required by the Condominium Act, being Act No. 59 of the Public Acts of 1978. This review consisted of preparing dedication deeds, approving design and construction plans, and performing inspections on the following condominiums:

South Street Industrial Properties Condominium	Summit Township
Stone Village Site Condominium	Summit Township

PROPOSED DEVELOPMENT REVIEWS AND RECOMMENDATIONS

Six (6) proposed developments were reviewed by this office, over and above the previously mentioned plat reviews or condominium reviews. The reviews were conducted in response to a request by a municipality for a recommendation regarding the drainage of the proposed development.

This review consisted of inspections of the site, meetings with the developer, and letters to the municipalities indicating the observations of this office, and the recommendations with regard to drainage of the following:

Comcast Addition	Summit Township
Country Garden Veterinary Clinic	Summit Township
Dollar General	Spring Arbor Township
Dollar General (2 locations)	Summit Township
Grass Lake Schools	Grass Lake Township
Modern Waste	Napoleon Township
Save Time Convenience Store/Bank/ Subway/Gas Station	Columbia Township
Sparks Park Urban Fisheries	Summit Township

TYPICAL RESPONSES TO DRAINAGE PROBLEMS NOT DIRECTLY RELATED TO ESTABLISHED COUNTY DRAINS

The Drain Commissioner's office received approximately Seventy-six (76) complaints of drainage problems that required field investigation. These requests came from property owners, governmental officials and concerned citizens. The nature of those drainage problems ranged from: requests for solutions to certain problems with existing county drains; requests for technical advice on those problems involving private drains, and; requests for the establishment of new county drains.

The following are examples of the problems that received attention as a result of complaints being filed:

5091 Merriman Road, Summit Township

The property owner has "clear water" standing in the basement.

During the recent heavy rains, the property owner's basement had clear water in it until the sump pump could handle the water.

The property owner cleaned the plugged gutters and extended the downspouts away from the foundation of the house.

12885 Peacock Road, Rives Township

The drain tile in front of the property owner's house is not operating properly. This property and the neighboring property have holes in the yard.

The outlet of the W.B. Miner Drain tile is submerged.

Directed that the open ditch between the W.B. Miner Drain tile and the Jackson County Road Commission culvert beneath Territorial Road be cleaned out to relieve upstream pressure, which is causing the "blow holes". The tile now sees "day light".

Typical Responses to Drainage Problems
Not Directly Related to Established County Drains
(Continued)

1133 Pointe North, Summit Township

The property owner lives on the lake and would like to add a culvert tile to the existing drain. The property owner would like to remove a metal grate and add a tile that will outlet to the lake, and is willing to do the work if given the correct specifications and materials to purchase.

Someone filled the marsh approximately 20 feet to the shore of the lake. Twenty feet of 12" ADS N-12 is needed to extend sewer to edge of lake and eliminate the short section of open ditch.

Explained the above information to the property owner and informed them that it would be their responsibility to purchase and install the pipe, remove and relocate the end section and grate, all to the specifications of the Jackson County Drain Commission.

Southern Shores Drive, Columbia Township

The property owner at 215 Southern Shores has filled in the shallow ditch in front of the property owner's house with sand. This is causing water to stand on the road.

The roadside ditch has been filled. The property owner at 215 Southern Shores did not want the road run-off in their yard.

Explained to the property owner that the Jackson County Road Commission has exclusive jurisdiction over the roadside ditch and the responsibility to manage the surface water run-off generated from the road right-of-way.

Typical Responses to Drainage Problems
Not Directly Related to Established County Drains
(Continued)

10512 Wolf Lake Forest Road, Grass Lake Township

The property owner has standing water coming up to the house, which is washing out part of the private drive.

There is a large amount of water standing in the property owner's yard. The water cannot flow toward Wolf Lake because the Jackson County Road Commission has raised the elevation of Forest Lake Road. There is a French drain flowing under the road, which is slowing draining the "ponding" water. The recent heavy rains were too large for the French drain to handle.

Explained the above information to the property owner, along with the procedure to petition for a county drain.

REVOLVING DRAIN FUND

The following Revolving Drain Fund deficits will be cleared by future drain tax levies or other Act 40 reimbursements:

Argus Court	190.50
Beebe-Taylor	$2,096.45
Cascades Vista	1,070.00
Chanter	4,276.04
Chapel Heights	275.00
Community College (Utility)	240.30
Corwin	631.50
Cranberry Ackerson Lake	4,686.21
Decker	12,084.35
Doty	101.00
Eagle Crest	5,795.20
Gatewood	1,230.09
Glenngary	1,128.60
Grand River	513.07
Grand River (Tetra Tech)	2,000.00
Grand River (Tetra Tech) $72	1,232.03
Grass Lake	1,358.38
Hendee	5,828.00
Hurd Marvin	6,710.28
Huttenlocker	65.00
Imperial Shores	110.00
Kedron	399.70
Kennedy	9,534.55
Kent	810.40
Ladd-Main	337.08
Loder	107.00
McCready	203.75
W.B. Miner	6,097.77
Munith	11,573.64
Murray Branch	2,803.41
Noon Lateral	1,210.80
Oak Hill Estates	101.23
O'Leary	14,169.82
Ricks	2,135.10
Robinson Road Lateral	630.00
Ruel	1,153.57
Saines	6,525.80
Springbrook & Pretty Branch	1,027.43
Stonegate Farms	2,082.67
Summit	4,350.04
Thompson Lake	790.98

REVOLVING DRAIN FUND

The following Revolving Drain Fund deficits will be cleared by future drain tax levies or other Act 40 reimbursements: (continued)

Three Forty Farms	105.00
Timber Meadows	845.44
Tobin-Snyder	117.10
Todd-Klee	255.55
Upper Grand River (319)	5,750.00
West Jackson	21,070.01
Winchell & Townsend	159.96
Whispering Woods	421.98
Whitman	3,271.38
Wild Intercounty	29,315.60
Total	$177,815.49

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DRAIN	DATE	NUMBER	PURPOSE	AMOUNT
Blackman	Allen Branch Of Thompson Lk	2/23	12256	Maintenance	64.50
		5/25	12279	Maintenance	34.50
		8/10	12306	Maintenance	66.50
		10/19	12334	Maintenance	62.50
					228.00
Blackman	Campbell & Extn.	5/25	12780	Engineering	97.50
Blackman	Hurd Marvin	12/08	12357	Maintenance	1,860.00
Blackman	Noon Lateral of Moe-Brewer	5/14	12272	Publication	204.88
		5/14	12273	Ct. Reporting	414.50
		6/29	12294	Bd. of Det.	51.83
		6/29	12295	Bd. of Det.	52.76
		6/29	12296	Bd. of Det.	51.02
		6/29	12297	Bd. of Det.	40.81
		8/10	12318	Engineering	395.00
					1,210.80
Blackman	Murray	3/31	12267	Maintenance	1,753.30
		10/19	12342	Engineering	105.00
					1,858.30
Blackman	Thompson Lake	2/23	12260	Maintenance	64.50
		5/25	12287	Maintenance	34.50
		10/19	12343	Maintenance	62.50
					161.50
Blackman	Wheeler	5/25	12284	Engineering	47.50

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DRAIN	DATE	NUMBER	PURPOSE	AMOUNT
Columbia	Imperial Shores	10/19	12340	Engineering	110.00
Columbia	Kedron	11/09	12352	Engineering	47.50
Columbia	Lynn-Haven	8/10	12308	Maintenance	119.50
Columbia	Plumb Brook	10/19	12356	Maintenance	162.00
Columbia	Sunset View	8/10	12314	Maintenance	36.00
Concord	Loder	10/19	12341	Engineering	107.00
Grass Lake	O'Leary	3/11	12263	Maintenance	13,250.00
		9/14	12326	Maintenance	858.00
					13,835.00
Leoni	Decker	2/23	12258	Maintenance	63.50
		5/25	12282	Maintenance	33.50
		8/10	12316	Maintenance	33.50
		8/05	12179	Maintenance	139.85
		10/19	12335	Maintenance	62.00
					192.50
Leoni	Huttenlocker	8/10	12317	Engineering	65.00
Leoni	Kennedy	2/23	12259	Engineering	125.00

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DRAIN	DATE	NUMBER	PURPOSE	AMOUNT
Leoni	Plumb Van Antwerp	8/10	12311	Engineering	107.50
Napoleon	Austin	8/10	12307	Engineering	35.00
Napoleon	Stoney Lake	8/10	12313	Engineering	35.00
Napoleon	Winchell-Townshend	8/10	12313	Engineering	71.00
Napoleon	Winchell & Townsend	12/08	12247	Engineering	95.00
Rives	W.B. Miner	5/14	12274	Maintenance	1,660.00
		5/25	12286	Engineering	302.50
		8/10	12322	Maintenance	1,404.75
					3,367.25
Spring Arbor	Springbrook	5/05	12270	Maintenance	631.00
Springport	Moore (Otter Creek)	1/11	12249	Electrical	453.86
		2/04	12253	Electrical	141.90
		3/11	12262	Electrical	1,686.24
		3/31	12268	Electrical	485.22
		5/	12275	Electrical	198.47
		6/01	12291	Bank Note	52,780.80
		6/29	12298	Electrical	429.89
		7/27	12303	Electrical	668.78

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DRAIN	DATE	NUMBER	PURPOSE	AMOUNT
Springport	Moore (Otter Creek) Cont.	8/	12325	Electrical	251.96
		9/	12328	Electrical	533.01
		7/28	12171	Electrical	592.48
		10/19	12345	Electrical	203.77
		12/08	12356	Electrical	206.62
		12/30	12358	Electrical	206.77
					58,247.29
Springport	Peacock Intercounty	8/	12323	Maintenance	1,001.00
		8/24	12324	Maintenance	1,500.00
					2,501.00
Summit	Argus Court	10/19	12339	Engineering	95.50
		11/09	12351	Engineering	95.00
					190.50
Summit	Beverly Hills	6/01	12290	Maintenance	675.00
		11/19	12346	Engineering	47.50
					722.50
Summit	Carson	10/19	12332	Special Tax	20,142.86
Summit	Cascades Vista	7/27	12304	Maintenance	1,070.00
Summit	Conger	5/25	12281	Maintenance	32.00
Summit	Fisk	1/27	12250	Engineering	102.50
		3/12	12264	Engineering	287.85
					390.35

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DRAIN	DATE	NUMBER	PURPOSE	AMOUNT
Summit	Glengarry	10/19	12338	Engineering	145.00
Summit	McCain	8/10	12309	Engineering	31.50
Summit	Oak Street	8/10	12310	Engineering	80.50
		10/19	12331	Special Tax	7,657.14
					7,737.64
Summit	Ricks	8/10	12312	Engineering	147.50
		11/19	12347	Engineering	95.00
					242.50
Summit	Stonewall	10/19	12337	Engineering	94.00
Summit	Three Forty Farms	8/10	12315	Engineering	33.50
		8/10	12319	Engineering	105.00
					138.50
Summit	Timber Meadows	11/09	12348	Supplies	105.44
		11/09	12350	Maintenance	740.00
					845.44

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DRAIN	DATE	NUMBER	PURPOSE	AMOUNT
Summit	Watts Tile	2/23	12254	Ct. Reporting	205.00
		2/23	12255	Publication	95.40
		2/23	12257	Engineering	378.00
		5/25	12283	Engineering	195.00
		8/10	12305	Engineering	142.50
					1,012.90
Summit	West Jackson	1/27	12251	Engineering	909.75
		5/05	12269	Maintenance	2,274.00
		5/25	12285	Maintenance	1,522.50
		5/25	12288	Engineering	427.00
		6/29	12299	Maintenance	836.00
		7/27	12301	Maintenance	2,240.00
		7/27	12302	Maintenance	4,055.00
		8/10	12320	Engineering	128.50
		9/14	12327	Maintenance	3,500.00
		10/19	12344	Engineering	1,165.00
		11/09	12353	Engineering	95.00
		11/19	12349	Maintenance	5,555.74
					22,708.99
Tompkins	Grand River Intercounty	3/12	12265	Web Services	150.00
		3/12	12266	Web Services	150.00
		5/14	12271	Engineering	10,910.15
		5/21	12276	Engineering	21,346.15
		5/21	12277	Engineering	15,626.00
		5/21	12278	Engineering	8,089.75
		7/21	12300	Web Services	150.00
		10/06	12329	Engineering	8,421.55
		10/06	12330	Engineering	9,499.98
		10/19	12333	Web Services	150.00
					74,493.58

Total Drain Orders $215,256.40

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY BONDS
(Clark Lake Section)
SERIES 1994 and 2002
FUND NO. 851.170.959.000

DRAIN ORDERS WRITTEN - 2010

VILLAGE/TWP	DATE	NUMBER	PURPOSE	AMOUNT
Columbia	5/05	10185	Paying Agent Fee	262.50
	5/05	10186	Paying Agent Fee	137.50
	9/14	10213	Paying Agent Fee	137.50
	11/09	10215	Paying Agent Fee	262.50
			Total Drain Orders Written	$ 800.00

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WATER SUPPLY FACILITY
(Grass Lake Section) BONDS
SERIES 2002A
FUND NO. 851.236.959.000

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DATE	NUMBER	PURPOSE	AMOUNT
Grass Lake	5/19	10192	Paying Agent Fee	137.50
		Total Drain Orders		$ 137.50

COUNTY OF JACKSON
STATE OF MICHGIAN
WASTEWATER DISPOSAL FACILITY
(Lake Columbia Section) BONDS
SERIES 2004
FUND NO. 851.185.959.170

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DATE	NUMBER	PURPOSE	AMOUNT
Columbia	3/12	10179	Progress Payment	37,100.39
	5/19	10191	Paying Agent Fee	112.50
	6/01	10197	Engineering	1,671.14
	6/01	10198	Engineering	2,686.82
	6/01	10199	Engineering	1,239.37
	6/01	10200	Engineering	682.15
	6/01	10201	Engineering	703.27
	6/01	10202	Engineering	1,718.49
	6/01	10203	Engineering	1,114.81
	12/08	10230	Legal Services	2,789.00
	12/30	10232	Closing Const. Fund	46,570.86
	12/30	10234	Legal Services	1,631.75
			Total Drain Orders	$98,020.40

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(Napoleon Village Section) BONDS
FUND NO. 851.225.959.000

DRAIN ORDERS WRITTEN - 2010

VILLAGE/TWP	DATE	NUMBER	PURPOSE	AMOUNT
Napoleon Village	1/27	10174	Paying Agent Fee	137.50
	7/07	10207	Paying Agent Fee	137.50
	12/30	10231	Paying Agent Fee	137.50
			Total Drain Orders Written	$ 412.50

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(Parma Village LDFA)
SERIES 2002A
FUND NO. 851.231.959.000

DRAIN ORDERS WRITTEN - 2010

VILLAGE/TWP	DATE	NUMBER	PURPOSE	AMOUNT
Parma Village	8/19	10189	Paying Agent Fee	125.00
			Total Drain Orders Written	$ 125.00

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER IMPROVEMENTS
(Parma Village Section)
FUND NO. 851.233.959.000

DRAIN ORDERS WRITTEN - 2010

VILLAGE/TWP	DATE	NUMBER	PURPOSE	AMOUNT
Parma	4/07	10181	Transfer Tax	55.90
Village	4/07	10182	Legal Services	9,107.80
	6/04	10204	Engineering	15,177.94
	6/04	10205	Progress Payment	144,599.94
			Total Drain Orders	$ 159,833.78

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(Rives Township Section)
FUND NO. 851.255.959.000

DRAIN ORDERS WRITTEN - 2010

VILLAGE/TWP	DATE	NUMBER	PURPOSE	AMOUNT
Rives	4/07	10183	Progress Payment	9,332.50
	4/07	10184	Flow Calculations	415.00
	11/22	10227	Maintenance	20,714.55
			Total Drain Orders Written	$ 30,462.05

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(Round Lake/Farwell Lake Sanitary Sewer) BONDS
SERIES 2005
FUND NO. 851.245.959.000

DRAIN ORDERS WRITTEN - 2010

VILLAGE/TWP	DATE	NUMBER	PURPOSE	AMOUNT
Hanover/ Liberty	6/10	10193	Paying Agent Fee	112.50
			Total Drain Orders Written	$ 112.50

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(Southern Regional Interceptor Section) BONDS
SERIES 2005
FUND NO. 851.195.959.000

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DATE	NUMBER	PURPOSE	AMOUNT
Columbia/ Hanover Leoni Liberty	2/16	10176	Paying Agent Fee	112.50
	317	10177	Progress Payment	8,062.03
			Total Drain Orders	$ 8,174.53

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WATER SUPPLY FACILITY
(Spring Arbor Township Section) BONDS
SERIES 2005
FUND NO. 851.155.959.000

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DATE	NUMBER	PURPOSE	AMOUNT
Spring Arbor	5/19	10195	Paying Agent Fee	112.50

Total Drain Orders $ 112.50

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(U.S.-127 Sanitary Sewer)
FUND NO. 851.260.959.000

DRAIN ORDERS WRITTEN - 2009

VILLAGE/TWP	DATE	NUMBER	PURPOSE	AMOUNT
Columbia	7/22	10136	Reimbursement	12,085.98
		Total Drain Orders Written		$12,085.98

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(Village of Brooklyn Section) BONDS
SERIES 1996
FUND NO. 851.180.959.000

DRAIN ORDERS WRITTEN - 2010

VILLAGE/TWP	DATE	NUMBER	PURPOSE	AMOUNT
Brooklyn Village	5/19	10190	Paying Agent Fee	150.00
			Total Drain Orders Written	$ 150.00

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(Vineyard Lake Section) BONDS
SERIES 2003
FUND NO. 851.250.959.000

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DATE	NUMBER	PURPOSE	AMOUNT
Columbia/	2/10	10175	Legal Services	1,054.00
Norvell	3/31	10179	Legal Services	228.75
	5/19	10196	Legal Services	1,650.00
	5/19	10194	Paying Agent Fee	112.50
	6/07	10206	Legal Services	1,262.60
	7/27	10208	Legal Services	1,858.00
	8/24	10210	Legal Services	888.50
	9/14	10212	Legal Services	640.30
	10/06	10216	Legal Services	2,027.25
	12/08	10229	Legal Services	125.00
	12/30	10233	Closing Fund	73,855.13
			Total Drain Orders	$83,702.03

COUNTY OF JACKSON
STATE OF MICHIGAN
JACKSON COUNTY WASTEWATER DISPOSAL FACILITY
(Wolf Lake Section) BONDS
SERIES 2000 and 2006
FUND NO. 851.220.959.000

DRAIN ORDERS WRITTEN - 2010

TOWNSHIP	DATE	NUMBER	PURPOSE	AMOUNT
Grass Lake/	5/19	10187	Paying Agent Fee	150.00
Napoleon	5/19	10188	Paying Agent Fee	112.50
			Total Drain Orders Written	$ 262.50

Drain	801 DRAIN FUND FOR THE MONTH OF DECEMBER						802 DRAIN FUND FOR THE MONTH OF DECEMBER						NET TOTAL FOR THE MONTH OF DECEMBER					
	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010
Ackerson Lake	61.30		0.01			61.31	0.00					0.00	61.30	0.00	0.01	0.00	0.00	61.31
Acme	90,742.88		8.94			90,751.82	0.00					0.00	90,742.88	0.00	8.94	0.00	0.00	90,751.82
Adams-Disbrow	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Argus Court	0.00		0.00			0.00	190.50					190.50	-190.50	0.00	0.00	0.00	0.00	-190.50
Anderson	2.92		0.00			2.92	0.00					0.00	2.92	0.00	0.00	0.00	0.00	2.92
Angevine	536.55		0.05			536.60	0.00					0.00	536.55	0.00	0.05	0.00	0.00	536.60
Allen Branch	5,467.84		0.54			5,468.38	0.00					0.00	5,467.84	0.00	0.54	0.00	0.00	5,468.38
Ashley Swale	393.49		0.04			393.53	0.00					0.00	393.49	0.00	0.04	0.00	0.00	393.53
Austin #1	21,206.63		2.09			21,208.72	0.00					0.00	21,206.63	0.00	2.09	0.00	0.00	21,206.72
Avery Drive	601.77		0.06			601.83	0.00					0.00	601.77	0.00	0.06	0.00	0.00	601.83
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ballard Creek	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Banvell Pellets	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Bateman	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Beaver Creek	694.51		0.07			694.58	0.00					0.00	694.51	0.00	0.07	0.00	0.00	694.58
Beebe-Taylor Lateral	4,340.35		0.43			4,340.78						0.00	4,340.35	0.00	0.43	0.00	0.00	4,340.78
Beebe-Taylor	1,494.46		0.15			1,494.61	2,096.45					2,096.45	-601.99	0.00	0.15	0.00	0.00	-601.84
Beverly Hills	84,206.45		8.30			84,214.75	0.00					0.00	84,206.45	0.00	8.30	0.00	0.00	84,214.75
Blackman #2	-78.60		-0.01			-78.61	0.00					0.00	-78.60	0.00	-0.01	0.00	0.00	-78.61
Bliss	32,347.92		3.19			32,351.11	0.00					0.00	32,347.92	0.00	3.19	0.00	0.00	32,351.11
Boland	32,581.05		3.21			32,584.26	0.00					0.00	32,581.05	0.00	3.21	0.00	0.00	32,584.26
Booth	10,169.33		1.00			10,170.33	0.00					0.00	10,169.33	0.00	1.00	0.00	0.00	10,170.33
Bradford Hicks	150.76		0.01			150.77	0.00					0.00	150.76	0.00	0.01	0.00	0.00	150.77
Brodock & Hungerford	2.75		0.00			2.75	0.00					0.00	2.75	0.00	0.00	0.00	0.00	2.75
Bromley Tile	55.24		0.01			55.25	0.00					0.00	55.24	0.00	0.01	0.00	0.00	55.25
Brookside	1,381.18		0.14			1,381.32	0.00					0.00	1,381.18	0.00	0.14	0.00	0.00	1,381.32
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Cascades Vista	1.14		0.00			1.14	1,070.00					1,070.00	-1,068.86	0.00	0.00	0.00	0.00	-1,068.86
Cavanaugh	635.34		0.06			635.40	0.00					0.00	635.34	0.00	0.06	0.00	0.00	635.40
Cahoogan	69.86		0.01			69.87	0.00					0.00	69.86	0.00	0.01	0.00	0.00	69.87
Campbell Extension	14,117.19		1.39			14,118.58	0.00					0.00	14,117.19	0.00	1.39	0.00	0.00	14,118.58
Campbell & Rice Creek	0.16		0.00			0.16	0.00					0.00	0.16	0.00	0.00	0.00	0.00	0.16
Carric Estates	618.77		0.06			618.83	0.00					0.00	618.77	0.00	0.06	0.00	0.00	618.83
Carson	17,528.38		1.73			17,530.11	0.00					0.00	17,528.38	0.00	1.73	0.00	0.00	17,530.11
Chanter	546.58		0.05			546.63	4,276.04					4,276.04	-3,729.46	0.00	0.05	0.00	0.00	-3,729.41
Chapel Heights	3.35		0.00			3.35	275.00					275.00	-271.65	0.00	0.00	0.00	0.00	-271.65
Chappel	293.98		0.03			294.01	0.00					0.00	293.98	0.00	0.03	0.00	0.00	294.01
Chappel & Benn	96.53		0.01			96.54	0.00					0.00	96.53	0.00	0.01	0.00	0.00	96.54
Chappel & Finch	11,095.97		1.09			11,097.06	0.00					0.00	11,095.97	0.00	1.09	0.00	0.00	11,097.06
Charmin Highlands	42,063.69		4.14			42,067.83	0.00					0.00	42,063.69	0.00	4.14	0.00	0.00	42,067.83
Christie	21,145.40		2.08			21,147.48	0.00					0.00	21,145.40	0.00	2.08	0.00	0.00	21,147.48
Clinton	1.61		0.00			1.61	0.00					0.00	1.61	0.00	0.00	0.00	0.00	1.61
Cobb Lake	2.39		0.00			2.39	0.00					0.00	2.39	0.00	0.00	0.00	0.00	2.39
Colbrook Meadows	2.98		0.00			2.98	0.00					0.00	2.98	0.00	0.00	0.00	0.00	2.98
Columbia Mobile Villa	366.50		0.04			366.54	0.00					0.00	366.50	0.00	0.04	0.00	0.00	366.54
Community College (Utility)	191.59		0.02			191.61	240.30					240.30	-48.71	0.00	0.02	0.00	0.00	-48.69
Conger Lateral	28,213.44		2.78			28,216.22	0.00					0.00	28,213.44	0.00	2.78	0.00	0.00	28,216.22
Conner & Bennett	17.85		0.00			17.85	0.00					0.00	17.85	0.00	0.00	0.00	0.00	17.85
Cooke's Landing	6.89		0.00			6.89	0.00					0.00	6.89	0.00	0.00	0.00	0.00	6.89
Cooper (Hanover)	93.13		0.01			93.14	0.00					0.00	93.13	0.00	0.01	0.00	0.00	93.14
Cooper Sulfate	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Corwin	7.48		0.00			7.48	631.50					631.50	-624.02	0.00	0.00	0.00	0.00	-624.02
Country River Estates	444.59		0.04			444.63	0.00					0.00	444.59	0.00	0.04	0.00	0.00	444.63
Cranberry & Ackerson	0.73		0.00			0.73	4,686.21					4,686.21	-4,685.48	0.00	0.00	0.00	0.00	-4,685.48
Crane Hollow Estates	406.70		0.04			406.74	0.00					0.00	406.70	0.00	0.04	0.00	0.00	406.74
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Darling Christie	209.21		0.02			209.23	0.00					0.00	209.21	0.00	0.02	0.00	0.00	209.23
Decker	5,225.78		0.51			5,226.29	12,084.35					12,084.35	-6,858.57	0.00	0.51	0.00	0.00	-6,858.06
Dietz	1,226.04		0.12			1,226.16	0.00					0.00	1,226.04	0.00	0.12	0.00	0.00	1,226.16
Dolbee Branch	3.34		0.00			3.34	0.00					0.00	3.34	0.00	0.00	0.00	0.00	3.34
Donnely Road	2.40		0.00			2.40	0.00					0.00	2.40	0.00	0.00	0.00	0.00	2.40
Doty	0.00		0.00			0.00	101.00					101.00	-101.00	0.00	0.00	0.00	0.00	-101.00
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eagle Crest	0.04		0.00			0.04	5,795.20					5,795.20	-5,795.16	0.00	0.00	0.00	0.00	-5,795.16
East Clark Lake	6,687.00		0.66			6,687.66	0.00					0.00	6,687.00	0.00	0.66	0.00	0.00	6,687.66
East Cranberry Lake	215.14		0.02			215.16	0.00					0.00	215.14	0.00	0.02	0.00	0.00	215.16
Erie Street	14,432.66		1.42			14,434.08	0.00					0.00	14,432.66	0.00	1.42	0.00	0.00	14,434.08
Erin's Court	238.80		0.02			238.82	0.00					0.00	238.80	0.00	0.02	0.00	0.00	238.82
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Farrand & McCann	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Fisher	109.10		0.01			109.11	0.00					0.00	109.10	0.00	0.01	0.00	0.00	109.11
Fisk	17,655.52		1.74			17,657.26	0.00					0.00	17,655.52	0.00	1.74	0.00	0.00	17,657.26
Forner	2,778.51		0.27			2,778.78	0.00					0.00	2,778.51	0.00	0.27	0.00	0.00	2,778.78
Foster-Dodd	5,745.13		0.57			5,745.70	0.00					0.00	5,745.13	0.00	0.57	0.00	0.00	5,745.70
Freeman Marsh	2.07		0.00			2.07	0.00					0.00	2.07	0.00	0.00	0.00	0.00	2.07
Fry	134.95		0.01			134.96	0.00					0.00	134.95	0.00	0.01	0.00	0.00	134.96
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00

Drain	801 DRAIN FUND FOR THE MONTH OF DECEMBER						802 DRAIN FUND FOR THE MONTH OF DECEMBER						NET TOTAL FOR THE MONTH OF DECEMBER					
	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010
Gang of Lakes	180.33		0.02			180.35	0.00					0.00	180.33	0.00	0.02	0.00	0.00	180.35
Ganton Drive Lateral	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Gatewood	1,231.35		0.12			1,231.47	1,230.09					1,230.09	1.26	0.00	0.12	0.00	0.00	1.38
Gillette Dey Ludlow	0.15		0.00			0.15	0.00					0.00	0.15	0.00	0.00	0.00	0.00	0.15
Glenngary	1,129.76		0.11			1,129.87	1,128.60					1,128.60	1.16	0.00	0.11	0.00	0.00	1.27
Golfside Terrace	23,129.43		2.28			23,131.71	0.00					0.00	23,129.43	0.00	2.28	0.00	0.00	23,131.71
Goodall Branch	3,177.97		0.31			3,178.28	0.00					0.00	3,177.97	0.00	0.31	0.00	0.00	3,178.28
Grand River	0.34		0.00			0.34	513.07					513.07	-512.73	0.00	0.00	0.00	0.00	-512.73
Grand River & Twin Lakes	118.78		0.01			118.79	0.00					0.00	118.78	0.00	0.01	0.00	0.00	118.79
Grand River Watershed Dues	0.15		0.00			0.15	0.00					0.00	0.15	0.00	0.00	0.00	0.00	0.15
Grand River Watershed	-0.66		0.00			-0.66	0.00					0.00	-0.66	0.00	0.00	0.00	0.00	-0.66
Grand River/Phase II	0.39		0.00			0.39	0.00					0.00	0.39	0.00	0.00	0.00	0.00	0.39
Grand River (SEMCOG)	0.07		0.00			0.07	0.00					0.00	0.07	0.00	0.00	0.00	0.00	0.07
Grand River (Watershed Ad)	12,666.16		1.25			12,667.41	0.00					0.00	12,666.16	0.00	1.25	0.00	0.00	12,667.41
Grand River (Tetra Tech)	-35.81		0.00			-35.81	2,000.00					2,000.00	-2,035.81	0.00	0.00	0.00	0.00	-2,035.81
Grand River (Tetra Tech) S72	0.00		0.00			0.00	1,232.03					1,232.03	-1,232.03	0.00	0.00	0.00	0.00	-1,232.03
Grand River (ASTI)	0.24		0.00			0.24	0.00					0.00	0.24	0.00	0.00	0.00	0.00	0.24
Grass Lake	1,360.14		0.13			1,360.27	1,358.38					1,358.38	1.76	0.00	0.13	0.00	0.00	1.89
Grass Lake Sanitary	14,593.24		1.44			14,594.68	0.00					0.00	14,593.24	0.00	1.44	0.00	0.00	14,594.68
Grass Lake Water	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Greenbriar	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Gregory	20.02		0.00			20.02	0.00					0.00	20.02	0.00	0.00	0.00	0.00	20.02
Griffith Lake	19.56		0.00			19.56	0.00					0.00	19.56	0.00	0.00	0.00	0.00	19.56
Gurley Lake & Branch	40,616.97		4.00			40,620.97	0.00					0.00	40,616.97	0.00	4.00	0.00	0.00	40,620.97
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Hammond-Bridenstein	4.93		0.00			4.93	0.00					0.00	4.93	0.00	0.00	0.00	0.00	4.93
Hankerd Grove	673.67		0.07			673.74	0.00					0.00	673.67	0.00	0.07	0.00	0.00	673.74
Harr-Katz Branch	1,624.35		0.16			1,624.51	0.00					0.00	1,624.35	0.00	0.16	0.00	0.00	1,624.51
Harris-Pomeroy	2.90		0.00			2.90	0.00					0.00	2.90	0.00	0.00	0.00	0.00	2.90
Hatt	3,352.93		0.33			3,353.26	0.00					0.00	3,352.93	0.00	0.33	0.00	0.00	3,353.26
Havens	172.74		0.02			172.76	0.00					0.00	172.74	0.00	0.02	0.00	0.00	172.76
Hawley-Klein	3,429.44		0.34			3,429.78	0.00					0.00	3,429.44	0.00	0.34	0.00	0.00	3,429.78
Heisler	37.59		0.00			37.59	0.00					0.00	37.59	0.00	0.00	0.00	0.00	37.59
Hendee	2,506.85		0.25			2,507.10	5,828.00					5,828.00	-3,321.15	0.00	0.25	0.00	0.00	-3,320.90
Henrietta	50.33		0.00			50.33	0.00					0.00	50.33	0.00	0.00	0.00	0.00	50.33
Hollis	18.30		0.00			18.30	0.00					0.00	18.30	0.00	0.00	0.00	0.00	18.30
Hubbard-Densmore	1.03		0.00			1.03	0.00					0.00	1.03	0.00	0.00	0.00	0.00	1.03
Huntoon Lake	124.59		0.01			124.60	0.00					0.00	124.59	0.00	0.01	0.00	0.00	124.60
Hurd Marvin	0.07		0.00			0.07	4,850.28	1,860.00				6,710.28	-4,850.21	1,860.00	0.00	0.00	0.00	-6,710.21
Huttenlocker	0.62		0.00			0.62	65.00					65.00	-64.38	0.00	0.00	0.00	0.00	-64.38
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Imperial Shores	-121.06		-0.01			-121.07	110.00					110.00	-231.06	0.00	-0.01	0.00	0.00	-231.07
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Jewell	4,507.79		0.44			4,508.23	0.00					0.00	4,507.79	0.00	0.44	0.00	0.00	4,508.23
Johnson-Minor	1.29		0.00			1.29	0.00					0.00	1.29	0.00	0.00	0.00	0.00	1.29
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Kedron	30.14		0.00			30.14	399.70					399.70	-369.56	0.00	0.00	0.00	0.00	-369.56
Kennedy	4,495.63		0.44			4,496.07	9,534.55					9,534.55	-5,038.92	0.00	0.44	0.00	0.00	-5,038.48
Kent	3.17		0.00			3.17	810.40					810.40	-807.23	0.00	0.00	0.00	0.00	-807.23
King-Harrington	31.49		0.00			31.49	0.00					0.00	31.49	0.00	0.00	0.00	0.00	31.49
King-Needham	1.94		0.00			1.94	0.00					0.00	1.94	0.00	0.00	0.00	0.00	1.94
Knowles-Borner	-19.72		0.00			-19.72	0.00					0.00	-19.72	0.00	0.00	0.00	0.00	-19.72
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ladd-Main	0.00		0.00			0.00	337.08					337.08	-337.08	0.00	0.00	0.00	0.00	-337.08
Leslie	11.60		0.00			11.60	0.00					0.00	11.60	0.00	0.00	0.00	0.00	11.60
Liberty Heights	309.80		0.03			309.83	0.00					0.00	309.80	0.00	0.03	0.00	0.00	309.83
Liberty Waldo	342.50		0.03			342.53	0.00					0.00	342.50	0.00	0.03	0.00	0.00	342.53
Loder	0.20		0.00			0.20	107.00					107.00	-106.80	0.00	0.00	0.00	0.00	-106.80
Lowe-Ridgeway	1,181.18		0.12			1,181.30	0.00					0.00	1,181.18	0.00	0.12	0.00	0.00	1,181.30
Lusk Lake	665.72		0.07			665.79	0.00					0.00	665.72	0.00	0.07	0.00	0.00	665.79
Lynn-Haven	15,197.38		1.50			15,198.88	0.00					0.00	15,197.38	0.00	1.50	0.00	0.00	15,198.88
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
McCain	5,942.99		0.59			5,943.58	0.00					0.00	5,942.99	0.00	0.59	0.00	0.00	5,943.58
McConnell	6,875.78		0.68			6,876.46	0.00					0.00	6,875.78	0.00	0.68	0.00	0.00	6,876.46
McCready	0.70		0.00			0.70	203.75					203.75	-203.05	0.00	0.00	0.00	0.00	-203.05
McKarr Court	304.48		0.03			304.51	0.00					0.00	304.48	0.00	0.03	0.00	0.00	304.51
Mantleville	22,840.47		2.25			22,842.72	0.00					0.00	22,840.47	0.00	2.25	0.00	0.00	22,842.72
Mayette	867.74		0.09			867.83	0.00					0.00	867.74	0.00	0.09	0.00	0.00	867.83
Meadow Lanes	15,575.82		1.53			15,577.35	0.00					0.00	15,575.82	0.00	1.53	0.00	0.00	15,577.35
Mercedes Lake	2,722.19		0.27			2,722.46	0.00					0.00	2,722.19	0.00	0.27	0.00	0.00	2,722.46
Meridian	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Miles-Kirkby	743.69		0.07			743.76	0.00					0.00	743.69	0.00	0.07	0.00	0.00	743.76
Miller	1,534.00		0.15			1,534.15	0.00					0.00	1,534.00	0.00	0.15	0.00	0.00	1,534.15
Miller Lake	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
W. B. Miner	0.16		0.00			0.16	6,097.77					6,097.77	-6,097.61	0.00	0.00	0.00	0.00	-6,097.61
Mitchell	0.27		0.00			0.27	0.00					0.00	0.27	0.00	0.00	0.00	0.00	0.27
Moe-Brewer	6,540.94		0.64			6,541.58	0.00					0.00	6,540.94	0.00	0.64	0.00	0.00	6,541.58
Moore	50,507.31	413.39	4.98			50,098.90	0.00					0.00	50,507.31	413.39	4.98	0.00	0.00	50,098.90

	801 DRAIN FUND FOR THE MONTH OF DECEMBER						802 DRAIN FUND FOR THE MONTH OF DECEMBER						NET TOTAL FOR THE MONTH OF DECEMBER					
Drain	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010
Moore-O'Neil	3,706.65		0.37			3,707.02	0.00					0.00	3,706.65	0.00	0.37	0.00	0.00	3,707.02
Moors	403.39		0.04			403.43	0.00					0.00	403.39	0.00	0.04	0.00	0.00	403.43
Munith	5,793.82		0.57			5,794.39	11,573.64					11,573.64	-5,779.82	0.00	0.57	0.00	0.00	-5,779.25
Murdock	669.23		0.07			669.30	0.00					0.00	669.23	0.00	0.07	0.00	0.00	669.30
Murray Branch	0.16		0.00			0.16	2,803.41					2,803.41	-2,803.25	0.00	0.00	0.00	0.00	-2,803.25
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Natural	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Neil	1,580.85		0.16			1,581.01	0.00					0.00	1,580.85	0.00	0.16	0.00	0.00	1,581.01
Noon Lateral	0.00		0.00			0.00	1,210.80					1,210.80	-1,210.80	0.00	0.00	0.00	0.00	-1,210.80
Nooney	14,772.79		1.46			14,774.25	0.00					0.00	14,772.79	0.00	1.46	0.00	0.00	14,774.25
N.W. Hills	35.33		0.00			35.33	0.00					0.00	35.33	0.00	0.00	0.00	0.00	35.33
Nylen	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Oak Hill Estates	0.00		0.00			0.00	101.23					101.23	-101.23	0.00	0.00	0.00	0.00	-101.23
Oak Street	13,438.80		1.32			13,440.12	0.00					0.00	13,438.80	0.00	1.32	0.00	0.00	13,440.12
Oak Tree Lane	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ogle	22,908.47		2.26			22,910.73	0.00					0.00	22,908.47	0.00	2.26	0.00	0.00	22,910.73
O'Leary	0.17		0.00			0.17	14,169.82					14,169.82	-14,169.65	0.00	0.00	0.00	0.00	-14,169.65
Olney	8.46		0.00			8.46	0.00					0.00	8.46	0.00	0.00	0.00	0.00	8.46
	0.00		0.00			0.00	53.00					53.00	-53.00	0.00	0.00	0.00	0.00	-53.00
Page/Kennedy	9,791.40		0.96			9,792.36	0.00					0.00	9,791.40	0.00	0.96	0.00	0.00	9,792.36
Page (Summit Twp.)	9,140.72		0.90			9,141.62	0.00					0.00	9,140.72	0.00	0.90	0.00	0.00	9,141.62
Pahl	1,961.39		0.19			1,961.58	0.00					0.00	1,961.39	0.00	0.19	0.00	0.00	1,961.58
Paka Plaza	24,748.84		2.44			24,751.28	0.00					0.00	24,748.84	0.00	2.44	0.00	0.00	24,751.28
Palmer Case	183.22		0.02			183.24	0.00					0.00	183.22	0.00	0.02	0.00	0.00	183.24
Park Forest	2,336.56		0.23			2,336.79	0.00					0.00	2,336.56	0.00	0.23	0.00	0.00	2,336.79
Parks-Tobin	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Parma Village	811.03		0.08			811.11	0.00					0.00	811.03	0.00	0.08	0.00	0.00	811.11
Pauline Dr.	452.61		0.04			452.65	0.00					0.00	452.61	0.00	0.04	0.00	0.00	452.65
Peacock & Extension	12,197.70		1.20			12,198.90	0.00					0.00	12,197.70	0.00	1.20	0.00	0.00	12,198.90
Perry Branch	8.77		0.00			8.77	0.00					0.00	8.77	0.00	0.00	0.00	0.00	8.77
Pierce	-25.94		0.00			-25.94	0.00					0.00	-25.94	0.00	0.00	0.00	0.00	-25.94
Pine View	309.49		0.03			309.52	0.00					0.00	309.49	0.00	0.03	0.00	0.00	309.52
Piper	0.16		0.00			0.16	0.00					0.00	0.16	0.00	0.00	0.00	0.00	0.16
Platt	257.35		0.03			257.38	0.00					0.00	257.35	0.00	0.03	0.00	0.00	257.38
Plum Brook	12,609.45		1.24			12,610.69	0.00					0.00	12,609.45	0.00	1.24	0.00	0.00	12,610.69
Plum Orchard CK	12,214.21		1.20			12,215.41	0.00					0.00	12,214.21	0.00	1.20	0.00	0.00	12,215.41
Plum VanAntwerp	334.19		0.03			334.22	0.00					0.00	334.19	0.00	0.03	0.00	0.00	334.22
Poole	-168.46		-0.02			-168.48	0.00					0.00	-168.46	0.00	-0.02	0.00	0.00	-168.48
Portage River	2,120.56		0.21			2,120.77	0.00					0.00	2,120.56	0.00	0.21	0.00	0.00	2,120.77
Pretty Branch	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ranch Park	3,118.01		0.31			3,118.32	0.00					0.00	3,118.01	0.00	0.31	0.00	0.00	3,118.32
Rhodes	1,027.79		0.10			1,027.89	0.00					0.00	1,027.79	0.00	0.10	0.00	0.00	1,027.89
Rice Creek	4,560.45		0.45			4,560.90	0.00					0.00	4,560.45	0.00	0.45	0.00	0.00	4,560.90
Richard Street	312.17		0.03			312.20	0.00					0.00	312.17	0.00	0.03	0.00	0.00	312.20
Ricks	1,032.47		0.10			1,032.57	2,135.10					2,135.10	-1,102.63	0.00	0.10	0.00	0.00	-1,102.53
Rives Blackman	11,005.65		1.08			11,006.73	0.00					0.00	11,005.65	0.00	1.08	0.00	0.00	11,006.73
Robinson Rd. Lateral	-3,835.16		-0.38			-3,835.54	630.00					630.00	-4,465.16	0.00	-0.38	0.00	0.00	-4,465.54
Rosemary Lane	406.62		0.04			406.66	0.00					0.00	406.62	0.00	0.04	0.00	0.00	406.66
Ruel	321.60		0.03			321.63	0.00					0.00	321.60	0.00	0.03	0.00	0.00	321.63
Russell	58.25		0.01			58.26	0.00					0.00	58.25	0.00	0.01	0.00	0.00	58.26
Russell-Mead	8,236.61		0.81			8,237.42	0.00					0.00	8,236.61	0.00	0.81	0.00	0.00	8,237.42
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Saines	3,266.37		0.32			3,266.69	6,525.80					6,525.80	-3,259.43	0.00	0.32	0.00	0.00	-3,259.11
Saltzgaber	2,799.80		0.28			2,800.08	0.00					0.00	2,799.80	0.00	0.28	0.00	0.00	2,800.08
Sand Hill Estates	310.33		0.03			310.36	0.00					0.00	310.33	0.00	0.03	0.00	0.00	310.36
Sandstone & Black	22,599.71		2.23			22,601.94	0.00					0.00	22,599.71	0.00	2.23	0.00	0.00	22,601.94
Sandy Ridge	810.05		0.08			810.13	0.00					0.00	810.05	0.00	0.08	0.00	0.00	810.13
Sanford	2,333.78		0.23			2,334.01	0.00					0.00	2,333.78	0.00	0.23	0.00	0.00	2,334.01
Seifert	600.26		0.06			600.32	0.00					0.00	600.26	0.00	0.06	0.00	0.00	600.32
Sharp	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Shaw	-92.15		-0.01			-92.16	0.00					0.00	-92.15	0.00	-0.01	0.00	0.00	-92.16
Shoemaker Woods	3,826.73		0.38			3,827.11	0.00					0.00	3,826.73	0.00	0.38	0.00	0.00	3,827.11
Simon Fortino	4,377.73		0.43			4,378.16	0.00					0.00	4,377.73	0.00	0.43	0.00	0.00	4,378.16
Smith	26,633.31		2.62			26,635.93	0.00					0.00	26,633.31	0.00	2.62	0.00	0.00	26,635.93
South Grass Lake	550.51		0.05			550.56	0.00					0.00	550.51	0.00	0.05	0.00	0.00	550.56
Span's Farm	415.74		0.04			415.78	0.00					0.00	415.74	0.00	0.04	0.00	0.00	415.78
Spencer Lake	444.35		0.04			444.39	0.00					0.00	444.35	0.00	0.04	0.00	0.00	444.39
Springbrook	27,178.72		2.68			27,181.40	0.00					0.00	27,178.72	0.00	2.68	0.00	0.00	27,181.40
Springbrook Farms	32.74		0.00			32.74	0.00					0.00	32.74	0.00	0.00	0.00	0.00	32.74
Springbrook & Pretty	464.18		0.05			464.23	1,027.43					1,027.43	-563.25	0.00	0.05	0.00	0.00	-563.20
Spring Mill	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Stanfield	70.11		0.01			70.12	0.00					0.00	70.11	0.00	0.01	0.00	0.00	70.12
Stillwell	4.25		0.00			4.25	0.00					0.00	4.25	0.00	0.00	0.00	0.00	4.25
Stonegate Farms	0.00		0.00			0.00	2,082.67					2,082.67	-2,082.67	0.00	0.00	0.00	0.00	-2,082.67
Stonewall	38,381.35		3.78			38,385.13	0.00					0.00	38,381.35	0.00	3.78	0.00	0.00	38,385.13
Stoney Lake	23.68		0.00			23.68	0.00					0.00	23.68	0.00	0.00	0.00	0.00	23.68

Drain	801 DRAIN FUND FOR THE MONTH OF DECEMBER						802 DRAIN FUND FOR THE MONTH OF DECEMBER						NET TOTAL FOR THE MONTH OF DECEMBER					
	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	Dedication Deed	As of 12/31/2010
Summit	0.00		0.00			0.00	4,350.04					4,350.04	-4,350.04	0.00	0.00	0.00	0.00	-4,350.04
Suncrest	396.05		0.04			396.09	0.00					0.00	396.05	0.00	0.04	0.00	0.00	396.09
Sunnydell	0.47		0.00			0.47	0.00					0.00	0.47	0.00	0.00	0.00	0.00	0.47
Sunny Meadows Estates	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Sunset Ranch	513.25		0.05			513.30	0.00					0.00	513.25	0.00	0.05	0.00	0.00	513.30
Sunset View	16,776.14		1.65			16,777.79	0.00					0.00	16,776.14	0.00	1.65	0.00	0.00	16,777.79
Sutton	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Sweezey Lake	8,833.88		0.87			8,834.75	0.00					0.00	8,833.88	0.00	0.87	0.00	0.00	8,834.75
Swiss Village	312.07		0.03			312.10	0.00					0.00	312.07	0.00	0.03	0.00	0.00	312.10
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Tamarack Glen	337.89		0.03			337.92	0.00					0.00	337.89	0.00	0.03	0.00	0.00	337.92
Tanglewood	0.07		0.00			0.07	-4.02					-4.02	4.09	0.00	0.00	0.00	0.00	4.09
Thompson Lake	-65.05		-0.01			-65.06	790.98					790.98	-856.03	0.00	-0.01	0.00	0.00	-856.04
Three-Forty Farms	47.98		0.00			47.98	105.00					105.00	-57.02	0.00	0.00	0.00	0.00	-57.02
Timber Meadows	1.10		0.00			1.10	845.44					845.44	-844.34	0.00	0.00	0.00	0.00	-844.34
Tim's Lake	115.65		0.01			115.66	0.00					0.00	115.65	0.00	0.01	0.00	0.00	115.66
Tobin-Snyder	0.00		0.00			0.00	119.70		2.60			117.10	-119.70	0.00	-2.60	0.00	0.00	-117.10
Todd-Klee	-471.81		-0.05			-471.86	255.55					255.55	-727.36	0.00	-0.05	0.00	0.00	-727.41
Tompkins-Springport	0.00		0.00			0.00	-5.68					-5.68	5.68	0.00	0.00	0.00	0.00	5.68
Torrey Whitney	10.48		0.00			10.48	0.00					0.00	10.48	0.00	0.00	0.00	0.00	10.48
Towsey-Fellows	692.54		0.07			692.61	0.00					0.00	692.54	0.00	0.07	0.00	0.00	692.61
Trillium	349.88		0.03			349.91	0.00					0.00	349.88	0.00	0.03	0.00	0.00	349.91
T.T. Townsend	2,528.52		0.25			2,528.77	0.00					0.00	2,528.52	0.00	0.25	0.00	0.00	2,528.77
Tucker	70.90		0.01			70.91	0.00					0.00	70.90	0.00	0.01	0.00	0.00	70.91
Twin Lakes	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Twin Meadows	311.43		0.03			311.46	0.00					0.00	311.43	0.00	0.03	0.00	0.00	311.46
Upper Grand River (IDEP)	698.32		0.07			698.39	0.00					0.00	698.32	0.00	0.07	0.00	0.00	698.39
Upper Grand River (319)	-0.53		0.00			-0.53	5,750.00					5,750.00	-5,750.53	0.00	0.00	0.00	0.00	-5,750.53
Village Green	343.84		0.03			343.87	0.00					0.00	343.84	0.00	0.03	0.00	0.00	343.87
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Watts Tile	15,344.87		1.51			15,346.38	0.00					0.00	15,344.87	0.00	1.51	0.00	0.00	15,346.38
West Jackson	-2,238.74		-0.22			-2,238.96	21,070.01					21,070.01	-23,308.75	0.00	-0.22	0.00	0.00	-23,308.97
W. Jackson Courtland Blvd.	0.20		0.00			0.20	0.00					0.00	0.20	0.00	0.00	0.00	0.00	0.20
Wetmore	2.98		0.00			2.98	0.00					0.00	2.98	0.00	0.00	0.00	0.00	2.98
Wheeler	1,493.67		0.15			1,493.82	0.00					0.00	1,493.67	0.00	0.15	0.00	0.00	1,493.82
Winchell & Townsend	0.00		0.00			0.00	159.96					159.96	-159.96	0.00	0.00	0.00	0.00	-159.96
Whispering Winds	0.00		0.00			0.00	421.98					421.98	-421.98	0.00	0.00	0.00	0.00	-421.98
Whisper Woods	36.90		0.00			36.90	0.00					0.00	36.90	0.00	0.00	0.00	0.00	36.90
Whitman	0.50		0.00			0.50	3,271.38					3,271.38	-3,270.88	0.00	0.00	0.00	0.00	-3,270.88
Whitney	1.15		0.00			1.15	0.00					0.00	1.15	0.00	0.00	0.00	0.00	1.15
Wilcox Wooster	53.75		0.01			53.76	0.00					0.00	53.75	0.00	0.01	0.00	0.00	53.76
Wild	15,438.46		1.52			15,439.98	29,315.60					29,315.60	-13,877.14	0.00	1.52	0.00	0.00	-13,875.62
Wolflake Highlands	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Woodbine	5,006.82		0.49			5,007.31	0.00					0.00	5,006.82	0.00	0.49	0.00	0.00	5,007.31
Woodliff	870.27		0.09			870.36	0.00					0.00	870.27	0.00	0.09	0.00	0.00	870.36
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
Younkin	100.90		0.01			100.91	0.00					0.00	100.90	0.00	0.01	0.00	0.00	100.91
	0.00		0.00			0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
GRAND TOTAL	1,112,093.38	413.39	109.58	0.00	0.00	1,111,789.50	176,011.09	1,860.00	2.60	0.00	0.00	177,868.49	936,082.29	2,273.39	106.98	0.00	0.00	933,921.01

LAKE LEVEL DISTRICTS

INLAND LAKE LEVEL PROJECTS

The County Drain Commission addressed the following Lake Level projects, established and regulated through Act No. 146, of the Public Acts or 1961, in 2001, in the following manner:

NORVELL MILL POND, Norvell Township

Completed the inspection and report required by the State of Michigan Department of Natural Resources and Environment.

ROUND LAKE, Hanover Township

The dam outlet was full of sand. The drain was vacuumed and jetted to clear the line. Stop logs were periodically removed and replaced. The grate was periodically cleaned out.

DAM INSPECTION REPORTS

Under the authority of Part 307, Inland Lake Levels, of the Natural Resources and Environmental Protection Act, 1994 PA 451, as amended (NREPA), the following Lake Levels were inspected:

Horton Mill Pond	Hanover Township
Mirror Lake Level Control Structure	Liberty Township
Norvell Mill Pond	Norvell Township

REVOLVING LAKE LEVEL FUND

The following Revolving Lake Level Fund deficits will be cleared by future drain tax levies or other Act 40 reimbursements:

Norvell Mill Pond	337.59
Round Lake	4,889.45
Total	$5,227.04

LAKE LEVEL ORDERS WRITTEN - 2010

TOWNSHIP	LAKE LEVEL	DATE	NUMBER	PURPOSE	AMOUNT
Liberty/ Hanover	Round Lake	1/27	12252	Maintenance	644.55
		2/23	12261	Maintenance	327.00
		6/07	12292	Maintenance	250.00
		6/07	12293	Maintenance	4,700.00
		11/09	12254	Maintenance	192.00
					6,113.55
Norvell	Norvell Mill Pond	5/25	12289	Engineering	688.99

Total Lake Level Orders $ 6,802.54

	841 DRAIN FUND FOR THE MONTH OF DECEMBER					842 DRAIN FUND FOR THE MONTH OF DECEMBER					NET TOTAL FOR THE MONTH OF DECEMBER				
Drain	As of 12/01/2010	Debits	Credits	Assessments	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	As of 12/31/2010	As of 12/01/2010	Debits	Credits	Assessments	As of 12/31/2010
Cranberry Lake	1,951.82		0.18		1,952.00	0.00		0.00		0.00	1,951.82	0.00	0.18	0.00	1,952.00
Gillett's Lake	1,442.18		0.13		1,442.31	0.00		0.00		0.00	1,442.18	0.00	0.13	0.00	1,442.31
Horton Mill/Moscow Rd.	1,071.78		0.10		1,071.88	0.00		0.00		0.00	1,071.78	0.00	0.10	0.00	1,071.88
Mirror Lake	54,208.52		5.06		54,213.58	0.00		0.00		0.00	54,208.52	0.00	5.06	0.00	54,213.58
Norvell Mill	3,907.82		0.36		3,908.18	337.59		0.00		337.59	3,570.23	0.00	0.36	0.00	3,570.59
Pleasant Lake	9,263.44		0.86		9,264.30	0.00		0.00		0.00	9,263.44	0.00	0.86	0.00	9,264.30
Round Lake	49.37		0.00		49.37	4,889.45		0.00		4,889.45	-4,840.08	0.00	0.00	0.00	-4,840.08
Sharp	0.00		0.00		0.00	0.00		0.00		0.00	0.00	0.00	0.00	0.00	0.00
White Lake	1,200.38		0.11		1,200.49	0.00		0.00		0.00	1,200.38	0.00	0.11	0.00	1,200.49
TOTALS	73,095.31		6.82		73,102.11	5,227.04	0.00		0.00	5,227.04	67,868.27	0.00	6.82	0.00	67,875.07

Governmental Accounting Standards Board GASB Statement No. 34

Governmental Accounting Standards Board
(GASB Statement No. 34)

The Governmental Accounting Standards Board (GASB No. 34) is the new financial reporting model, which has been established for the purpose of reporting infrastructure assets. Traditionally, state and local governments have not been required to report general infrastructure assets (e.g. road, bridges, dams, drains, sanitary sewers) in their financial statements. However, GASB Statement No. 34 requires that all capital assets, including general infrastructure assets, be capitalized in the financial statements at their historical costs or estimated historical costs. Furthermore, this requirement, as a rule, will apply retroactively to major general infrastructure assets that were required in fiscal years beginning after June 15, 1980, or that received major renovations, restorations, or improvements since that date.

Following is a list of all of the infrastructures, and their costs relative to our Office:

Jackson County Drain Commission				
2010				
	GASB STATEMENT NO. 34			
DRAIN & LAKE LEVEL	CARD	YEAR	YEAR- MOST RECENT	AMOUNT
		1st CONSTRUCTED	CONSTRUCTION ACTIVITY	
Ackerson Lake	Yes	1919		1,800.00
Acme	Yes	1961		142,718.00
Allen Branch of Thompson Lake	Yes	1902		96,788.00
Argus Court	Yes	1961		8,984.00
Austin	Yes	1975		42,000.00
Bailey	Yes	1983		25,000.00
Baldwin	Yes	1917		
Barnes & Carpenter Intercounty				
Barrett Lateral	Yes	1954		96,337.00
Bateman	Yes			
Batteese Creek (Ingham Co.Only)				
Beaver Creek Intercounty	Yes	1908		840.00
Beebe- Taylor	Yes	1911		26,800.00
Beebe-Taylor Lateral	Yes	1988		23,933.00
Bennett Road		1982		
Blackman #2	Yes	1942		
Bliss	Yes	1922		1,080.00
Boland	Yes	1980		89,452.00
Booth	Yes	1917		4,874.00
Bromley Tile	Yes	1912		262.00
C.E. Walker Intercounty	Yes	1962		
Campbell	Yes	1983		
Carric		2001		
Carson	Yes	1925		4,548.00
Cascades Manor	Yes	1955		8,229.00
Cascades Vista	Yes	1980		9,500.00
Chanter	Yes	1893		
Chapel & Benn	Yes	1886		
Chapel & Finch	Yes	1989		
Chapel Heights		2004		50,000.00
Charmin Higlands	Yes	1969		63,171.00
Christie	Yes	1966		45,000.00
Clinton	Yes	1956		5,255.00
Coachlight West	Yes	1989		80,000.00
Colbrook Meadows		2000		65,000.00
Collier Mud Creek Intercounty				
Conger	Yes	1983		85,000.00
Conger Lateral	Yes	1986		6,000.00
Conner & Bennett	Yes	1898		
Cortland Boulevard	Yes	1942		1,915.00
Country Manor	Yes	1986		32,000.00
Country River Estates	Yes	1996		
Coy	Yes	1992		
Cranberry Lake	Yes	1879		6,462.00
Crane Hallow Estates		2001		65,000.00
Crittenden	Yes	1888		
Curtis Lateral		1993		28,000.00
Darling-Christey/Torey Whitney Branch	Yes	1885		28,000.00
Decker	Yes	1917		1,167.00
Dolbee	Yes	1891		657.00
Donnelly Road	Yes	1961		
Doty	Yes	1952		12,571.00
Eagle Crest		2000		60,000.00
Erie Street	Yes	1962		23,500.00
Erin's Court		2002		20,000.00
Farwell & Pine Hill Dam	Yes	1970		
Faye Lake				
Fisher	Yes	1909		600.00
Fisher Big Wheel				
Fisk	Yes	1929		155,000.00
Flansburgh	Yes	1988		7,084.00
Foote Groove	Yes	1960		17,000.00
Forner & Twin Lake	Yes	1983		175,000.00
Foster-Dodd	Yes			4,124.00
Fox Farm	Yes	1990		11,000.00
Freeman-Marsh Intercounty	Yes	1898		728.00
Fry	Yes	1907		
Gang of Lakes	Yes	1916		10,950.00
Ganton Drive Lateral	Yes	1986		
Gatewood Subdivision	Yes	1992		538,000.00
Gillette Day-Ludlow	Yes	1913		70,000.00
Gillette's Lake Level	Yes	1965		2,900.00
Glenngarry	Yes	1997		45,000.00
Golfside terrace	Yes	1968		43,500.00
Golfview Hills	Yes	1990		
Goodall	Yes	1897		42,156.00
Grand Boulevard				
Grass Lake	Yes	1874		
Greenbriar		2001		110,000.00
Greg-Deck	Yes			
Gregory	Yes	1904		12,270.00
Gurley Lake	Yes	1887		2,610.00

DRAIN & LAKE LEVEL	CARD	YEAR	YEAR- MOST RECENT	AMOUNT
		1st CONSTRUCTED	CONSTRUCTION ACTIVITY	
Hammond-Bridenstine	Yes	1940		3,582.00
Harris & Pomeroy	Yes	1886		
Hatt	Yes	1906		5,022.00
Havens Intercounty	yes	1892		460.00
Hendee	Yes	1891		
Henrietta	Yes	1884		525.00
Hollis	Yes	1942		
Horton		1984		23,000.00
Horton Mill Pond	Yes	1965		16,226.00
Huff	Yes			
Hunton Lake				
Huntoon Lake Intercounty	Yes	1920		23,000.00
Hunttenlocker	Yes	1903		
Hurd-Marvin	Yes	1888		155,309.00
Hutchs Lateral	Yes	1988		
Imperial Shores	Yes	1978		
Jewell Intercounty	Yes	1904		2,350.00
John Saines	Yes	1988		12,740.00
Kalamazoo River				
Kedron	Yes	1883		33,071.00
Kennedy	Yes	1917		1,209.00
Kent	Yes	1930		5,100.00
Kibby	Yes	1970		146,000.00
King-Needham	Yes	1887		
Knowles-Borner	Yes	1898		1,130.00
Ladd& Manin	yes	1893		16,485.00
Lancashire Downs	Yes			
Laurence Ave.-Hurd-Marvin				
Leslie Intercounty	Yes	1914		7,100.00
Liberty Woods Subdivision		2001		94,000.00
Lime Lake				
Loder	Yes	1918		
Lonepine		1998		15,000.00
Loretta Branch of the John Saines	Yes	1973		141,000.00
Lowe-Ridgeway	Yes	1969		11,000.00
Lynn Haven	Yes	1983		59,000.00
McKarr		2002		33,000.00
Mac Boulevard	Yes	1989		
Mantleville	Yes	1916		33,950.00
Mar-Rich	Yes	1981		
Mayette & Moe Brewer		1873		
McCain	Yes	1917		4,354.00
Meado Lane	Yes	1965		15,000.00
Meadow Lark Acres	Yes			475,000.00
Melody Lane	Yes	1982		34,000.00
Mercedes Lake		1995		97,339.00
Meridian	Yes	1903		10,605.00
Meyers Avenue	Yes	1982		17,000.00
Miles-Kirkby	Yes	1949		462.00
Miller Acres	Yes	1921		1,750.00
Minard	Yes	1905		
Minard Mill Dam		1905		
Mirror Lake	Yes	1966		190,000.00
Mitchell	Yes	1899		961.00
Moe Lateral at John Saines	Yes	1979		162,000.00
Moe-Brewer	Yes	1890		714.00
Moore (Intercounty)	Yes	1908		2,915.00
Munith	Yes	1961		25,687.00
Murray	Yes	1892		535.00
Natural		2003		85,000.00
Neil	Yes	1934		2,300.00
Nooney	Yes	1953		33,000.00
North Chesning & Dover	Yes	1954		14,603.00
Norvell City	Yes	1983		
Norvell Mill Pond Dam	Yes	1983		280,000.00
Norvell-Manchester	Yes	1883		165,000.00
Oak Street	Yes	1962		52,947.00
Oak View Estates				
O'Leary	Yes	1951		13,036.00
Olney	Yes	1890		294.00
O'Neil Lateral				
Otter Creek				
Otts	Yes			

DRAIN & LAKE LEVEL	CARD	YEAR	YEAR- MOST RECENT	AMOUNT
		1st CONSTRUCTED	CONSTRUCTION ACTIVITY	
Page Avenue Lateral	Yes	1984		56,000.00
Pahl	Yes	1956		36,971.00
Park Forest	Yes	1977		260,000.00
Park Road	Yes			
Parma Village	Yes	1883		
Parnall Road Lateral		1997		
Parsons Lateral		1993		46,300.00
Pauline Drive		1999		
Peacock	Yes	1987		163,265.00
Pierce	Yes	1914		525.00
Pine Hill Lake Dam				
Pleasant Bay Estates		1989		27,680.00
Pleasant Lake Dam	Yes	1962		45,723.00
Pleasant View Lateral		2003		80,932.00
Plum Brook	Yes	1919		4,960.00
Plum Orchard Creek	Yes	1900		10,121.00
Plumb VanAntweep	Yes	1916		1,516.00
Poole	Yes	1912		4,961.00
Portage River				
Portage River (Intercounty)	Yes	1881		94,500.00
Price Lake Farms Subdivision		1998		46,000.00
Ranch Park	Yes	1960		4,320.00
Rhodes	Yes	1893		90,000.00
Rice Creek (Intercounty)	Yes	1883		387.00
Richard St. Site Condo.		2002		13,000.00
Ricks	Yes	1972		36,500.00
Rives-Blackman	yes	1869		374.00
Robinson	Yes	1960		637,849.00
Robinson Road Lateral				24,124.00
Rosemary Lane		2001		139,235.00
Round Lake	Yes	1971		125,000.00
Ruel		2003		16,410.00
Russell & Mead	Yes	1890		249.00
Sand Hill Estates		2000		84,000.00
Sandstone Balckman	Yes	1884		120,000.00
Sandy Ridge Subdivision	Yes	1993		76,000.00
Sanford	Yes	1917		1,191.00
Sharp	Yes	1903		22,012.00
Shaw	Yes	1900		
Shoemaker Woods Lateral		1989		98,000.00
Simon Fortino Lateral	Yes	1986		237,651.00
Spaan's Farm		1999		6,000.00
Spencer Lake Drive		2000		13,000.00
Spring Arbor & Concord	Yes	1886		16,148.00
Spring Arbor Heights		1999		18,000.00
Spring Mill Condo	Yes	1995		115,000.00
Springbrook & Pretty Branch	Yes	1891		139,875.00
Springbrook Farms	Yes	1993		8,000.00
Springport Lateral	Yes	1991		127,628.00
Stanfield	Yes	1893		744.00
Stillwell	Yes	1948		6,986.00
Stonegate Farms	Yes	1981		430,000.00
Stonewall	yes	1970		270,000.00
Stoney Lake	Yes	1868		165.00
Summit	Yes	1924		7,380.00
Suncrest		1999		13,000.00
Sunny Meadows		1999		26,000.00
Sunset Park	Yes	1984		52,000.00
Sunset Ranch Estate Condo.		1999		81,000.00
Surrey Lane	Yes	1981		34,500.00
Swains Lake Dam	Yes	1985		30,000.00
Swank	Yes	1964		1,719.00
Sweezey Lake	Yes	1958		4,202.00
T.T. Townsend	Yes	1890		510.00
TAC Lateral	Yes	1997		11,242.00
Tamarack Glenn		2003		95,000.00
Tanagelwood Lateral		1992		48,000.00
Thompson Lake	Yes	1859		158,000.00
Three Forty Farms	Yes	1980		360,000.00
Timber Medows	Yes	1980		423,806.00
Tim's Lake		1992		30,000.00
Tobin & Snyder	Yes	1898		317.00
Todd-Klee	Yes	1916		1,449.00
Tompkins-Springport	Yes	1885		1,335.00
Towsey-Fellows	Yes	1886		208.00
Tucker Drain & Foster Branch	Yes	1894		10,805.00
Twenty-second Street	Yes	1930		2,225.00
Twin Lake	Yes	1889		6,925.00
Twin Meadows		2004		146,000.00
Utopia				

DRAIN & LAKE LEVEL	CARD	YEAR	YEAR- MOST RECENT	AMOUNT
		1st CONSTRUCTED	CONSTRUCTION ACTIVITY	
Valleys		2001		145,000.00
Vandercook Drive	Yes	1988		77,000.00
Vera Cruz Lateral		1996		26,000.00
W.B. Miner	Yes	1917		1,078.00
Walcott Road Lateral		1983		11,500.00
Walden Woods	Yes	1982		78,240.00
Wamplers Lake	Yes	1995		5,675.00
Watts Tile	Yes	1911		821.00
West Jackson	Yes	1957		944,725.00
Wheaton Road Lateral		1987		44,000.00
Wheeler	Yes	1897		330,600.00
Whispering Woods Estate	Yes	1990		127,430.00
Whitman	Yes	1893		17,000.00
Whitney Intercounty	Yes			
Wilcox-Wooster	Yes	1886		525.00
Wild Intercounty	Yes	1961		29,700.00
Wolf Lake Highlands	Yes	1997		40,000.00
Woodbine	Yes	1976		17,152.00
Woodliff	Yes	1898		7,759.00
Woodview Height				
Woodworth Intercounty				
TOTAL				12,242,656.00
TOTAL1980-Present				5,982,542.00
SANITARY SEWER COLLECTION SYSTEMS	CARD	YEAR		AMOUNT
		1st CONSTRUCTED		
Clark Lake Sanitary Sewer		1994		787,500.00
Grass Lake Sanitary Sewer		1990		2,638,505.00
Lake Columbia Sanitary Sewer		2004		11,000,000.00
Napoleon Village		2001		1,125,000.00
Parma Village Improvements		2008		2,780,000.00
Rives Sanitary Sewer		2008		2,575,000.00
Round/Farwell Lake Sanitary Sewer		2007		3,900,000.00
Southern Regional Interceptor		2006		4,600,000.00
Sylvain Township		2002		6,500,000.00
U.S. 127 Interceptor		2007		
Village of Brooklyn Sanitary Sewer		1996		1,550,000.00
Village of Springport		1990		300,000.00
Vineyard Lake Extension		1997		500,000.00
Wolf Lake Sanitary Sewer		2000		4,900,000.00
TOTAL SEWER & COLLECTION SYSTEMS				43,156,005.00
WATER DISTRIBUTION SYSTEMS				
Grass Lake Township Water	2002B	2002		565,000.00
Grass Lake Village Water	2002A	2002		2,255,000.00
Parma Village	2002B	2002		1,100,000.00
Parma Village Water	2002A	2001		1,800,000.00
Spring Arbor Water		2005		480,000.00
TOTAL WATER SYSTEMS				6,200,000.00
TOTAL SEWER & WATER 1980-Present				49,356,005.00
GRAND TOTAL FOR DRAINS, SEWERS & WATER				55,398,661.00
GRAND TOTAL FOR DRAIN, SEWER & WATER 1980 to Present				55,338,547.00

Jackson County

RESOLUTION (10-11.31)
TO BE ADOPTED BY THE BOARD OF COMMISSIONERS

A Meeting of the Board of Commissioners of the County of Jackson (the "Company") was held on October 18, 2011. Sufficient members were present to constitute a quorum of the Commissioners. Following a reading of the Plan and an extensive discussion concerning the provisions, the following resolutions were, upon motion duly made, unanimously adopted:

RESOLVED**,** the County of Jackson Group Health Plan for Non-POAM Employees and the County of Jackson Group Health Plan for POAM Employees ("Plans") are adopted in the attached form, effective as of the dates contained therein.

RESOLVED FURTHER**,** that Michael Overton, County Administrator/Controller, is authorized and directed on behalf of the Company to execute all documents that are necessary for the formal adoption of the Plans.

I certify that the above is a true and complete record of action taken by the Board of Commissioners of the County of Jackson on the 18th day of October, 2011.

By: _____
Amanda Riska

Its: _____
Clerk

COUNTY OF JACKSON
DEPARTMENT OF HUMAN RESOURCES

120 West Michigan Avenue
Jackson, Michigan 49201

Telephone (517) 788-4340
FAX (517) 788-4404

To: Michael Overton
County Administrator/Controller

Date: September 20, 2011

From: Joni Johnson
Deputy Director – Human Resources

Re: Amended & Restated Health Plan Document

The attached documents (PDF and Word files) are the new Amended & Restated Health Plan Documents for the County of Jackson Health Plan. Although we are not legally required to have a health plan document there have been situations that have occurred in recent history regarding rights to health insurance coverage that lead us to develop a document. This document will not only protect the County, but will provide greatly needed clarification for employees and retirees regarding their rights to health insurance coverage through Jackson County.

Under health care reform the County has both a grandfathered and non-grandfathered health plan. Because of this, two documents had to be prepared accordingly. The full Amended & Restated Group Health Plan document is for administrative use and is more detailed than the Summary Plan Description (SPD). The SPD must be provided to all plan participants and is in a more easy to understand format than the full plan document.

The Board of Commissioners must formally adopt these Plans and adopt the attached Resolution and incorporate them into the Board minutes.

I'll be happy to address any questions you or members of the Board may have regarding these documents.

Thank you.

Cc: Adam Brown, Deputy County Administrator
Crystal Dixon, City/County Director of Human Resources

Blue Vision Care (A80) Coverage Benefits-at-a-Glance

County of Jackson

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	Participating provider	Nonparticipating provider
Member's responsibility (copays)		
Eye exam	$5 copay	$5 copay
Prescription glasses (lenses and/or frames)	A **combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge
Medically necessary contact lenses	$7.50 copay	Member responsible for difference between approved amount and provider's charge
Eye exam		
Eye exam by a physician or optometrist	$5 copay	75% of approved amount after $5 copay
	One eye exam in any period of 24 **consecutive** months	
Lenses and frames		
Standard lenses, not to exceed 65 mm in diameter, when prescribed or dispensed by a physician, optometrist or optician	$7.50 copay (one copay applies to both lenses and frames)	Covered up to predetermined amount
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	
Standard frames	$7.50 copay (one copay applies to both lenses and frames)	Covered up to predetermined amount
	One frame in any period of 24 **consecutive** months	
Contact lenses		
Medically necessary contact lenses (must meet criteria of medically necessary)	$7.50 copay	Covered up to predetermined amount
	One pair of contact lenses in any period of 24 **consecutive** months	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	Covered up to a maximum payment of $35 (member responsible for difference)	Covered up to a maximum payment of $35 (member responsible for difference)
	One pair of contact lenses in any period of 24 **consecutive** months	

Blue Choice℠ PPO
County of Jackson

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		Panel	Non-panel
Member's responsibility (deductibles, copays and dollar maximums)			
Deductibles		None	$100 per member or $200 for the family per calendar year
Copays	Fixed dollar copays	• $10 for office visits • $75 for emergency room visits	• $10 for office visits • $75 for emergency room visits
	Percent copays	None	20 percent of the approved amount
Copay dollar maximums – excludes fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays		Not applicable	$1,000 per member or $2,000 for the family per calendar year
Dollar maximums		None except as noted for individual services	Subject to a $1 million lifetime benefit maximum
Preventive care services			
Health maintenance exam		$10 copay	Not covered
Gynecological exam - One per calendar year		$10 copay	Covered - 80 percent of the approved amount after deductible
Routine laboratory and radiology services – includes chest x-ray, EKG, cholesterol screening and select lab procedures – one per calendar year		100% of approved amount	Covered - 80 percent of the approved amount after deductible
Pap smear screening - One per calendar year		100% of approved amount	Covered - 80 percent of the approved amount after deductible
Well-baby and child care		$10 copay	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics		100% of approved amount	Not covered
Proctoscopic exam - Once every 36 months at age 40 and older		100% of approved amount	Covered - 80 percent of the approved amount after deductible
Fecal occult blood screening - One per calendar year		100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel
Preventive care services- continued		
Flexible sigmoidoscopy exam - One per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Prostate specific antigen (PSA) screening - One per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Mammography		
Mammography screening – one baseline for ages 35-40, one annually after age 40	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Physician office services		
Office visits	$10 copay	Covered - 80 percent of the approved amount after deductible
Outpatient and home medical care visits	$10 copay	Covered - 80 percent of the approved amount after deductible
Office consultations	$10 copay	Covered - 80 percent of the approved amount after deductible
Urgent care visits	$10 copay	Covered - 80 percent of the approved amount after deductible
Emergency medical care		
Hospital emergency room – copay is waived when admitted	$75 copay	$75 copay
Ambulance services – must be medically necessary	100% of approved amount, ground service, and air service required for **emergency** transportation	Covered - 80 percent of the approved amount after deductible
Diagnostic services		
Laboratory and pathology services	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Diagnostic tests and x-rays	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Therapeutic radiology	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Maternity services by a physician or certified nurse midwife		
Prenatal and postnatal care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Delivery and nursery care	100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a **participating** hospital.	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Unlimited days	
Inpatient consultations	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Chemotherapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Alternatives to hospital care		
Skilled nursing care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Up to 120 days per calendar year	
Hospice care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Home infusion therapy – must be medically necessary	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Presurgical consultations	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Colonoscopy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Voluntary sterilization	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Human organ transplants		
Specified human organ transplants – in designated facilities **only**	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Must be coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	
Bone marrow transplants	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Must be coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	
Specified oncology clinical trials	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Kidney, cornea and skin transplants	100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel

Mental health care and substance abuse treatment

** **Note:** Mental health and substance abuse services **must** be coordinated by the Behavioral Health Manager to be considered in-network.

Inpatient mental health care and inpatient substance abuse treatment	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient mental health care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient substance abuse treatment – in approved facilities	100% of approved amount	Covered - 80 percent of the approved amount after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Allergy testing	$10 copay	Covered - 80 percent of the approved amount after deductible
Allergy therapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Chiropractic spinal manipulation	$10 copay	Covered - 80 percent of the approved amount after deductible
	Up to 20 visits per calendar year	
Outpatient physical, speech and occupational therapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Up to 60 visits per condition per calendar year	
Durable medical equipment	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Prosthetic and orthotic appliances	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Private duty nursing	100% of approved amount	Covered - 80 percent of the approved amount after deductible

Blue Choice℠ PPO
County of Jackson

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Member's responsibility (deductibles, copays and dollar maximums)

		Panel	Non-panel
Deductibles		None	$100 per member or $200 for the family per calendar year
Copays	Fixed dollar copays	• $5 for office visits • $25 for emergency room visits	• $5 for office visits • $25 for emergency room visits
	Percent copays	None	20 percent of the approved amount
Copay dollar maximums – excludes fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays		Not applicable	$1,000 per member or $2,000 for the family per calendar year
Dollar maximums		None except as noted for individual services	Subject to a $1 million lifetime benefit maximum

Preventive care services

Health maintenance exam	$5 copay	Not covered
Gynecological exam - One per calendar year	$5 copay	Covered - 80 percent of the approved amount after deductible
Routine laboratory and radiology services – includes chest x-ray, EKG, cholesterol screening and select lab procedures – one per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Pap smear screening - One per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Well-baby and child care	$5 copay	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	100% of approved amount	Not covered
Proctoscopic exam - Once every 36 months at age 40 and older	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Fecal occult blood screening - One per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel
Preventive care services- continued		
Flexible sigmoidoscopy exam - One per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Prostate specific antigen (PSA) screening - One per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Mammography		
Mammography screening – one baseline for ages 35-40, one annually after age 40	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Physician office services		
Office visits	$5 copay	Covered - 80 percent of the approved amount after deductible
Outpatient and home medical care visits	$5 copay	Covered - 80 percent of the approved amount after deductible
Office consultations	$5 copay	Covered - 80 percent of the approved amount after deductible
Urgent care visits	$5 copay	Covered - 80 percent of the approved amount after deductible
Emergency medical care		
Hospital emergency room – copay is waived when admitted	$25 copay	$25 copay
Ambulance services – must be medically necessary	100% of approved amount, ground service, and air service required for **emergency** transportation	Covered - 80 percent of the approved amount after deductible
Diagnostic services		
Laboratory and pathology services	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Diagnostic tests and x-rays	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Therapeutic radiology	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Maternity services by a physician or certified nurse midwife		
Prenatal and postnatal care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Delivery and nursery care	100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a **participating** hospital.	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Unlimited days	
Inpatient consultations	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Chemotherapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Alternatives to hospital care		
Skilled nursing care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Up to 120 days per calendar year	
Hospice care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Home infusion therapy – must be medically necessary	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Presurgical consultations	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Colonoscopy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Voluntary sterilization	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Human organ transplants		
Specified human organ transplants – in designated facilities **only**	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Must be coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	
Bone marrow transplants	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Must be coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	
Specified oncology clinical trials	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Kidney, cornea and skin transplants	100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel

Mental health care and substance abuse treatment

** **Note:** Mental health and substance abuse services **must** be coordinated by the Behavioral Health Manager to be considered in-network.

Inpatient mental health care and inpatient substance abuse treatment	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient mental health care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient substance abuse treatment – in approved facilities	100% of approved amount	Covered - 80 percent of the approved amount after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Allergy testing	$5 copay	Covered - 80 percent of the approved amount after deductible
Allergy therapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Chiropractic spinal manipulation	$5 copay	Covered - 80 percent of the approved amount after deductible
	Up to 20 visits per calendar year	
Outpatient physical, speech and occupational therapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Up to 60 visits per condition per calendar year	
Durable medical equipment	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Prosthetic and orthotic appliances	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Private duty nursing	100% of approved amount	Covered - 80 percent of the approved amount after deductible

Blue Choice℠ PPO
County of Jackson
44305/Non-Grandfathered

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		Panel	Non-panel
Member's responsibility (deductibles, copays and dollar maximums)			
Deductibles		None	$100 per member or $200 for the family per calendar year
Copays	Fixed dollar copays	• $10 for office visits • $75 for emergency room visits	• $10 for office visits • $75 for emergency room visits
	Percent copays	None	20 percent of the approved amount
Copay dollar maximums – excludes fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays		Not applicable	$1,000 per member or $2,000 for the family per calendar year
Dollar maximums		None except as noted for individual services	Subject to a $1 million lifetime benefit maximum
Preventive care services			
Health maintenance exam		100% of approved amount	Not covered
Gynecological exam - One per calendar year		100% of approved amount	Covered - 80 percent of the approved amount after deductible
Routine laboratory and radiology services – includes chest x-ray, EKG, cholesterol screening and select lab procedures – one per calendar year		100% of approved amount	Covered - 80 percent of the approved amount after deductible
Pap smear screening - One per calendar year		100% of approved amount	Covered - 80 percent of the approved amount after deductible
Well-baby and child care		100% of approved amount	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics		100% of approved amount	Not covered
Proctoscopic exam - Once every 36 months at age 40 and older		100% of approved amount	Covered - 80 percent of the approved amount after deductible
Fecal occult blood screening - One per calendar year		100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel
Preventive care services- continued		
Flexible sigmoidoscopy exam - One per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Prostate specific antigen (PSA) screening - One per calendar year	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Mammography		
Mammography screening – one baseline for ages 35-40, one annually after age 40	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Physician office services		
Office visits	$10 copay	Covered - 80 percent of the approved amount after deductible
Outpatient and home medical care visits	$10 copay	Covered - 80 percent of the approved amount after deductible
Office consultations	$10 copay	Covered - 80 percent of the approved amount after deductible
Urgent care visits	$10 copay	Covered - 80 percent of the approved amount after deductible
Emergency medical care		
Hospital emergency room – copay is waived when admitted	$75 copay	$75 copay
Ambulance services – must be medically necessary	100% of approved amount, ground service, and air service required for **emergency** transportation	Covered - 80 percent of the approved amount after deductible
Diagnostic services		
Laboratory and pathology services	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Diagnostic tests and x-rays	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Therapeutic radiology	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Maternity services by a physician or certified nurse midwife		
Prenatal and postnatal care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Delivery and nursery care	100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a **participating** hospital.	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Unlimited days	
Inpatient consultations	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Chemotherapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Alternatives to hospital care		
Skilled nursing care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Up to 120 days per calendar year	
Hospice care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Home infusion therapy – must be medically necessary	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Presurgical consultations	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Colonoscopy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Voluntary sterilization	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Human organ transplants		
Specified human organ transplants – in designated facilities **only**	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Must be coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	
Bone marrow transplants	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Must be coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	
Specified oncology clinical trials	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Kidney, cornea and skin transplants	100% of approved amount	Covered - 80 percent of the approved amount after deductible

	Panel	Non-panel

Mental health care and substance abuse treatment

** **Note:** Mental health and substance abuse services **must** be coordinated by the Behavioral Health Manager to be considered in-network.

Inpatient mental health care and inpatient substance abuse treatment	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient mental health care	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient substance abuse treatment – in approved facilities	100% of approved amount	Covered - 80 percent of the approved amount after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Allergy testing	$10 copay	Covered - 80 percent of the approved amount after deductible
Allergy therapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Chiropractic spinal manipulation	$10 copay	Covered - 80 percent of the approved amount after deductible
	Up to 20 visits per calendar year	
Outpatient physical, speech and occupational therapy	100% of approved amount	Covered - 80 percent of the approved amount after deductible
	Up to 60 visits per condition per calendar year	
Durable medical equipment	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Prosthetic and orthotic appliances	100% of approved amount	Covered - 80 percent of the approved amount after deductible
Private duty nursing	100% of approved amount	Covered - 80 percent of the approved amount after deductible

Dental Coverage – Plan D33
Benefits-at-a-Glance

County of Jackson

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information

- **DenteMax PPO network** – DenteMax PPO dentists agree to accept our approved amount as payment in full and participate on all claims. DenteMax is an independent company that leases its network to BCBSM to provide access to Blues members. You'll also receive discounts on noncovered services when you use PPO dentists. You can choose from more than 110,000 dentist access points* nationwide where dental services are available through our partnership with the **DenteMax** PPO network. To find a **DenteMax** dentist, please call 1-800-752-1547 or go to the DenteMax Web site at **dentemax.com.**

  ***** *A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.*

- **Blue Par Select**[SM] – Most dentists participate with the Blues on a "per claim" basis, so you should ask your dentist if he or she participates before every procedure. These dentists accept payment in full from BCBSM for covered services and you pay the dentist only applicable copays and deductibles, and any fees for noncovered services. You won't be balance billed for any difference between our approved amount and the dentist's charge. We call this arrangement "Blue Par Select." To find a dentist who may participate with BCBSM, go to **bcbsm.com**. Select the **Dental Professionals** subsection of "**Where You Can Go for Care"** page.

Note: If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

Copays	
• Class I services	None
• Class II services	25% of approved amount
• Class III services	50% of approved amount
• Class IV services	50% of approved amount
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,000 per member
• Lifetime maximum (for Class IV services)	$1,000 per member

Class I services

Oral exams	100% of approved amount, twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount, twice per calendar year
Full-mouth and panoramic x-rays	100% of approved amount, once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount, twice per calendar year
Pit and fissure sealants – for members age 19 or under	100% of approved amount, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatment	100% of approved amount, two per calendar year
Space maintainers – missing posterior (back) primary teeth – for members under age 19	100% of approved amount, once per quadrant per lifetime

Class II services

Fillings – permanent (adult) teeth	75% of approved amount, replacement fillings covered after 24 months or more after initial filling
Fillings – primary (baby) teeth	75% of approved amount, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth – for members age 12 or older	75% of approved amount, once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	75% of approved amount, three times per tooth per calendar year after six months from original restoration
Oral surgery including extractions	75% of approved amount
Root canal treatment – permanent tooth	75% of approved amount, once every 12 months for tooth with one or more canals
Scaling and root planing	75% of approved amount, once every 24 months per quadrant
Limited occlusal adjustments	75% of approved amount, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	75% of approved amount, once every 12 months
General anesthesia or IV sedation	75% of approved amount, when medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	75% of approved amount, six months or more after it is delivered
Relining or rebasing of a partial or complete denture	75% of approved amount, once every 36 months per arch
Tissue conditioning	75% of approved amount, once every 36 months per arch

Class III services

Removable dentures (complete and partial)	50% of approved amount, once every 60 months
Bridges (fixed partial dentures) – for members age 16 or older	50% of approved amount, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

COUNTY OF JACKSON

Dental Plan 08
Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Member's responsibility (copays and dollar maximums)

Copays	50% of approved amount for all covered services
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,000 per member for all covered services
• Lifetime maximum (for Class IV services)	Not applicable

Class I services

Oral exams – once every six consecutive months	Covered – 50% of approved amount
Teeth cleaning – once every six months	Covered – 50% of approved amount
Bitewing x-rays – once every six consecutive months	Covered – 50% of approved amount
Full-mouth x-rays – once every 36 months	Covered – 50% of approved amount
Fluoride treatments	Covered – 50% of approved amount
Space maintainers	Covered – 50% of approved amount, up to age 19

Class II services

Fillings (amalgam, acrylic or silicate)	Covered – 50% of approved amount
Inlays, onlays and crowns	Covered – 50% of approved amount
Root canal therapy	Covered – 50% of approved amount
Periodontic treatments	Covered – 50% of approved amount
Palliative (emergency) treatment	Covered – 50% of approved amount
General anesthesia	Covered – 50% of approved amount
Oral surgery including extractions	Covered – 50% of approved amount
Repairs to existing dentures	Covered – 50% of approved amount

Class III services

Removable dentures	Covered – 50% of approved amount
Fixed bridges	Covered – 50% of approved amount

Class IV services – Orthodontic services for dependents under age 19

Habit breaking appliances	Not covered
Minor tooth guidance appliances	Not covered
Full-banding treatment	Not covered
Monthly, active treatment visits	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins. If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

COUNTY OF JACKSON

Blue Preferred® Rx Prescription Drug Coverage with $10 Generic / $20 Formulary Brand / $40 Nonformulary Brand Triple-Tier Copay
Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com**. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

	Network pharmacy	Non-network pharmacy
Member's responsibility (copays)		
Tier 1 – Generic or prescribed over-the-counter drugs	$10 copay	$10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Tier 2 – Formulary brand-name drugs	$20 copay	$20 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Tier 3 – Nonformulary brand-name drugs	$40 copay	$40 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 30 day supply:** • $10 copay for Tier 1 (generic) drugs • $20 copay for Tier 2 (formulary brand) drugs • $40 copay for Tier 3 (nonformulary brand) drugs **Copay for a 31 to 90 day supply:** • $10 copay for Tier 1 (generic) drugs • $20 copay for Tier 2 (formulary brand) drugs • $40 copay for Tier 3 (nonformulary brand) drugs	No coverage

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic ***plus*** the applicable copay.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

	Network pharmacy	Non-network pharmacy
Covered services		
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Contraceptive injections, Prescription contraceptive devices and Prescription contraceptive medications	Coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).	

Features of your prescription drug plan	
BCBSM custom formulary	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ **Tier 2 (formulary brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay. ▪ **Tier 3 (nonformulary brand)** – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at **bcbsm.com**. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com**.

Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug, It applies only to prescriptions being filed for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com**, **along with the preferred medications**. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.

COUNTY OF JACKSON

Blue Preferred® Rx Prescription Drug Coverage with $15 Generic / $25 Formulary Brand / $40 Nonformulary Brand Triple-Tier Copay Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com**. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

	Network pharmacy	Non-network pharmacy
Member's responsibility (copays)		
Tier 1 – Generic or prescribed over-the-counter drugs	$15 copay	$15 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Tier 2 – Formulary brand-name drugs	$25 copay	$25 copay ***plus*** and additional 25% of BCBSM approved amount for the drug
Tier 3 – Nonformulary brand-name drugs	$40 copay	$40 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 30 day supply:** • $15 copay for Tier 1 (generic) drugs • $25 copay for Tier 2 (formulary brand) drugs • $40 copay for Tier 3 (nonformulary brand) drugs **Copay for a 31 to 90 day supply:** • $15 copay for Tier 1 (generic) drugs • $25 copay for Tier 2 (formulary brand) drugs • $40 copay for Tier 3 (nonformulary brand) drugs	No coverage

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic ***plus*** the applicable copay.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

	Network pharmacy	Non-network pharmacy
Covered services		
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Contraceptive injections, Prescription contraceptive devices and Prescription contraceptive medications	Coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).	
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	100% of approved amount less plan copay	No coverage

Features of your prescription drug plan	
BCBSM custom formulary	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ **Tier 2 (formulary brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay. ▪ **Tier 3 (nonformulary brand)** – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at **bcbsm.com**. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com**.

Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug, It applies only to prescriptions being filed for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com**, **along with the preferred medications**. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.

COUNTY OF JACKSON

Blue Preferred® Rx Prescription Drug Coverage with $20 Generic / $30 Formulary Brand / $40 Nonformulary Brand Triple-Tier Copay
Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com**. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

	Network pharmacy	Non-network pharmacy
Member's responsibility (copays)		
Tier 1 – Generic or prescribed over-the-counter drugs	$20 copay	$20 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Tier 2 – Formulary brand-name drugs	$30 copay	$30 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Tier 3 – Nonformulary brand-name drugs	$40 copay	$40 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 30 day supply:** • $20 copay for Tier 1 (generic) drugs • $30 copay for Tier 2 (formulary brand) drugs • $40 copay for Tier 3 (nonformulary brand) drugs **Copay for a 31 to 90 day supply:** • $20 copay for Tier 1 (generic) drugs • $30 copay for Tier 2 (formulary brand) drugs • $40 copay for Tier 3 (nonformulary brand) drugs	No coverage

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic ***plus*** the applicable copay.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

	Network pharmacy	Non-network pharmacy
Covered services		
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Contraceptive injections, Prescription contraceptive devices and Prescription contraceptive medications	Coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).	

Features of your prescription drug plan	
BCBSM custom formulary	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ **Tier 2 (formulary brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay. ▪ **Tier 3 (nonformulary brand)** – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at **bcbsm.com**. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com**.

Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug, It applies only to prescriptions being filed for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com**, **along with the preferred medications**. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.

COUNTY OF JACKSON

Blue Vision[SM] 12/12/12
Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	A **combined** $10 copay	Member responsible for difference between approved amount and provider's charge, less a $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, less a $10 copay
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – $5 copay	Reimbursement up to $35, less a $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note**: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	Covered – $10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Covered – $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $45, less a $10 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

	VSP network doctor	Non-VSP provider
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Covered – $10 copay	Reimbursement up to $210 after a $10 copay (member responsible for any difference)
	One pair of contact lenses in any period of 12 **consecutive** months	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	Covered – $130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered – $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 12 **consecutive** months	

COUNTY OF JACKSON

Blue Vision[SM] 24/24/24
Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	A **combined** $10 copay	Member responsible for difference between approved amount and provider's charge, less a $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, less a $10 copay
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – $5 copay	Reimbursement up to $35, less a $5 copay (member responsible for any difference)
	One eye exam in any period of 24 **consecutive** months	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note**: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	Covered – $10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Covered – $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $45, less a $10 copay (member responsible for any difference)
	One frame in any period of 24 **consecutive** months	

	VSP network doctor	Non-VSP provider
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Covered – $10 copay	Reimbursement up to $210 after a $10 copay (member responsible for any difference)
	One pair of contact lenses in any period of 24 **consecutive** months	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	Covered – $130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered – $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 24 **consecutive** months	

Community Blue[SM] PPO3
Benefits-at-a-Glance

COUNTY OF JACKSON

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Member's responsibility (deductibles, copays and dollar maximums)

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network
Deductibles	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year **Note**: Deductible waived if service is performed in a PPO physician's office.	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note**: Out-of-network deductible amounts also apply toward the in-network deductible.
Copays • Fixed dollar copays	• $10 copay for office visits • $75 copay for emergency room visits	$75 copay for emergency room visits
• Percent copays	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.	• 50% of approved amount for private duty nursing • 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.
Copay dollar maximums • Percent copay maximums – includes general medical only – **excludes** fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays	$1,000 for one member, $2,000 for two or more members each calendar year	$3,000 for one member, $6,000 for two or more members each calendar year **Note**: Out-of-network copays also apply toward the in-network maximum.
• Percent copay maximums - copays for mental health care and substance abuse treatment are subject to a separate copay maximum	$1,000 for one member, $2,000 for two or more members each calendar year	$3,000 for one member, $6,000 for two or more members each calendar year **Note**: Out-of-network copays also apply toward the in-network maximum.
Dollar maximums	$1 million lifetime maximum per covered specified human organ transplant type and a **separate** $5 million lifetime maximum per member for all other covered services and as noted for individual services	

	In-network	Out-of-network
Preventive care services – *Payment for preventive services is limited to a combined maximum of $500 per member per calendar year		
Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered
Mammography		
Mammography screening	Covered – 80% after deductible	Covered – 60% after deductible
	One per calendar year, no age restrictions	
Physician office services		
Office visits	Covered – $10 copay per office visit	Covered – 60% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office consultations	Covered – $10 copay per office visit	Covered – 60% after deductible, must be medically necessary
Urgent care visits	Covered – $10 copay per office visit	Covered – 60% after deductible, must be medically necessary
Emergency medical care		
Hospital emergency room	Covered – $75 copay per visit (copay waived if admitted or for an accidental injury)	Covered – $75 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Diagnostic services		
Laboratory and pathology services	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic tests and x-rays	Covered – 80% after deductible	Covered – 60% after deductible
Therapeutic radiology	Covered – 80% after deductible	Covered – 60% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100%	Covered – 60% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80% after deductible	Covered – 60% after deductible
	Includes delivery provided by a certified nurse midwife	

	In-network	Out-of-network
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 80% after deductible	Covered – 60% after deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 60% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per member per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Home infusion therapy – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 80% after deductible	Covered – 60% after deductible
Presurgical consultations	Covered – 100%	Covered – 60% after deductible
Colonoscopy	Covered – 80% after deductible	Covered – 60% after deductible
Voluntary sterilization	Covered – 80% after deductible	Covered – 60% after deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities **only**
	Limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after deductible	Covered – 60% after deductible
Specified oncology clinical trials	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, cornea and skin transplants	Covered – 80% after deductible	Covered – 60% after deductible

	In-network	Out-of-network

Mental health care and substance abuse treatment

Note: Your copays for mental health care and substance abuse treatment are subject to a separate, combined annual copay dollar maximum. See "Copay dollar maximums" section for these amounts.

Inpatient mental health care	Covered – 80% after deductible	Covered – 60% after deductible
Inpatient substance abuse treatment	Covered – 80% after deductible	Covered – 60% after deductible
Outpatient mental health care • Facility and clinic	Covered – 80% after deductible	Covered – 60% after deductible
• Physician's office	Covered – 80% after deductible	Covered – 60% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 80% after deductible	Covered – 60% after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 80% after deductible	Covered – 60% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – 100%	Covered – 60% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 80% after deductible	Covered – 60% after deductible
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 80% after deductible	Covered – 80% after deductible
Prosthetic and orthotic appliances	Covered – 80% after deductible	Covered – 80% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible
Carryover deductible exclusion	Excludes any carryover deductible amounts from the last three months of the previous calendar year to be credited to the deductible requirement of a new calendar year.	

Community Blue[SM] PPO1 – Plan 2
Benefits-at-a-Glance

COUNTY OF JACKSON

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Member's responsibility (deductibles, copays and dollar maximums)

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network
Deductibles	None	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year
Copays • Fixed dollar copays	• $10 copay for office visits • $50 copay for emergency room visits	$50 copay for emergency room visits
• Percent copays	50% of approved amount for private duty nursing See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.
Copay dollar maximums • Percent copay maximums – includes general medical only – **excludes** fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays	Not applicable	$2,000 for one member, $4,000 for two or more members each calendar year
• Percent copay maximums - copays for mental health care and substance abuse treatment are subject to a separate copay maximum	Not applicable	$2,000 for one member, $4,000 for two or more members each calendar year
Dollar maximums	$1 million lifetime maximum per covered specified human organ transplant type and a **separate** $5 million lifetime maximum per member for all other covered services and as noted for individual services	

	In-network	Out-of-network
Preventive care services – *Payment for preventive services is limited to a **combined** maximum of $500 per member per calendar year		
Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered
Mammography		
Mammography screening	Covered – 100%	Covered – 80% after deductible
	One per calendar year, no age restrictions	
Physician office services		
Office visits	Covered – $10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – $10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – $10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Emergency medical care		
Hospital emergency room	Covered – $50 copay per visit (copay waived if admitted or for an accidental injury)	Covered – $50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 100%	Covered – 100%
Diagnostic services		
Laboratory and pathology services	Covered – 100%	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100%	Covered – 80% after deductible
Therapeutic radiology	Covered – 100%	Covered – 80% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 100%	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	

	In-network	Out-of-network
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 100%	Covered – 80% after deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 100%	Covered – 100%
	Up to 120 days per member per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 100%	Covered – 100%
Home infusion therapy – must be medically necessary	Covered – 100%	Covered – 100%
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 100%	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 100%	Covered – 80% after deductible
Voluntary sterilization	Covered – 100%	Covered – 80% after deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities **only**
	Limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100%	Covered – 80% after deductible
Kidney, cornea and skin transplants	Covered – 100%	Covered – 80% after deductible

	In-network	Out-of-network

Mental health care and substance abuse treatment

Note: Your copays for mental health care and substance abuse treatment are subject to a separate, combined annual copay dollar maximum. See "Copay dollar maximums" section for these amounts.

Inpatient mental health care	Covered – 100%	Covered – 80% after deductible
Inpatient substance abuse treatment	Covered – 100%	Covered – 80% after deductible
Outpatient mental health care • Facility and clinic	Covered – 100%	Covered – 80% after deductible
• Physician's office	Covered – 100%	Covered – 80% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 100%	Covered – 80% after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – 100%	Covered – 80% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered – 80% after deductible
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 100%	Covered – 100%
Prosthetic and orthotic appliances	Covered – 100%	Covered – 100%
Private duty nursing	Covered – 50%	Covered – 50%
Carryover deductible exclusion	Excludes any carryover deductible amounts from the last three months of the previous calendar year to be credited to the deductible requirement of a new calendar year.	

Community Blue[SM] PPO1 – Plan 3
Benefits-at-a-Glance

COUNTY OF JACKSON

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Member's responsibility (deductibles, copays and dollar maximums)

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network
Deductibles	None	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year
Copays • Fixed dollar copays	• $10 copay for office visits • $75 copay for emergency room visits	$75 copay for emergency room visits
• Percent copays	50% of approved amount for private duty nursing See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.
Copay dollar maximums • Percent copay maximums – includes general medical only – **excludes** fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays	Not applicable	$2,000 for one member, $4,000 for two or more members each calendar year
• Percent copay maximums - copays for mental health care and substance abuse treatment are subject to a separate copay maximum	Not applicable	$2,000 for one member, $4,000 for two or more members each calendar year
Dollar maximums	$1 million lifetime maximum per covered specified human organ transplant type and a **separate** $5 million lifetime maximum per member for all other covered services and as noted for individual services	

	In-network	Out-of-network
Preventive care services – *Payment for preventive services is limited to a **combined** maximum of $500 per member per calendar year		
Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered
Mammography		
Mammography screening	Covered – 100%	Covered – 80% after deductible
	One per calendar year, no age restrictions	
Physician office services		
Office visits	Covered – $10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – $10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – $10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Emergency medical care		
Hospital emergency room	Covered – $75 copay per visit (copay waived if admitted or for an accidental injury)	Covered – $75 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 100%	Covered – 100%
Diagnostic services		
Laboratory and pathology services	Covered – 100%	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100%	Covered – 80% after deductible
Therapeutic radiology	Covered – 100%	Covered – 80% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 100%	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	

	In-network	Out-of-network
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 100%	Covered – 80% after deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 100%	Covered – 100%
	Up to 120 days per member per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 100%	Covered – 100%
Home infusion therapy – must be medically necessary	Covered – 100%	Covered – 100%
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 100%	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 100%	Covered – 80% after deductible
Voluntary sterilization	Covered – 100%	Covered – 80% after deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities **only**
	Limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100%	Covered – 80% after deductible
Kidney, cornea and skin transplants	Covered – 100%	Covered – 80% after deductible

	In-network	Out-of-network

Mental health care and substance abuse treatment

Note: Your copays for mental health care and substance abuse treatment are subject to a separate, combined annual copay dollar maximum. See "Copay dollar maximums" section for these amounts.

Inpatient mental health care	Covered – 100%	Covered – 80% after deductible
Inpatient substance abuse treatment	Covered – 100%	Covered – 80% after deductible
Outpatient mental health care		
• Facility and clinic	Covered – 100%	Covered – 80% after deductible
• Physician's office	Covered – 100%	Covered – 80% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 100%	Covered – 80% after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – 100%	Covered – 80% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered – 80% after deductible
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 100%	Covered – 100%
Prosthetic and orthotic appliances	Covered – 100%	Covered – 100%
Private duty nursing	Covered – 50%	Covered – 50%
Carryover deductible exclusion	Excludes any carryover deductible amounts from the last three months of the previous calendar year to be credited to the deductible requirement of a new calendar year.	

County of Jackson

Amended and Restated Group Health Plan

Non-POAM Employees

Prepared by:
Fraser Trebilcock Davis & Dunlap, P.C.
124 West Allegan, Suite 1000
Lansing, Michigan 48933
Telephone: (517) 482-5800
Facsimile: (517) 482-0887

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County of Jackson
Amended and Restated Group Health Plan for Non-POAM Employees

Preamble

The County of Jackson has adopted a Welfare Benefit Plan for its Employees. This Plan is the overall plan by the Employer to provide benefits to its Employees through self-funded programs and through contracts with insurance companies and/or contract administrators.

Each of the underlying benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another governing document prepared by the Employer or contract administrators. Because of the involvement of third-party insurers and providers, this Plan will necessarily incorporate by reference the various certificates of coverage, insurance contracts and other documents which provide relevant terms of this Plan. This Plan, accompanied by the above-referenced documents, constitutes the plan document. Moreover, the Plan shall be treated as a single employee welfare benefit plan. However, this Plan does not expand the responsibilities regarding the included benefits beyond the requirements of federal and state law. It is intended that the health and welfare benefits provided through the underlying benefit programs are eligible for exclusion from income under Internal Revenue Code section 105.

Article 1

Definitions

When used in this Plan, the following words shall have the following meanings, unless the context clearly indicates otherwise:

1.1 **"Administrator" or "Plan Administrator"** means the County of Jackson or another person or entity designated by its Board of Commissioners to administer the Plan.

1.2 **"Affiliate"** means an employer that is sufficiently affiliated with the Employer to be able to participate in the same benefit plan or plans pursuant to the Code.

1.3 **"Benefits"** means the benefits provided under any of the Component Benefit Programs.

1.4 **"Board of Commissioners"** means Employer's governing body.

1.5 **"Claimant"** means any Participant who seeks to file a claim pursuant to the terms of this Plan.

1.6 **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. References in the Plan to any COBRA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.7 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. References in the Plan to any Code section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the Code section.

1.8 **"Component Benefit Programs"** means all programs and plans providing benefits which are being combined under this Plan, whether through Insurance Contracts or otherwise. Specifically, the Component Benefit Programs offered under this Plan are:

- Medical and prescription benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")
- Dental and vision benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")

1.9 **"Contract Administrator"** means any third-party with whom Employer has contracted to provide and/or administer benefits under the Plan.

1.10 **"Dependent"** generally means a Participant's Spouse and any person who is a dependent of the Participant within the meaning of Code section 152 (however, for health benefits, a Dependent generally means any person who is a dependent as defined as set forth in Code sections 105(b), 106 and the regulations and other authority thereunder) and who is eligible to participate in the underlying Component Benefit Programs. Dependents also include those Dependents allowed continued participation under Michelle's Law, Pub. L. No. 110-381 (2008). Dependents may or may not be eligible to participate in certain Benefits within the Component Benefit Programs.

1.11 **"Effective Date"** of this Plan is January 1, 2011.

1.12 **"Electronic Protected Health Information (EPHI)"** means individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

1.13 **"Employee"** means an individual that the Employer classifies as a common law employee and who is on the Employer's W-2 payroll, but does not include temporary or leased employees, casual employees, seasonal employees, contract workers or independent contractors.

1.14 **"Employer"** means the County of Jackson and any successor which shall maintain this Plan. Any Affiliate which elects to participate in the Plan, and receives the consent of its Board of Directors to do so, shall also be deemed the Employer with respect to its eligible Employees.

1.15 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time. References in the Plan to any ERISA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section. This Plan is exempt as a "governmental plan" from the provisions of ERISA. Any reference to ERISA within this document is for informational purposes only and does not cause this Plan to become subject to ERISA.

1.16 **"FMLA"** means the Family and Medical Leave Act of 1993, as amended from time to time. References in the Plan to any FMLA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.17 **"GINA"** means the Genetic Information Nondiscrimination Act of 2008, as amended from time to time.

1.18 **"Grandfathered Plan"** means a group health plan or health insurance coverage which had an individual enrolled in it on March 23, 2010 (and for as long as it maintains that status under the PPACA and its implementing regulations). This Plan is deemed to be a Grandfathered Plan.

1.19 **"Health Care Component"** means the components of this Plan which are subject to HIPAA's Privacy Rules and Security Rules. Specifically, the Health Care Components within this Plan and which, if separate entities, would also be covered entities under HIPAA, are the following:

- Medical and prescription benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")
- Dental and vision benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")

1.20 **"Highly Compensated Individual"** means an individual defined under Code section 105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

1.21 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time. References in the Plan to any HIPAA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.22 **"Individually Identifiable Health Information"** means the information that is a subset of health information, including demographic information collected from an individual, and: (a) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (b) relates to the past, present or future physical or mental health or condition, the provision of health care, or payment for the provision of health care to an individual and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

1.23 **"Insurance Contracts"** means any insurance contracts, certificates of coverage, certificates of insurance, benefit booklets, policies or other contracts between the Employer and Contract Administrators providing and/or administering benefits under the applicable Component Benefit Programs to Participants and their eligible Dependents.

1.24 **"MHPA"** means the Mental Health Parity Act, as amended from time to time. References in the Plan to any MHPA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.25 **"MHPAEA"** means the Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time. References in the Plan to any MHPAEA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.26 **"Named Fiduciary"** means the Plan Sponsor and Plan Administrator. For purposes of self-funded benefit appeals, the Named Fiduciaries are:

County of Jackson
120 West Michigan Avenue
Jackson, Michigan 49201
(517) 768-6602

1.27 **"NMHPA"** means the Newborns' and Mothers' Health Protection Act of 1996, as amended from time to time. References in the Plan to any NMHPA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.28 **"Participant"** means an Employee or Retiree who has satisfied the eligibility requirements of Article 2 and who is participating in the Plan pursuant to the terms of the Plan or any continuation requirements of State or Federal law.

1.29 **"PHSA"**means the Public Health Service Act of 1944, as amended. References in the Plan to any PHSA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.30 **"Plan"** means the County of Jackson Amended and Restated Group Health Plan for Non-POAM Employees set forth in this document and all subsequent amendments.

1.31 **"Plan Sponsor"** means the County of Jackson.

1.32 **"Plan Year"** means the 12-month period ending on each December 31; however, there may be different plan years for each individual underlying benefit as set forth in the Component Benefit Programs.

1.33 **"PPACA"** means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and as may be further amended from time to time. References in the Plan to any PPACA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.34 **"Privacy Rules"** means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E , as amended from time to time.

1.35 **"Protected Health Information (PHI)"** means individually identifiable health information, except as provided below in this definition, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.

Protected health information excludes individually identifiable health information in Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and employment records held by a covered entity in its role as employer.

1.36 **"Qualified Beneficiary"** means those beneficiaries entitled to COBRA coverage under Article 5.

1.37 **"Qualifying Event"** means those events specified in Section 5.3.

1.38 **"Retiree"** means an Employee who has retired from full-time employment with Employer and is no longer an Employee.

1.39 **"Security Rules"** means the Security Standards and Implementation Specifications at 45 CFR Part 160 and Part 164, subpart C, as amended from time to time.

1.40 **"Spouse"** means an individual who is legally married to a Participant as determined under applicable Michigan state law and who is treated as a spouse under the Code.

1.41 **"Summary Health Information (SHI)"** means information that may be individually identifiable health information, as defined by the HIPAA Privacy Rules as amended from time to time, and (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and (b) from which names and geographic subdivisions smaller than a State has been deleted, except that such geographic information need only be aggregated to the level of a five-digit zip code.

1.42 **"USERRA"** means the Uniform Services Employment and Reemployment Rights Act, as amended from time to time. References in the Plan to any USERRA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.43 **"WHCRA"** means the Women's Health and Cancer Rights Act of 1998, as amended from time to time. References in the Plan to any WHCRA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

Article 2

Eligibility and Participation

2.1 **Eligibility and Participation Requirements.** The eligibility requirements for this Plan and requirements for commencing participation are governed by the terms and conditions of the Component Benefit Programs, attached as Exhibit A, by the Employer's policies or directives and/or by any collective bargaining agreements between the Employer and any union representing Employees.

Employee Coverage

Unless otherwise provided, each Employee who meets all of the following requirements shall be eligible to participate in the Plan:

(a) The Employee is regularly scheduled to work at least 20 hours per week and will normally be scheduled to work more than six months during the Plan Year; and

(b) The Employee is either:

(1) a non-union part-time or full-time Employee of Employer; or

(2) a part-time or full-time Employee of Employer, is included in a collective bargaining unit which bargained in good faith for employee benefits, and the collective bargaining agreement provides that the Employee shall be eligible to participate in the Plan. In such case, the Employee may only participate in the Plan to the extent that the collective bargaining agreement provides.

(d) The Employee is not included in a collective bargaining unit of the Police Officers Association of Michigan ("POAM").

The Employee may be responsible for the cost of coverage under this Plan as provided within the collective bargaining agreements, employee handbooks, benefit summaries, and/or enrollment materials.

Some of the Component Benefit Programs may require the Employee to make an annual election to enroll for coverage. The details of such annual elections are described in the underlying documents. In certain circumstances, enrollment may occur outside the open enrollment period.

Retiree Eligibility and Coverage for Medical and Prescription Benefits Only

Except as otherwise provided in a collective bargaining agreement, a Retiree who meets each of the following requirements will be eligible to participate in the medical and prescription coverage portions of this Plan:

(a) The Retiree has retired from the full-time employment of Employer, but not as a POAM Employee;

(b) The Retiree is not eligible for Medicare;

(c) The Retiree was eligible for Employer's group health plan at the time of retirement;

(d) With regard to non-union Retirees and Retirees who retired under the APA collective bargaining agreement, the Retiree was hired as an Employee of Employer prior to December 1, 2010; and

(e) With regard to non-union Retirees, the Retiree has met certain service requirements, specifically:

(i) For full-time Employees hired on or after August 20, 2008, the Retiree must have 21 years of service actually worked with Employer at the time of retirement;

(ii) For full-time Employees hired on or after January 1, 2008 and on or before August 19, 2008, the Retiree must have 10 years of service actually worked with Employer at the time of retirement;

(iii) For full-time Employees hired on or after January 1, 2006 and prior to January 1, 2008, at the time of retirement the Retiree must have actually worked:

i. 30 years of service with Employer;

ii. 25 years of service with Employer and attained the age of 55; or

iii. 10 years of service with Employer and attained the age of 60.

(iv) Except as indicated in subsection (v) below, for full-time Employees hired prior to January 1, 2006, at the time of retirement the Retiree must have actually worked:

i. 25 years of service with Employer;

ii. 10 years of service with Employer and attained the age of 55; or

iii. 8 years of service with Employer and attained the age of 60.

(v) For full-time Employees who have four (4) or more years of service actually worked as of December 31, 1999, the Retiree must have eight (8) or more years of service actually worked with Employer at the time of retirement.

Eligibility factors for Retiree Health for Employees / Retirees covered by collective bargaining agreements are set for in those agreements.

Retirees and their Dependents are not eligible for any dental or vision coverage under this Plan.

The Retiree may be responsible for the cost of coverage under this Plan as provided within the collective bargaining agreements, employee handbooks, benefit summaries, and/or enrollment materials.

Some of the Component Benefit Programs may require an annual election to enroll for coverage. The details of such annual elections are described in the underlying documents. In certain circumstances, enrollment may occur outside the open enrollment period.

Dependent Eligibility and Coverage in General

Coverage may also be provided to Dependents who are eligible to participate in the underlying Component Benefit Programs. Dependents may or may not be eligible to participate in certain Benefits within the Component Benefit Programs. Please see the underlying Component Benefit Programs for more information on Dependent eligibility.

Dependent Coverage Under BCBSM Plan

Effective January 1, 2011, coverage for Dependent children will be available for an adult child until the day prior to the date the child turns 26 years of age. However, for plan years beginning before January 1, 2014, coverage for Dependent children shall not be made available to an adult child who is eligible to enroll in an eligible employer-sponsored health plan (as defined in Code section 5000A(f)(2)) other than a group health plan of a parent for as long as this Plan is deemed a Grandfathered Plan. A "child" for this purpose is defined as a son, daughter, stepson, stepdaughter, or eligible foster child of the Participant as defined in Code section 152(f)(1). The definition of "child" for this purpose shall not include a child of the Participant's child.

However, an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical disability may be covered to any age if such physical or mental disability occurred before the child turned 26 years of age, the child is chiefly dependent on the Participant for support and maintenance, and the Participant has submitted proof (medical certification) of the child's incapacity to the carrier prior to the child turning age 26 or within 31 days thereafter.

NOTE: The Participant shall be required to present, upon request, to the employer certified documentation providing proof of parentage, spousal and/or dependent relationships, proof of the physically or mentally disabled, and proof of dependent eligibility status. This required documentation may be requested at any time to determine eligibility status.

NOTE: If full-time student status is required for coverage of any Dependent children, this Plan will comply with Michelle's Law, Code section 9813. Michelle's Law provides for continued coverage if the Dependent would otherwise lose coverage due to loss of full-time student status at a postsecondary educational institution because of a medically necessary leave of absence that begins while the Dependent is suffering from a serious illness or injury. Coverage may continue for up to one year after the first day of the medically necessary leave of absence, ending earlier only if coverage under the Plan would otherwise terminate (such as reaching the maximum age requirement). Written certification by the Dependent's treating

physician is required stating that the leave is medically necessary and that the child is suffering from a serious illness or injury as defined in Michelle's Law.

Coverage for a Dependent will be effective on the date the Employee's coverage becomes effective if he applies for Dependent coverage when he enrolls in the Plan. In no event will the Employee's Dependents be covered before the date the Employee's coverage begins. An Employee without a Dependent on the date he becomes eligible for coverage who later acquires a Dependent may enroll his Dependent in this Plan by written application within 30 days after he acquires that Dependent.

A newborn child, adopted child, or child placed for adoption will be covered if enrolled within the 30 day period following birth, adoption, or adoption placement. This Plan is intended to comply with OBRA '93 with respect to dependent child eligibility and Qualified Medical Child Support Orders. If coverage for a Dependent (including newborns, adopted children, or children placed for adoption) is applied for more than 30 days following the date that Dependent becomes eligible for coverage, the Dependent may only be able to enroll during the open enrollment/election period.

Additionally, for purposes of the BCBSM Plans, if two (2) Employees under this Plan are married and both want coverage, they may choose to both be covered as Employees, or one of them may be covered as the Employee and the other may be covered as a Dependent. However, eligible Dependent children of two (2) parents who are both covered under this Plan may be enrolled as Dependents of only one (1) of the Employees. In the event that one (1) Employee's coverage should terminate, his/her eligible covered Dependents will be eligible to become covered Dependents under the remaining parent's Employee coverage.

2.2 **Election Periods.**

Initial Election Period

An Employee who does not apply for coverage within thirty (30) days of the date he or she becomes eligible for coverage may only be able to enroll during the open enrollment / election period, unless otherwise required by law.

Open Enrollment / Election Period

An Employee and/or Dependent who wishes to make an election change, or who does not apply for coverage when initially eligible but later wishes to apply, may do so only during the open enrollment / election period in the Fall for an effective date of January 1. However, an election change may be made before the open enrollment/election period if a special enrollment event occurs such as marital status change, change in number of Dependents or dependent status, other eligibility change, involuntary loss of coverage from another Plan, or another event legally requiring mid-year enrollment, as long as the proper notice is provided within the required 30 day time period from the date of the special enrollment event.

2.3 **Date of Participation**

Unless otherwise provided in the Component Benefit Programs or the collective bargaining agreements, and as long as all required enrollment materials are completed and submitted, an Employee or Retiree will become a Participant on the later of the Effective Date of this Plan or the date the Employee or Retiree becomes eligible to participate pursuant to this Article.

2.4 **HIPAA Special Enrollment**. An Employee or Participant may revoke an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f). Unless otherwise provided, such change shall take place on a prospective basis.

(a) As required by HIPAA, a 30-day special enrollment right will arise if:

(1) A current Employee is eligible for, but declined enrollment in, this group health plan coverage (or a Dependent of such Employee is eligible for, but was not enrolled in, this group health plans coverage) because the Employee or Dependent was covered under another group health plan or had other health insurance coverage when this group health plan coverage was previously offered and the other coverage was lost due to either: (i) if the other coverage was COBRA continuation coverage, that coverage has been exhausted; or (ii) if the other coverage was not COBRA continuation coverage, either the coverage was terminated as a result of loss of eligibility for the coverage (including, but not limited to, as a result of legal separation, judgment of separate maintenance, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment; in the case of an HMO, the individual no longer resides, lives or works in the service area where the HMO provides benefits and, in cases of the group market, no other package is available to the individual; an individual incurs a claim meeting or exceeding a lifetime limit on all benefits; or the plan no longer offers any benefits to the class of similarly situated individuals that includes the individual), or employer contributions towards such coverage were terminated. Unless otherwise provided in the Component Benefit Programs, the eligible Employee must request enrollment not later than 30 days after the loss of other coverage (or after a claim is denied due to the operation of a lifetime limit on all benefits). Any eligible Dependent may only enroll if that Dependent (or the Employee) meets the above requirements; or

(2) A new Dependent is acquired as a result of marriage, birth, or adoption or placement for adoption, and the group health plan makes coverage available with respect to a Dependent of a Participant or an Employee who has met any waiting period requirements and is eligible to participate under that plan. Unless otherwise provided in the Component Benefit Programs, these election changes to add coverage must be made within 30 days of the date of the marriage, birth or adoption or placement for adoption (or the date dependent coverage is made available, if later). An election to add the following individuals (if otherwise eligible for coverage under the Plan) as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption is consistent with the special enrollment right: (i) a current Employee who is eligible but not enrolled; (ii) a current Employee who is eligible but not enrolled, and the Spouse of such Employee; (iii) a current Employee who is eligible but not enrolled, and the newly acquired Dependent of such Employee; (iv) the Spouse

of a Participant; (v) a current Employee who is eligible but not enrolled, and the Spouse and newly acquired Dependent; and (vi) a newly acquired Dependent of a Participant.

Enrollment applications received after the special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Unless otherwise provided in the Component Benefit Programs, coverage under the special enrollment period for timely submitted requests must be effective no later than the first day of the month after the plan or issuer receives the request for special enrollment. However, with regard to enrollment requests made within 30 days on behalf of a new Dependent acquired due to birth, adoption, or placement for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for adoption (or the date the plan makes dependent coverage available, if later).

(b) As required by HIPAA, effective April 1, 2009, a 60-day special enrollment right will arise if the Employee or Dependent is eligible for, but not enrolled in, the Plan and either:

(1) loses coverage under Medicaid, specifically, if the Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for coverage; or

(2) becomes eligible for a Medicaid subsidy, specifically, if the Employee or Dependent becomes eligible for premium assistance, with respect to coverage under the Plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Employee or Dependent with the special enrollment right under subsection (b) must request enrollment within the first 60 days from the date of termination of such coverage under (b)(1) or 60 days from the date the applicant is determined to be eligible for premium assistance under (b)(2). Enrollment applications received after the 60-day special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Coverage under this Plan shall take effect on the same date coverage for this HIPAA special enrollment right takes effect in the underlying Component Benefit Programs.

This Section only applies to group health plan coverage covering two or more Employees within the Component Benefit Programs. This Section does not apply to retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, specified disease or fixed indemnity coverage or health flexible spending accounts that qualify as "excepted benefits," as defined in Treasury Regulations section 54.9831-1(c).

2.5 **PPACA Special Enrollment.**

(a) As required by the PPACA, effective the first day of the first plan year beginning on or after September 23, 2010, a 30-day special enrollment right will be available to any child (i) whose coverage ended, or who was denied coverage (or was not eligible

for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26; and (ii) who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010. The plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage shall take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(b) As required by the PPACA, effective the first day of the first plan year beginning on or after September 23, 2010, a 30-day special enrollment right will be available to any individual (i) whose coverage or benefits under a group health plan or group health insurance coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits for any individual; and (ii) who becomes eligible (or is required to become eligible) for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010. The plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. If the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage shall take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(c) This Section only applies to group health plan coverage covering two or more Employees within the Component Benefit Programs. This subsection does not apply to retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c).

2.6 **Cessation of Participation and Loss of Benefits.** Unless provided otherwise in the Component Benefit Programs or collective bargaining agreements, a Participant's participation in the Plan will automatically cease at 11:59 p.m. on the earliest of the following dates:

(a) date the Participant terminates employment with Employer or is laid off;

(b) date the Participant ceases to be in a class of employees eligible for coverage;

(c) date the Participant fails to make any required contribution for coverage;

(d) date the Plan is terminated;

(e) date Employer terminates coverage;

(f) (1) the original effective date of coverage if coverage is rescinded due to misrepresentation on the Participant's enrollment application; (2) however, effective January 1, 2011, a group health plan or a health insurance issuer offering group health plan coverage (the "plan") shall not rescind (i.e., cancel or discontinue coverage retroactively when such cancellation or discontinuance is not attributable to a failure to timely pay required premiums towards the cost of coverage) coverage under the plan, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan, unless the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded. This subsection (f)(2) shall only apply for group health plan coverage covering two or more Employees within the Component Benefit Programs (but not for retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c).

(g) the date of the Participant's death; however, upon a Retiree's death, coverage for the Retiree's Spouse who was covered under this Plan on the date of the Retiree's death, spousal coverage continues for the life of the surviving Spouse (unless the Retiree had selected a Straight Life retirement option);

(h) the date the Participant otherwise lose eligibility under the Plan;

(i) the date the Participant revokes his or her election as permitted under the terms of the relevant Component Benefit Program; or

(j) for Retirees, the date the Retiree becomes entitled to Medicare, at which time the Retiree will be enrolled in the HUMANA Medicare Advantage Plan; any medical and prescription coverage for Dependents at the time of the Retiree's Medicare entitlement will continue under this BCBSM Plan as long as the Retiree is enrolled in HUMANA, until such coverage is otherwise terminated as specified below.

Cessation of Dependent Coverage

Generally, Dependents will lose coverage under the Component Benefit Programs as of the earlier of the date they are no longer eligible or at the same time the Participant loses coverage for any of the events listed above. Please see the Component Benefit Programs for more details.

With regard to coverage under the BCBSM Plans, Dependents will lose coverage as of the same time the Participant loses coverage for any of the events listed above, unless otherwise provided for Retirees.

Additionally, and unless otherwise provided in the Component Benefit Programs, coverage of any Dependent under the BCBSM Plans will automatically cease at 11:59 p.m. on the earliest of the following dates, unless coverage is otherwise required to continue by law:

(a) for Spouses:

(1) upon judgment of separate maintenance or legal separation (if applicable within the applicable State); or

(2) upon divorce.

(b) beginning January 1, 2011, for Dependent children:

(1) the day prior to the date the child reaches age 26;

(2) in the case of a disabled Dependent, upon the Dependent being medically certified as no longer incapable of self-sustaining employment by reason of mental retardation of physical disability; or

(3) for plan years beginning before January 1, 2014 and to the extent this Plan has maintained its status as a Grandfathered Plan, upon becoming eligible to enroll in an eligible employer-sponsored health plan (as defined in Code section 5000A(f)(2)) other than a group health plan of a parent.

Other circumstances can result in the termination, reduction or denial of benefits. The Participant should consult the Component Benefit Program documents for additional information. Termination of participation will automatically revoke elections and benefits as of the dates specified in the Component Benefit Programs. The Participant may also be entitled to continue certain benefits pursuant to state and federal law after participation ends. Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), a former Participant (or his or her covered Spouse or Dependent children) may be able to elect to continue certain group medical benefits provided under this Plan for a limited period of time by paying the cost of the benefits.

2.7 **May Benefits Be Continued During a Leave of Absence?** In addition to the rights provided under COBRA, FMLA and USERRA as described in this Plan, benefit coverage under the Component Benefit Programs may be continued if an Employee is on an approved leave of absence. Please see the Employer's policies for further information.

2.8 **USERRA Leave of Absence.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, as applicable, the Employer will continue to maintain the Participant's health benefits on the same terms and conditions as if the Participant were still an active Employee. These rights apply only to Participant-Employees and their Dependents covered under the Plan

before the Employee left for military service. To be entitled to USERRA rights, the Participant must give the Employer advance notice of the Participant's absence from employment for uniformed service, unless precluded by military necessity or if it is otherwise impossible or unreasonable under all the circumstances. Additionally, subject to certain exceptions, the Participant's absence from work may not exceed five years.

USERRA rights include up to 24 months of continued health care coverage. For periods of leave less than 31 days, the Participant only needs to pay his or her normal portion of the premium. For periods of leave 31 days or more, coverage will only be extended upon payment of the entire cost of coverage plus a reasonable administration fee.

Moreover, if coverage was terminated due to an Participant's service in the uniformed services, and the Participant is reemployed under USERRA, the Participant is entitled to reinstatement in the Plan. No preexisting conditions limitations will be applied in the Plan upon return from service. However, Plan exclusions and waiting periods may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

USERRA rights terminate if the Participant's discharge from the uniformed service was a result of “dishonorable” or other undesirable conduct, the Participant fails to report back to work or apply for reemployment within the time period required under USERRA, or if the Participant fails to pay coverage premiums.

The time periods within which to elect and pay for USERRA continuation of coverage shall be the same time periods within which to elect and pay for COBRA coverage under the Plan. If both USERRA and COBRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage.

This Section only applies to health plan coverage within the Component Benefit Programs.

2.9 **Family and Medical Leave Act (FMLA).** If the Employer is subject to FMLA, this Plan shall at all times comply with applicable requirements of the Family and Medical Leave Act of 1993 and its implementing regulation. During any leave taken under the Family and Medical Leave Act, the Employer will maintain health coverage under this Plan on the same conditions as coverage would have been provided if the Employee had been continuously employed during the entire leave period. Benefit coverage may be continued for all benefits up to the time limit allowed for an approved leave of absence that qualifies under FMLA.

If, during FMLA leave, the Employee does not wish to receive some or all of the coverage that he or she was receiving just prior to leave, the Employee must inform the Plan Administrator prior to the start of leave of which coverages will be dropped. If the Employee decides not to receive some or all of the covered medical benefits during FMLA leave, he or she may reinstate the same coverages upon return to work at the conclusion of FMLA leave.

If the Employee wishes to continue participation in the Plan, he or she must make arrangements with the Plan Administrator to pay for the coverages (in which the Employee is

currently enrolled) that he or she wishes to maintain during the course of leave. Eligibility to continue any coverage, which requires payments from the Employee, may be cancelled if he or she does not make the required payments during the period of FMLA leave.

If the Plan Administrator advances money by making any or all of these required payments for the Employee, it can recoup the amounts advanced through payroll deductions and by other means upon the Employee's return to employment following FMLA leave, to the extent permitted by law.

If the Employee fails to return from FMLA leave, and the reasons for failure are not beyond the Employee's control, the Employee is indebted to the Plan Administrator for the full amount of the cost of health coverage provided during FMLA leave. Employer intends to deduct any such amounts owed by an Employee from any compensable time payments owed to such Employee upon termination for failure to return from an FMLA leave, to the extent permitted by law. Employer may also use other means necessary to recoup these health care coverage costs.

An Employee should consult with the Plan Administrator before embarking on any FMLA qualified leave.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

This Section only applies to group health plan coverage within the Component Benefit Programs.

Article 3

Benefits Offered and Method of Funding

3.1 **Employer-Funded Benefits.** Additionally, the Plan offers Participants with the opportunity to participate in certain self-funded benefits:

- Medical and prescription benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")
- Dental and vision benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")

Summaries of these benefits are attached at Exhibit A. Any Insurance Contracts between the Employer and Contract Administrators providing and/or administering benefit coverage to Participants are incorporated by reference. The rights and conditions with respect to the benefits payable under these documents shall be determined from the terms of those documents. This Plan is not intended to expand or in any way increase the benefits available under those contracts.

3.2 **Contributions.** The cost of the benefits provided through the component benefit programs will be funded as provided in the underlying governing documents and collective bargaining agreements, including Employer contributions and/or pre-tax or after-tax employee contributions. Special rules apply with regard to pre-tax contributions, irrevocability of elections, and possible forfeitures as specified in the County of Jackson Second Amended and Restated Section 125 Cafeteria Plan, as amended from time to time. The Employee is also responsible for any deductible, co-payment, and coinsurance that may be required under the terms of the benefit programs. Unless provided otherwise in the collective bargaining agreements, the Employer will determine and periodically communicate the employee's cost of the benefits provided through each Component Benefit Program, and it may change that determination at any time.

3.3 **Funding**. Unless otherwise required by law, contributions to the self-funded portions of the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. The self-funded benefits are funded by the Employer and are not insured by an insurance company, with the exception of stop-loss insurance. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

3.4 **Reimbursements to Highly Compensated Individuals.** It is the intent of this Plan not to discriminate in violation of the Code and the Treasury Regulations thereunder. Therefore, reimbursements under any self-funded plan to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code section 105(h), as may be determined by the Administrator in its sole discretion. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

3.5 **Applicable Laws.** With respect to component benefit plans that are group health plans, the Plan will provide benefits in accordance with COBRA, FMLA, GINA, HIPAA, MHPA, MHPAEA, NMHPA, USERRA, WHCRA, PPACA and other group health plan laws to the extent required by such laws.

Article 4

HIPAA Privacy and Security Health Information for Self Insured Group Health Plans

4.1 **Permitted and Required Uses and Disclosures of Summary Health Information.** Unless otherwise permitted by law, the Plan may disclose SHI to the Plan sponsor, provided the Plan sponsor uses or discloses such SHI only for the following purposes:

(a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(b) Modifying, amending or terminating the Plan.

4.2 **Permitted and Required Uses and Disclosure of Protected Health Information.** Unless otherwise permitted by law, the Plan may disclose PHI to the Plan sponsor, provided the Plan sponsor uses or discloses such PHI only for the purpose of performing Plan administration functions.

4.3 **Permitted Disclosure of Enrollment/Disenrollment Information.** Unless otherwise permitted by law, the Plan may disclose information to the Plan sponsor, provided the Plan sponsor uses or discloses such PHI only for the purpose of determining whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

4.4 **Obligations of Plan Sponsor.** The Plan sponsor agrees that with respect to any PHI and EPHI, as applicable, disclosed to it by the Plan or any other covered entity, the Plan sponsor shall:

(a) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law.

(b) Ensure that any agents, including a subcontractor, to whom it provides PHI or EPHI received from the Plan agree to the same restrictions and conditions that apply to the Plan sponsor with respect to such information.

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make PHI available to the individual in accordance with the disclosure and timing requirements of the Privacy Rule.

(f) Make PHI available for amendment by the individual and incorporate any amendments to PHI in accordance with the Privacy Rule.

(g) Make information available to the individual to provide an accounting of disclosures in accordance with the Privacy Rule.

(h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule.

(i) If feasible, return or destroy all PHI received from the Plan that the Plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, 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 not feasible.

(j) Ensure that the adequate separation required by the Privacy Rule and Security Rule is established.

(k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Plan; and

(l) Report to the Plan any security incident, as defined by the HIPAA Security Rule, of which it becomes aware.

4.5 **Adequate Separation.** The Plan sponsor shall only allow employees with specific classifications/designations access to PHI and EPHI. The Plan sponsor shall designate these employees from time to time. These specified employees shall only have access to and use PHI and EPHI to the extent necessary to perform Plan administration functions that the Plan sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Article, that employee shall be subject to disciplinary action by the Plan sponsor for noncompliance pursuant to the discipline and termination procedures of the Plan sponsor.

4.6 **Certification of Plan Sponsor.** The Plan (or health insurance issuers or HMO with respect to the Plan) shall disclose PHI to the Plan sponsor only upon receipt of a certification by the Plan sponsor that the Plan has been amended to incorporate the provisions of Section 164.504(f)(2)(ii) of the Privacy Rule and that the Plan sponsor agrees to the conditions of the disclosures set forth in this Article.

4.7 **Miscellaneous Interpretive Provision.** The following provisions apply to limit and further define the operation of HIPAA to the Plan:

(a) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan sponsor be permitted to use or disclose health information in a manner that is inconsistent with HIPAA. Any ambiguity in this Article shall be resolved in favor of a meaning that permits the Plan and Plan sponsor to comply with HIPAA. Additionally, under no circumstances does this Section extend the rights and obligations of HIPAA to benefits that would otherwise be outside the scope of HIPAA. This Section does not create any contractual rights or obligations between the Plan and other parties to Plan benefits that would otherwise be outside the scope of HIPAA. This Article does not extend application of HIPAA to create any obligations for the Plan (or any part or component within the Plan) or the Plan sponsor that they would not otherwise have under HIPAA.

(b) This Article does not apply and has no legal effect on the Plan if the Plan does not meet the definition of "Health Plan" or "Group Health Plan" as defined by 45 CFR 160.103. Under HIPAA, a "Group Health Plan" is defined as an employee welfare benefit plan including insured and self-insured plans, to the extent that the plan provides medical care including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that: (1) has 50 or more participants; or (2) is administered by an entity other than the employer that established and maintains the plan.

(c) When permitted, it is the intention of the Plan (or any part or component within the Plan) to qualify as an exempted group health plan under 45 CFR 164.520(a)(2) and 164.530(k), or qualify under any exemption of any requirement under HIPAA.

4.8 **Effective Date and Applicability of this Article.** The requirements of the Privacy Rule within this Article shall be effective as of April 14, 2004, and the requirements of the Security Rule within this Article shall be effective as of April 20, 2005, and shall only apply to benefits provided and information received which pertain to health care and medical coverage. However, if this Plan should qualify as a "small plan" under HIPAA, the Security Rule aspects of this Article will instead become effective on April 20, 2006. In no event will this Article become effective prior to the Effective Date of this Plan.

4.9 **HITECH Act**. This Plan shall comply with the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), 42 USC 17930 et seq. as of the dates reflected within the HITECH Act.

This Article only applies to health plan coverage within the Component Benefit Programs.

Article 5

Continuation of Coverage for Group Health Plan Benefits

5.1 **In General.** The following provisions may apply to benefits provided to eligible Participants and their Qualified Beneficiaries under the Plan, but only to the extent that the benefits selected pertain to health care and medical coverage pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA).

This Article shall be applicable to Retirees only for purposes of the Component Benefit Programs which provide benefits to Retirees.

Importantly, this Article only applies to group health plan coverage within the Component Benefit Programs. It does not apply to non-health benefits.

5.2 **Continuation of Coverage.** To the extent required by Section 5.1 above, a covered Employee/Retiree or Qualified Beneficiary who would lose coverage under this Plan as a result of a Qualifying Event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a covered Employee/Retiree or Qualified Beneficiary who is a spouse of the covered Employee/Retiree will be deemed to include an election for continuation coverage under this provision on behalf of any other Qualified Beneficiary who would lose coverage by reason of a Qualifying Event.

If this Plan provides a choice among the types of coverage under this Plan, each Qualified Beneficiary is entitled to make a separate selection among such types of coverage. However, the

Qualified Beneficiary may only be able to continue that type of coverage which he or she would have lost as a result of the Qualifying Event.

5.3 **Qualifying Event.** The term "Qualifying Event" means any of the following events which, but for COBRA continuation coverage, would result in the loss of coverage of a covered Employee/Retiree or Qualified Beneficiary:

(a) death of the eligible Employee/Retiree;

(b) termination (other than by reason of such Employee's gross misconduct) or reduction of hours of the eligible Employee's employment;

(c) divorce, judgment of separate maintenance, or legal separation of the eligible Employee/Retiree from the Employee's/Retiree's spouse (or loss of coverage caused by the Employee/Retiree in anticipation of a divorce, judgment of separate maintenance, or legal separation which later occurs);

(d) eligible Employee/Retiree becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);

(e) a dependent child ceasing to be a dependent child under the generally applicable requirements of the Plan; or

(f) with regard to a covered Retiree, a bankruptcy proceeding under Title 11 of the United States Code, with respect to the Employer from whose employment the covered Retiree retired at any time. For purposes of an employer's bankruptcy proceedings, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary (spouse, surviving spouse, or covered Retiree who retired on or before the date coverage was substantially eliminated) within one year before or after the date the proceeding commenced.

An event described above is only a Qualifying Event if it causes a loss of coverage under the group health plan.

5.4 **Type of Coverage.** Continuation coverage under this provision is coverage which is identical to the coverage provided to similarly-situated beneficiaries under the group health plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under the plan is modified for any group of similarly-situated beneficiaries, the coverage shall also be modified in the same manner for all Qualified Beneficiaries under the plan in connection with such group.

5.5 **Duration of Coverage.** The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event listed below (unless otherwise provided) and ending not earlier than the earliest of the following:

(a) In the case of a terminated covered Employee (except for termination for gross misconduct) or a covered Employee whose hours have been reduced, and his or her Qualified Beneficiaries, the date which is 18 months after the Qualifying Event;

(b) In case of a loss of coverage due to bankruptcy proceeding under Title 11 of the United States Code, with respect to the Employer from whose employment the covered Retiree retired at any time, the lifetime of the Retiree or the Retiree's surviving spouse who is a Qualified Beneficiary; or for the surviving spouse and dependent children, 36 months after the date of the Retiree's death;

(c) In the case of any Qualifying Event except as described in Section 5.5(a) or (b), for the Qualified Beneficiaries, the date which is 36 months after the date of the Qualifying Event;

(d) In the case of a covered Employee or Qualified Beneficiary who is disabled at some point before the 61st day after the Qualifying Event as described in Section 5.5(a) and the disability lasts until the end of the 18-month period, the date which is 29 months after the Qualifying Event, provided the Administrator is given notice of the Social Security disability determination within 18 months of the Qualifying Event and within 60 days of the later of (i) the disability determination; (ii) the Qualifying Event; or (iii) the date coverage was lost as a result of the Qualifying Event;

(e) In the case of a second Qualifying Event (must be an event described in Section 5.5(c)) which occurs during the 18 months after the first Qualifying Event described in Section 5.5(a), for the Qualified Beneficiaries, the date which is 36 months after the date of the first Qualifying Event;

(f) In the case of a loss of coverage due to termination (except for gross misconduct) or reduction in hours of a covered Employee which occurs within 18 months after the Employee's entitlement to Medicare, for the Qualified Beneficiaries, the date which is 36 months from date of entitlement to Medicare;

(g) The date on which the participating Employer ceases to provide any group health plan to any Employee/Retiree;

(h) The date on which coverage ceases under the Plan by reason of failure to make timely payment of the required contribution pursuant to this provision;

(i) The date on which the covered Employee/Retiree or Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan (as an employee or otherwise), or becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the plan will not cease while such preexisting condition limitation under the other group plan remains in effect, subject to the maximum period of coverage limitations set forth in this Section;

(j) The first day of the month beginning more than 30 days after the date on which the disabled covered Employee or Qualified Beneficiary is determined by the Social Security Administration to be no longer disabled; or

(k) COBRA may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

5.6 **Payment of Premium.**

(a) A covered Employee/Retiree or Qualified Beneficiary shall only be entitled to continuation coverage provided the Qualified Beneficiary or covered Employee/Retiree pays the applicable premium required by the Employer in full and in advance, except as provided in (b) below. Such premium shall not exceed the requirements of applicable federal law. A Qualified Beneficiary or covered Employee/Retiree may elect to pay such premium in monthly installments.

(b) Except as provided in (c) below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.

(c) Notwithstanding (a) and (b) above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

5.7 **Qualified Beneficiary Must Notify Plan Administrator of Certain Qualifying Events.**

(a) It is the responsibility of the covered Employees/Retirees and Qualified Beneficiaries to provide the following notices to the Plan Administrator:

(1) Notice of the occurrence of a Qualifying Event that is a divorce, judgment of separate maintenance, or legal separation of a covered Employee/Retiree from his or her spouse;

(2) Notice of occurrence of a Qualifying Event that is a Qualified Beneficiary ceasing to be covered under the Plan as a dependent child;

(3) Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a covered Employee or Qualified Beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(5) Notice that a covered Employee/Retiree or Qualified Beneficiary: (i) with respect to whom a notice described in paragraph (a)(4) of this section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled, or (ii) subsequently becomes covered under Medicare or under other group health coverage (but only after any preexisting condition exclusions of the other plan have been exhausted or satisfied).

(b) Notice to the Plan Administrator must be made in writing and must be mailed or hand-delivered to:

Human Resources Department
County of Jackson
120 West Michigan Avenue
Jackson, Michigan 49201

Oral notice or electronic notice (by e-mail or facsimile) is not acceptable. If mailed, the notice must be postmarked no later than the deadline described below. If hand-delivered, notice must be received by the individual at the address above no later than the deadline described below.

(c) **Required Contents of Notice**. The notice must at a minimum contain the following information:

(1) the name of the Plan;

(2) the name and address of the Employee or former Employee who is or was covered under the Plan;

(3) the nature of the Qualifying Event, and, if applicable, the nature of the initial Qualifying Event that started the COBRA coverage, including any verifying documentation which may be required by the Employer;

(4) the date of this Qualifying Event, and, if applicable, the initial Qualifying Event;

(5) the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event or initial Qualifying Event, and, if applicable, whether those individuals are receiving COBRA coverage at the time of this notice;

(6) if the notice is for a disability extension, the name and address of the disabled covered Employee or Qualified Beneficiary;

(7) if the notice is for a disability extension, the date that the covered Employee or Qualified Beneficiary became disabled;

(8) if the notice is for a disability extension, the date that the Social Security Administration made its determination of disability. Additionally, a copy of the Social Security Administration's disability determination letter must be attached;

(9) if the notice is regarding (a) the Social Security Administration subsequently determining that the covered Employee or Qualified Beneficiary is no longer disabled or (b) subsequent entitlement of Medicare or coverage under another group health plan, the initial Qualifying Event and the subsequent event terminating coverage and the dates they occurred; and

(10) the signature, name, and contact information of the individual sending the notice.

Furthermore, the Plan requires that the following documents, if relevant to the particular Qualifying Event, be provided with the notice: Death Certificate; Divorce Decree, Judgment of Separate Maintenance or Legal Separation Agreement; Birth Certificate or Order of Adoption; Marriage Certificate; Social Security Administration's Disability Determination Letter; Spouse's Notice of Employment Termination or Proof of Loss of Coverage; Qualified Domestic Relations Order.

Any notice that does not contain all of the information required by the Plan must be supplemented in writing within 15 business days with the additional information necessary to meet the Plan's reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this section.

(d) **Time Periods To Provide Notice**. If written notice is not provided within the time periods provided below, the covered Employee/Retiree and Qualified Beneficiaries will lose the right to elect COBRA.

(1) Time limits for notices of Qualifying Events. The notice described in Section 5.7(a)(1), (2), or (3) must be furnished within 60 days after the latest of:

(A) the date on which the relevant Qualifying Event occurs; or

(B) the date on which the covered Employee or Qualified Beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event.

(2) Time limits for notice of disability determination. A notice described in Section 5.7(a)(4) must be furnished before the end of the first 18 months of continuation coverage and within 60 days after the latest of:

(A) the date of the disability determination by the Social Security Administration;

(B) the date on which the Qualifying Event occurs; or

(C) the date on which the covered Employee or Qualified Beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event.

(3) Time limits for notice of change in disability status, subsequent Medicare eligibility, or coverage under another group health plan. The notice described in Section 5.7(a)(5) must be furnished within 30 days after the date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the covered Employee or Qualified Beneficiary is no longer disabled or the date the covered Employee or Qualified Beneficiary becomes entitled to Medicare or covered under other group health coverage.

(e) **Person to Provide Notice**. With respect to each of the notice requirements of this section, any individual who is either the covered Employee/Retiree, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee/Retiree or Qualified Beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

5.8 **Notification to Qualified Beneficiary.**

(a) The Plan Administrator (or entity which it has hired) shall provide written notice to each covered Employee/Retiree and spouse of such covered Employee/Retiree of his/her right to continuation coverage under this provision as required by federal law.

(b) The Plan Administrator (or entity which it has hired) shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the Qualifying Event is the divorce, judgment of separate maintenance, or legal separation of the covered Employee/Retiree from the covered Employee's/Retiree's spouse or a dependent child ceasing to be a dependent under the terms of this Plan, the Plan Administrator shall only be required to notify a covered Employee/Retiree or Qualified Beneficiary of his/her right to elect continuation coverage if the covered Employee/Retiree or the Qualified Beneficiary notifies the Employer of such Qualifying Event as previously stated. Additionally, the right to extend COBRA coverage may only be provided upon the Plan Administrator receiving proper notice.

(c) Notification of the requirements of this provision to a Qualified Beneficiary who is the spouse of a covered Employee/Retiree shall be treated as notification to all other Qualified Beneficiaries residing with such spouse at the time notification is made.

5.9 **Special Election Period.** Special COBRA rights apply to certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible Employee or former Employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If the Employee qualifies for TAA or ATAA, he/she must contact the Employer promptly or the Employee will lose the right to elect COBRA during a special second election period.

5.10 **Interaction with FMLA.** If the Employer is subject to the Family and Medical Leave Act and the Employee does not return to work from the FMLA leave, the Employee and Qualified Beneficiaries may be entitled to continuation coverage under COBRA. A Qualifying Event under COBRA will occur if:

(a) the Employee and Qualified Beneficiaries are covered under the Employer's group health plan on the day before the first day of FMLA leave;

(b) the Employee does not return to work with the Employer at the end of the FMLA leave, and

(c) the Employee and Qualified Beneficiaries would, in the absence of COBRA, lose coverage under the group health plan before the end of the maximum coverage period.

The Qualifying Event would occur on the last day of the FMLA leave. The last day of FMLA leave may be the date the Employee notifies the Employer that the Employee will not be returning to work, if the notification was given before the FMLA was set to expire.

Article 6

Named Fiduciary Provisions

6.1 **Named Fiduciary.** The Named Fiduciaries shall have only those specific powers, duties, responsibilities, and obligations as are specifically given them under the Plan including, but not limited to, any agreement allocation or delegating their responsibilities, the terms of which are incorporated herein by reference. In general, the Employer shall have the sole authority to appoint and remove the Administrator; and to amend Plan provisions or terminate, in whole or in part, the Plan. The Administrator shall have the sole responsibility for the administration of the Plan, which responsibility is specifically described in the Plan. Furthermore, each Named Fiduciary may rely upon any such direction, information or action of another Named Fiduciary as being proper under the Plan, and is not required under the Plan to inquire into the propriety of any such direction, information or action. It is intended under the Plan that each Named Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan. Any person or group may serve in more than one Fiduciary capacity.

6.2 **General Fiduciary Responsibilities.** The Administrator and any other fiduciary shall discharge its duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan.

Article 7

Record Keeping and Administration

7.1 **Administrator.** The Administrator shall be designated by the Board of Commissioners and shall carry out the duties assigned to the Administrator under the Plan. The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

7.2 **Applicability of Article and Power and Authority of Contract Administrators.** This Article shall only apply to this Plan and to the underlying Component Benefit Programs which are self-funded and administered by the Plan Administrator. For all other Component Benefit Programs, this Article does not apply, and the Contract Administrators shall administer the Component Benefit Programs as provided in the Insurance Contracts and other governing documents, and the Plan Administrator shall retain no responsibility for such acts. Moreover, the Contract Administrators for the non-self-funded Component Benefit Programs are responsible for (1) paying claims; (2) determining eligibility for and the amount of any benefits payable under their respective component benefit plans; and (3) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective Component Benefit Program.

7.3 **Powers of the Administrator.** The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, subject to the pertinent provisions of the Code and Treasury Regulations. All determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(a) to make and enforce rules and regulations necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan;

(c) to approve reimbursement requests and to authorize the payment of Benefits;

(d) to prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Administrator determines to be appropriate;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

(f) to allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities in writing.

(g) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan; and

(h) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal.

The Plan Administrator, and other fiduciaries of the Plan (including any named fiduciary for claim appeals), have the requisite discretionary authority and control over the Plan to require deferential judicial review of its decisions, as set forth by the U.S. Supreme Court in Firestone Tire & Rubber Co. v. Bruch.

7.4 **Examination of Records.** The Administrator will make records available to each Participant for examination at reasonable times during normal business hours.

7.5 **Reliance on Participant, Tables, etc.** The Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

7.6 **Nondiscriminatory Exercise of Authority.** Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall also be consistent with the intent that the plan shall continue to comply with the terms of Code section 105(h) and the Treasury Regulations thereunder.

7.7 **Indemnification of Administrator.** The Employer agrees to indemnify and to defend, to the fullest extent permitted by law, any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission in connection with the Plan, if such act or omission is in good faith.

7.8 **Bonding.** The Administrator shall be bonded to the extent required by law.

7.9 **Records.** The Administrator shall keep records containing all relevant data pertaining to the administration of the Plan.

7.10 **Assurance of Receipt of Benefits.** The Administrator shall take all necessary action to ensure that Participants receive the Benefits to which they are entitled under the Plan.

7.11 **Conflict of Interest.** The Administrator may not decide any matter relating solely to the Administrator's rights or benefits under the Plan. These decisions shall be made by an individual appointed by the Board of Commissioners.

7.12 **Exercise of Discretion on a Uniform Basis.** In those instances where the Administrator is granted discretion in making its determinations, and the decision of the Administrator affects the benefits, rights or privileges of Participants, such discretion shall be exercised uniformly so that all Participants similarly situated are similarly treated.

7.13 **Timely Filing of Reports.** The Administrator shall cause to have prepared and filed or furnished, as the case may be, in a timely fashion, such information and reports as are required by applicable law and regulations to be filed or furnished by the Plan.

7.14 **Employment of Agents.** The Administrator has the right to employ agents and advisors to assist the Administrator in the performance of its duties.

7.15 **Provision for Third-Party Plan Service Providers.** The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

7.16 **Insurance Contracts.** The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan and to replace any such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

7.17 **Reliance Upon Information and Advice.** The Administrator may rely upon the written information, opinions or certificates supplied by any agent, counsel, actuary, investment manager, physician or fiduciary.

7.18 **Administration of Claims.** The Administrator shall administer all claims procedures under the Plan, except as otherwise provided.

7.19 **Compensation of Administrator**. The Administrator, if not an Employee of Employer, shall be paid a reasonable compensation for services on behalf of the Plan as may be agreed upon from time to time by Employer and the Administrator. Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

7.20 **Liability Limitations**. The Administrator is not liable or responsible for the acts or omissions of another fiduciary, unless:

(a) the Administrator knowingly participated or knowingly attempted to conceal the act or omission of another fiduciary and the Administrator knew the act or omission was a breach of fiduciary responsibility by the other fiduciary,

(b) the Administrator had knowledge of a breach by the other fiduciary and did not make reasonable efforts to remedy the breach, or

(c) the Administrator's breach of the Administrator's fiduciary responsibility permitted the other fiduciary to commit a breach.

7.21 **Resignation of Administrator.** The Administrator may resign by giving written notice to Employer not less than fifteen days before the effective date of the resignation.

7.22 **Removal of Administrator; Filling Vacancy.** The Administrator may be removed at any time, without cause, by the Board of Commissioners. In such case, the Board of Commissioners shall fill the vacancy as soon as reasonably possible after the vacancy occurs. Until a new Administrator is appointed, the Board of Commissioners has full authority to act as the Administrator.

Article 8

Claims Procedure and Appeal

8.1 **Applicability of Article .** The term "Administrator" shall also mean "Contract Administrator" for purposes of this Article only. Specifically, the term "Administrator" shall mean the relevant Administrator or Contract Administrator who is administering benefits under the particular Component Benefit Program.

Claims procedures and appeals set forth in the Component Benefit Programs control; this Article supplements those documents to the extent required by the PPACA for non-Grandfathered Plans and to impose the limitations period for filing suit.

To obtain benefits under a Component Benefit Program, the Participant must follow the claims procedures under that Program. The Contract Administrator will decide a participant's claim in accordance with its reasonable claims procedures, and, for non-Grandfathered Plans, as required by the PPACA.

The Contract Administrator may have the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the Contract Administrator denies a claim in whole or in part, then the participant may receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the participant may be allowed to appeal to the Contract Administrator for a review of the denied claim. The Contract Administrator will decide the appeal in accordance with its reasonable claims procedures, and, for non-Grandfathered Plans, as required by the PPACA.

The Component Benefit Program documents provide more information about how to file a claim and details regarding the Contract Administrator's claims procedures.

The remainder of this Article applies to non-Grandfathered Plans.

8.2 **Timing of Notification of Initial Benefit Determination.**

(a) **General Rule For Benefits Other Than Group Health Benefits.** The Administrator, with respect to benefits other than group health benefits, shall notify the Claimant of the benefit determination within 90 days after receipt of a claim by the Plan, unless the Administrator determines that special circumstances require an extension of time up to an additional 90 days for processing the claim. If an extension is necessary, the Administrator will provide the Claimant with written notice of the extension, before the end of the initial 90-day period, explaining the reason for the extension and the date the Administrator expects to make a decision. The extension will not exceed 90 days from the end of the initial 90-day period. Unless otherwise provided for within this Plan, if the Claimant fails to provide the Administrator with sufficient information to make a determination, the Administrator shall notify the Claimant of the specific information necessary to complete the claim and the Claimant shall be afforded 45 days to provide the specified information.

(b) **Pre-service Determinations.** In the case of pre-service determinations, the Administrator shall notify the Claimant of the Plan's benefit determination within a reasonable time, but no later than 15 days after receipt of the claim by the Plan if no further information is required. This period may be extended one time for 15 additional days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan. The Administrator will provide the Claimant with written notice of the extension before the end of the initial 15-day period, explaining the reason for the extension and the date the Administrator expects to make a decision. If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, but communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Administrator will provide oral notice (and in writing if requested) of the failure and the proper procedure to complete the claim, within five days of the failure. If the extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the Claimant shall have 45 days to provide the information. Failure to respond in a timely and complete manner will result in a benefit denial.

(c) **Post-service Decisions.** In the case of post-service claims, the Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable time, but no later than 30 days after receipt of the claim by the Plan if no further information is required. This period may be extended one time for 15 additional days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and the Administrator notifies the Claimant prior to expiration of the initial 30-day period of the reasons for the extension of time and the date by which the Administrator expects

to render a decision. If the extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the Claimant shall have at least 45 days to provide the information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

(d) **Concurrent Care Decisions.**

(1) In the case of a reduction or termination of an ongoing course of treatment which the Administrator had previously approved, the Administrator shall notify the Claimant of the Plan's benefit determination within a reasonable time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

(2) In the case of a request of a Claimant to extend the course of treatment which the Administrator had previously approved, the Administrator shall notify the Claimant of the Plan's benefit determination within 24 hours after receipt of the claim by the Plan, provided the claim is made at least 24 hours before the expiration of the period of time or number of treatments.

(e) **Urgent Care Decisions.** In the case of urgent care claims, the Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. However, if the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, but communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Administrator will provide notice of the failure and the proper procedure to complete the claim as soon as possible, but not later than 24 hours of the failure. The Claimant shall be afforded at least 48 hours to provide the specified information. The Administrator will notify the Claimant of the benefit determination as soon as possible, but not later than 48 hours of the earlier of receipt of the specified information or the end of the period in which the Claimant must provide the additional information.

8.3 **Content of Notification of Initial Benefit Determination.** A notice of benefit determination will be sent to the Claimant in written or electronic format in a manner calculated to be understood by the Claimant. In the case of urgent care decisions, the Claimant may be informed orally and will be sent a written or electronic notification within three days of the oral notification. The notification to the Claimant of an adverse determination will generally include:

(a) the specific reason or reasons for the adverse determination;

(b) reference to the specific Plan provisions on which the determination is based;

(c) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an adverse benefit determination on review;

(e) If the claim involves a decision by a group health plan:

(1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criteria, or a statement that such was relied upon in making the adverse benefit determination, will be provided free of charge to the Claimant upon request; and

(2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances, or a statement of such explanation, will be provided free of charge upon request.

(f) if the claim involves an urgent care decision, a description of the expedited review process for such claims.

8.4 **Appeal of Adverse Benefits Determinations.**

(a) Appealing Adverse Determination not Pertaining to Group Health Plan Benefits.

(1) A Claimant shall have 60 days following receipt of a notification of an adverse benefit determination not pertaining to group health plan benefits within which to appeal the determination to the appropriate named fiduciary of the plan.

(2) A Claimant may submit written comments, documents, records and other information relating to the claim for benefits.

(3) A Claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant's claim for benefits.

(4) The review will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) Appealing Adverse Determination Pertaining to Group Health Plan Benefits.

(1) A Claimant shall have 180 days following receipt of a notification of an adverse benefit determination pertaining to group health plan benefits within which to appeal the determination to the appropriate named fiduciary of the plan.

(2) The Plan must comply with items (2) through (4) under "Appealing Adverse Determination not Pertaining to Group Health Plan Benefits."

(3) The review will not give deference to the original determination and will be conducted by an appropriate name fiduciary of the plan who is neither the person who made the original determination subject to appeal, nor the subordinate of such individual.

(4) If the determination was based on medical judgment, including determinations of whether a particular drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary shall consult with an appropriate health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment.

(5) Medical or vocational experts consulted on behalf of the Plan in connection with the determination must be identified, whether or not the advice was relied upon in the determination.

(6) The health care professional consulted under (4) shall be an individual not consulted for the original determination, nor the subordinate of such individual.

(7) If the claim involves urgent care, an expedited review will occur, which may be requested orally or in writing by the Claimant and all necessary information, including the determination on review, shall be transmitted between the Administrator and the Claimant by telephone, facsimile or other available similarly expeditious method.

8.5 **Timing of Notification of Benefits Determination on Review.**

(a) **Generally.** Unless otherwise provided for within this Plan, the Administrator shall notify the Claimant of the benefit determination on review within 60 days after receipt of Claimant's request of review, unless the Administrator determines that special circumstances require an extension of time up to an additional 60 days for processing the claim. If the Administrator determines an extension is necessary, written notice will be provided to the Claimant before the end of the initial 60-day period. The notice shall indicate the reasons for the extension and the date by which the Administrator expects to render a decision.

(b) **Pre-service Decisions.** The Administrator shall notify the Claimant of the benefit determination on review concerning pre-service determinations within 30 days after receipt of Claimant's request of review.

(c) **Post-service Decisions.** The Administrator shall notify the Claimant of the benefit determination on review concerning post-service determinations within 60 days after receipt of Claimant's request of review.

(d) **Urgent Care Decisions.** The Administrator shall notify the Claimant of the benefit determination on review concerning urgent care determinations within 72 hours after receipt of Claimant's request of review.

8.6 **Content of Notification of Benefit Determination on Review.** A notice of benefit determination on review will be sent to the Claimant in written or electronic format in a manner calculated to be understood by the Claimant. The notification to the Claimant will generally include:

(a) the specific reason or reasons for the adverse determination;

(b) reference to the specific Plan provisions on which the benefit determination is based;

(c) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant's claim for benefits;

(d) if any voluntary appeal right exist, a statement describing any voluntary appeal procedures offered by the plan and the Claimant's right to obtain the information about such procedures and a statement of the Claimant's right to bring an action;

(e) if the claim involves a decision by a group health plan:

(1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the determination, will be provided free of charge to the Claimant upon request;

(2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances, or a statement of such explanation, will be provided free of charge upon request.

(f) a statement of the Claimant's other voluntary alternative dispute resolution options, if any. However, if Claimant should initiate a lawsuit, it shall be brought within three years after exhaustion of the claims procedures.

Article 9

PPACA Claims Procedure and Appeal

9.1 **Application.** This Article 9 shall apply to non-Grandfathered Plans providing group health plan coverage covering two or more Employees within the Component Benefit Programs (but not for retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c)) for plan years beginning on or after September 23, 2010.

9.2 **Minimum Internal Claims and Appeals Standards.** A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503-1 and Article 8, except to the extent those requirements are modified or expanded by Article 9.

9.3 **Additional Internal Claims and Appeals Standards.** In addition to the applicable requirements set forth in Section 9.2, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the following requirements:

(a) Full and fair review. A plan and issuer must allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements set forth in Section 8.5:

(i) The plan or issuer must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under Section 8.6 to give the claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date of which the notice of final internal adverse benefit determination is required to be provided under Section 8.6 to give the Claimant a reasonable opportunity to respond prior to that date;

(b) Avoiding conflicts of interest. In addition to the requirements of 29 CFR 2560.503-1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits;

(c) Notice. Effective the first day of the first plan year beginning on or after January 1, 2012, a plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as set forth in 29 C.F.R. 2590.715-2719(e) with respect to applicable non-English languages) that complies with the requirements of 29 C.F.R. 2560.503-1(g) and (j). Effective the first day of the first plan year beginning on or after July 1, 2011 (unless a different effective date is set forth below in this paragraph), the plan and issuer must also comply with the following requirements:

(i) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes

information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable)).

(ii) Effective the first day of the first plan year beginning on or after January 1, 2012, the plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(iii) The plan and issuer must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under Sections 9.2, 9.3, or 9.4, or an external review under Section 9.5.

(iv) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(v) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(d) Deemed exhaustion of internal claims and appeals processes. Effective the first day of the first plan year beginning on or after January 1, 2012,

(i) In the case of a plan or issuer that fails to adhere to all the requirements of Sections 9.2, 9.3, and 9.4 with respect to a claim, the Claimant is deemed to have exhausted the internal claims and appeals process of this Article 9 except as provided in subparagraph (ii) of this paragraph (d). Accordingly, the Claimant may initiate an external review under Section 9.5. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(ii) Notwithstanding subparagraph (i) of this paragraph (d), the internal claims and appeals process of this Article 9 will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. The Claimant may request a written explanation of the violation from the plan or issuer, and the plan or issuer must provide such explanation within ten (10) days, including a

specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this Article 9 to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under subparagraph (i) of this paragraph (d) on the basis that the plan met the standards for the exception under this subparagraph (ii) of this paragraph (d), the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

9.4 **Provision of Continued Coverage Pending the Outcome of an Appeal.** A plan or issuer subject to the requirements of Sections 9.2 and 9.3 are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of Section 8.3(d), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

9.5 **External Review Process**

(a) In general. A Claimant may have the right to file a request for an external review of an adverse determination or final adverse determination with the plan. The Claimant may contact the Plan Administrator for more detailed information related to the external review process. The plan can be reached at (517) 768-6602 or 120 West Michigan Avenue, 5th Floor, Jackson, Michigan 49201.

(b) For fully-insured plans and self-insured nonfederal governmental plans,

(1) Through December 31, 2011, an applicable State external review process is binding on the issuer or plan. If there is no applicable State external review process, the issuer or plan is required to comply with the requirements set forth in paragraph (c) of this Section 9.5. For final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided on or after January 1, 2012, the external review process set forth in paragraph (c) of this Section 9.5 will apply unless the Department of Health and Human Services determines that a State law meets all temporary standards set forth in subparagraph (2) of this paragraph (b).

(2) Beginning January 1, 2012, and until the earlier of January 1, 2014, or the date an applicable State enacts an NAIC-parallel process, issuers and self-insured nonfederal governmental plans shall comply with an applicable State external review process that meets the following temporary standards (as set forth in Department of Labor Technical Release 2011-02):

(A) The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(B) The process provides for external review of adverse benefit determinations (and final internal adverse benefit determinations) involving experimental or investigational treatments or services and must have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(C) Issuers (or plans) are required to provide effective written notice to Claimants of their rights to external review in their summary plan descriptions and plan materials and on each notice of adverse benefit determination. These notice requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.

(D) If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (1) the internal appeal process timelines are not met; or (2) in an urgent care situation, the Claimant files for an external review without having exhausted the internal appeal process. These requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.

(E) The cost of an external review must be borne by the issuer (or plan), and the Claimant cannot be charged a filing fee in excess of $25 per external review.

(F) There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.

(G) The Claimant must have at least 60 days to file for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.

(H) The IRO must be assigned impartially. The Claimant and issuer (or plan) should have no discretion as to the IRO that is chosen.

(I) If the State contracts with, or otherwise identifies one or more IROs to provide external review, the State must have a process in place for quality assurance of IROs.

(J) If the State contracts with, or otherwise identifies one or more IROs to conduct external reviews, the State must ensure conflict of interest protections on the part of the IRO when it participates in external review decisions.

(K) The IRO decision is binding and must be enforceable by the State.

(L) For standard external reviews (those not involving urgent care), the IRO must inform the issuer and the Claimant, in writing, of its decision within 60 days from receipt of the request for external review.

(M) The process must provide for expedited external review of urgent care claims. In such cases, the IRO must inform the issuer and the Claimant of an urgent care decision within four business days or less (depending on medical exigencies of the case) from receipt of the request for review. If the IRO's decision was given orally, the IRO must provide written notice of its decision within 48 hours of the oral notification.

(3) Once an applicable State enacts an NAIC-parallel process (as determined by the Department of Health and Human Services), the external review process of that State law shall apply, unless the health insurance issuer or self-insured nonfederal governmental plan elects to follow a Federally administered external review process as permitted in subparagraph (5) of this paragraph (b).

(4) Beginning January 1, 2012, if a State process does not meet the standards set forth in subparagraphs (2) or (3) of this paragraph (b), health insurance issuers (and, if applicable, self-insured nonfederal governmental plans) in the State will be subject to the external review process set forth in paragraph (c) of this Section 9.5. Additionally, if a State-administered process reduces consumer protections below the level that applies at the time the Department of Health and Human Services makes its finding, plans and issuers in the State will be required to participate in the external review process set forth in paragraph (c) of this Section 9.5.

(5) Health insurance issuers and self-insured nonfederal governmental plans may elect to use a Federally administered external review process instead of the State process; specifically, such plans or issuers can elect to use the process set forth in paragraphs (b)(2) or (c) of this Section 9.5 by timely submitting appropriate information to the Department of Health and Human Services.

(c) ERISA and/or IRC self-insured plans will comply with the external review requirements under the PPACA if the following procedures are adhered to: Subject to the suspension provision set forth in subparagraph (1) of this paragraph (c) (and except to the extent provided otherwise by the Secretary of the Department of Labor in guidance) the external review process set forth in subparagraphs (2) and (3) of this paragraph (c) (i.e., the procedures set forth in Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-02) shall apply to any adverse benefit determination of final internal adverse benefit determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for external review process set forth in subparagraphs (2) and (3) of this paragraph (c).

(1) Unless or until this suspension is revoked in guidance by the Secretary of Labor, with respect to claims for which external review has not been initiated before September 20, 2011, the external review process set forth in subparagraphs (2) and (3) of this paragraph (c) applies only to: (i) an adverse benefit determination (including a final internal

adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (ii) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(2) Standard external review for self-insured group health plans. This subparagraph (2) sets forth procedures for standard external review for self-insured group health plans. Standard external review is external review that is not considered expedited (as described in subparagraph (3) of this paragraph (c)).

(A) Request for external review. A group health plan must allow a Claimant to file a request for an external review with the plan if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(B) Preliminary review. Within five business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

(ii) The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

(iii) The Claimant has exhausted the plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the plan must issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a Claimant to perfect the

request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(C) Referral to Independent Review Organization. The group health plan must assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan must take action against bias and to ensure independence. Accordingly, plans must contract with at least two (2) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between a plan and an IRO must provide the following:

(i) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.

(ii) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(iii) Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the Claimant and the plan.

(iv) Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the Claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

(v) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de

novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

A. The Claimant's medical records;

B. The attending health care professional's recommendation;

C. Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;

D. The terms of the Claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with the applicable law;

E. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

F. Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

G. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(vi) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claimant and the plan.

(vii) The assigned IRO's decision notice will contain:

A. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

B. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

C. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

D. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

E. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;

F. A statement that judicial review may be available to the Claimant; and

G. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(viii) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(D) Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

(3) Expedited external review for self-insured group health plans.

(A) Request for expedited external review. A group health plan must allow a Claimant to make a request for an expedited external review with the plan at the time the Claimant receives:

(i) An adverse benefit determination if the adverse benefit determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or

service for which the Claimant received emergency services, but has not been discharged from a facility.

(B) Preliminary review. Immediately upon receipt of the request for expedited external review, the plan must determine whether the request meets the reviewability requirements set forth in subparagraph (2)(B) above for standard external review. The plan must immediately send a notice that meets the requirements set forth in paragraph (2)(B) above for standard external review to the Claimant of its eligibility determination.

(C) Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO pursuant to the requirements set forth in subparagraph (2)(C) above for standing review. The plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

(D) Notice of final external review decision. The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in subparagraph (2)(C) above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the plan.

(d) To the extent that benefits under a group health plan are provided through health insurance coverage, the health insurance issuer has primary responsibility to comply with the external review process set forth in this Section 9.5.

Article 10

Amendment and Termination of the Plan

10.1 **Amendment and Termination.** Although Employer intends to maintain this Plan indefinitely, it reserves the right to amend or terminate the Plan at any time. Employer further reserves the right to change insurers and/or modify the terms of any contracts with insurers who are providing benefits pursuant to this Plan. The amendment or termination shall be made by a written instrument and shall be communicated to all Participants. Any decision to amend or terminate the Plan and any and all benefits provided under the Plan shall be made either by the Board of Commissioners of County of Jackson or by any person or persons authorized by the Board of Commissioners to take such action.

Unless otherwise provided in the Component Benefit Programs, no Employee, Participant, Dependent or any other person shall have any further right, title, interest or claim, legal or equitable, in or to any reimbursement or benefit payable under such Plan beyond the date in which such Plan or benefit is terminated. Assets remaining in the Plan upon termination arising from employer contributions will revert to the Employer.

Article 11

Miscellaneous Provisions

11.1 **Gender and Number.** Except where otherwise indicated by the context, as used in this agreement the masculine gender includes the feminine and neuter, and words used in the singular include the plural.

11.2 **Headings.** The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

11.3 **Controlling Law.** This Plan shall be construed, administered and enforced according to applicable state laws, to the extent not superseded by the Code, PHSA or any other federal law.

11.4 **Participation in Plan Not Contract of Employment.** The establishment of the Plan, the creation of any account, or the payment of any benefit does not create in any Employee, Participant, or other party a right to continuing employment with Employer. This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be consideration or an inducement for the employment of any Participant.

11.5 **Participants' Rights.** Except as may be required by law, the existence of the Plan shall not give any Participant or beneficiary any equity or other interest in the assets, business or affairs of the Employer; the right to challenge any action taken by the Employer's officers, directors or stockholders, or any policy adopted or followed by the Employer; or the right to examine any of the books and records of the Employer. The rights of all Participants and their beneficiaries shall be limited to their right to receive payment of their benefits from the Plan when due and payable in accordance with the terms of the Plan.

11.6 **Insurance Contract or Governing Document Controls.** Benefits are provided under the Plan pursuant to the Insurance Contracts or other governing document of the underlying Component Benefit Programs. If the terms of this document conflict with the terms of such other contracts or documents, then the terms of the Insurance Contract or governing document will control, rather than this Plan, unless otherwise required by law.

11.7 **Information to be Furnished by Participants.** Participants shall provide the Employer and Administrator with information and evidence, and shall sign documents, as may be reasonably requested from time to time for the purpose of administration of the Plan.

11.8 **Non-Assignability of Rights.** The right of any Participant to receive any Benefit under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

11.9 **Children Placed for Adoption.** This Plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries under the Plan, irrespective of whether the adoption has become final. Restrictions based on preexisting conditions at time of placement for adoption are prohibited. The term "placement," or being "placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

11.10 **National Medical Support Notices**. With respect to component benefit plans that are group health plans, the Plan will also provide benefits in accordance with the applicable requirements of any National Medical Support Notice conforming with section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105-200). In any case in which an appropriately completed National Medical Support Notice is issued in the case of a child of a Participant who is a noncustodial parent of the child, the Administrator, within 40 business days after the date of the National Medical Support Notice shall (1) notify the State agency issuing the National Medical Support Notice with respect to such child whether coverage of the child is available under the terms of the Plan and, if so, whether such child is covered under the Plan and either the effective date of the coverage or any steps necessary to be taken by the custodial parent (or by any official of a State or political subdivision thereof substituted in the National Medical Support Notice for the name of such child) to effectuate the coverage; and (2) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage. Nothing in the Section shall be construed as requiring the Plan, upon receipt of a National Medical Support Notice, to provide benefits under the plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such National Medical Support Notice.

11.11 **State Recovery of Medicaid Payments**. Notwithstanding any other provision of this Plan to the contrary, if this Plan provides benefit payments on behalf of a covered person who is also covered by a state's Medicaid program, the Plan shall be subject to the state's right to reimbursement for benefits the state has paid on behalf of the covered person, provided that the state has an assignment of rights made by or on behalf of the covered person, or the covered person's beneficiary, as may be required by the state medical assistance plan.

11.12 **Coordination with Medicaid**. Notwithstanding any other provisions of this Plan to the contrary, this Plan shall not take into account, with respect to Plan enrollment or the payment of benefits to a covered person or covered person's beneficiary, that such covered person or covered person's beneficiary qualifies for medical assistance under a state Medicaid plan.

11.13 **Honor of State Subrogation Rights**. Notwithstanding any other provision of this Plan to the contrary, the Plan will honor any subrogation rights that a state may have gained from a Medicare-eligible beneficiary covered by the Plan by virtue of the state's having paid Medicare benefits, provided that the Plan has a legal liability for coverage.

11.14 **Subrogation, Reimbursement and Third Party Recovery Provision.** Unless otherwise provided in the Component Benefit Programs, the Plan shall have the following rights:

(a) Benefits under the Plan shall be paid second to other rights of recovery and will be paid only if the Participant fully adheres to the terms and conditions of the Plan. The Plan shall have the right to recover from the Participant or beneficiary any payment for benefits paid by the Plan to which the Participant or beneficiary is entitled to recover from a third person, including but not limited to any liability insurance, uninsured/underinsured motorist proceeds, or other health plan. Specifically, the Plan has a first lien upon any recovery, whether by settlement, judgment or otherwise that the Participant or beneficiary receives from a third person, not to exceed the amounts of benefits paid by the Plan or the amount received by the Participant or beneficiary for such treatment. Any settlement or recovery shall first be applied to reimbursement of medical expenses paid by the Plan.

(b) If benefits are paid or payable by this Plan as the result of an action of a third party, this Plan shall be subrogated to all rights of recovery of any participant or beneficiary under this Plan in respect to such action. No Plan benefits shall be provided unless the Participant provides all information, documentation, and agreements required by the Plan or its agents to process a claim, including but not limited to, reimbursement and subrogation agreements as the Plan or its agents may request. Failure or refusal to execute such agreements or furnish such information does not preclude the Plan from exercising its rights to subrogation or obtaining full reimbursement. Participants receiving benefits under this Plan are obligated to avoid doing anything that would prejudice the Plan's rights, including but not limited to reimbursement.

(c) If any suit is filed, the Participant shall retain an attorney who will not assert the common fund, make-whole, or other apportionment actions in contravention of the Plan's reimbursement terms and that reimbursement shall be made immediately upon collection of any sum recovered regardless of its legal, financial or other sufficiency.

(d) If a suit is filed, the Plan may cause to be recorded a notice of payment of benefits, and such will constitute a lien on any judgment recovered less a pro rata share of court costs.

(e) If suit is filed against the Participant to enforce this provision, the Participant agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

(f) If a person to whom benefits are paid or payable under this Plan fails to bring suit promptly against a third party, the Plan may institute suit against such third party in its own name or in the name of such person and the Plan shall be entitled to retain from any judgment the amount of benefits paid or to be paid to such person without reduction for court

costs, attorney fees, comparative negligence, limits of collectability or responsibility, or otherwise. The remainder of any recovery shall be paid to such person or as the court directs.

(g) If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of applicable state law and whether the minor's representative has access or control of any recovery funds.

(h) The Plan Administrator has sole discretion to interpret the terms and conditions of this provision in its entirety and reserves the right to make changes as it deems necessary.

11.15 **Coordination of Benefits**. Benefits shall be coordinated as set forth in the Component Benefit Programs as outlined in the Summary Plan Description.

11.16 **Exclusive Benefit**. This Plan shall be maintained for the exclusive benefit of the Participants who participate in the Plan.

11.17 **Action by the Employer**. Whenever the Employer, under the terms of the Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.18 **No Guarantee of Tax Consequences**. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant'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. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Administrator if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.19 **Indemnification of Employer by Participants**. If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax, plus any penalties, that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.20 **Expenses.** All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

11.21 **Code and PHSA Compliance.** It is intended that this Plan meet all applicable requirements of the Code and PHSA, and of all regulations issued thereunder. This Plan shall be

construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or PHSA, the provisions of the Code and PHSA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

11.22 **Plan Provisions Controlling.** Except as provided in Section 11.6, in the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

11.23 **COBRA Continuation of Coverage.** Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the continuation coverage requirement of Code section 4980B (the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X, as amended, (COBRA)), the Plan will be operated in accordance with Code section 4980B and any regulations and guidance thereunder.

11.24 **Uniform Services Employment and Reemployment Rights Act (USERRA)**. Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and any regulations thereunder.

11.25 **Family and Medical Leave Act (FMLA)**. Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act, this Plan shall be operated in accordance with the FMLA and any regulations thereunder.

11.26 **Health Insurance Portability and Accountability Act (HIPAA)**. Notwithstanding anything in this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of HIPAA, this Plan shall be operated in accordance with HIPAA and any regulations thereunder.

11.27 **Newborns' and Mothers' Health Protection Act (NMHPA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of NMHPA, this Plan shall be operated in accordance with NMHPA and any regulations thereunder.

11.28 **Mental Health Parity Act (MHPA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of MHPA, this Plan shall be operated in accordance with MHPA and any regulations thereunder.

11.29 **Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of MHPA and/or the MHPAEA, this Plan shall be operated in accordance with MHPA and/or the MHPAEA and any regulations thereunder.

11.30 **Genetic Information Nondiscrimination Act of 2008 (GINA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this

Plan becomes subject to the requirements of GINA, this Plan shall be operated in accordance with GINA and any regulations thereunder.

11.31 **Women's Health and Cancer Rights Act of 1998 (WHCRA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of WHCRA, this Plan shall be operated in accordance with WHCRA and any regulations thereunder.

11.32 **Patient Protection and Affordable Care Act of 2010 (PPACA)** Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of PPACA, this Plan shall be operated in accordance with the PPACA and any regulations thereunder.

11.33 **Conformity with Statutes** This Plan is intended to conform with any and all applicable state and federal statutes. Any reference to any federal, state, local, or foreign statute or law shall be deemed also to refer to all rules and regulations promulgated thereunder, unless the context requires otherwise.

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

Executed this _____ day of _____, 2011.

County of Jackson

By:_____
Michael Overton
County Administrator/Controller

County of Jackson Amended and Restated Group Health Plan for Non-POAM Employees

Drafted By:
Elizabeth H. Latchana
Fraser Trebilcock Davis & Dunlap, P.C.
124 West Allegan, Suite 1000
Lansing, Michigan 48933
(517) 377-0826

Exhibit A

Component Benefit Program Information

County of Jackson

Amended and Restated Group Health Plan

POAM Employees

Prepared by:
Fraser Trebilcock Davis & Dunlap, P.C.
124 West Allegan, Suite 1000
Lansing, Michigan 48933
Telephone: (517) 482-5800
Facsimile: (517) 482-0887

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County of Jackson
Amended and Restated Group Health Plan for POAM Employees

Preamble

The County of Jackson has adopted a Welfare Benefit Plan for its Employees. This Plan is the overall plan by the Employer to provide benefits to its Employees through self-funded programs and through contracts with insurance companies and/or contract administrators.

Each of the underlying benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another governing document prepared by the Employer or contract administrators. Because of the involvement of third-party insurers and providers, this Plan will necessarily incorporate by reference the various certificates of coverage, insurance contracts and other documents which provide relevant terms of this Plan. This Plan, accompanied by the above-referenced documents, constitutes the plan document. Moreover, the Plan shall be treated as a single employee welfare benefit plan. However, this Plan does not expand the responsibilities regarding the included benefits beyond the requirements of federal and state law. It is intended that the health and welfare benefits provided through the underlying benefit programs are eligible for exclusion from income under Internal Revenue Code section 105.

Article 1

Definitions

When used in this Plan, the following words shall have the following meanings, unless the context clearly indicates otherwise:

1.1 **"Administrator" or "Plan Administrator"** means the County of Jackson or another person or entity designated by its Board of Commissioners to administer the Plan.

1.2 **"Affiliate"** means an employer that is sufficiently affiliated with the Employer to be able to participate in the same benefit plan or plans pursuant to the Code.

1.3 **"Benefits"** means the benefits provided under any of the Component Benefit Programs.

1.4 **"Board of Commissioners"** means Employer's governing body.

1.5 **"Claimant"** means any Participant who seeks to file a claim pursuant to the terms of this Plan.

1.6 **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. References in the Plan to any COBRA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.7 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. References in the Plan to any Code section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the Code section.

1.8 **"Component Benefit Programs"** means all programs and plans providing benefits which are being combined under this Plan, whether through Insurance Contracts or otherwise. Specifically, the Component Benefit Programs offered under this Plan are:

- Medical and prescription benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")
- Dental and vision benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")

1.9 **"Contract Administrator"** means any third-party with whom Employer has contracted to provide and/or administer benefits under the Plan.

1.10 **"Dependent"** generally means a Participant's Spouse and any person who is a dependent of the Participant within the meaning of Code section 152 (however, for health benefits, a Dependent generally means any person who is a dependent as defined as set forth in Code sections 105(b), 106 and the regulations and other authority thereunder) and who is eligible to participate in the underlying Component Benefit Programs. Dependents also include those Dependents allowed continued participation under Michelle's Law, Pub. L. No. 110-381 (2008). Dependents may or may not be eligible to participate in certain Benefits within the Component Benefit Programs.

1.11 **"Effective Date"** of this Plan is January 1, 2011.

1.12 **"Electronic Protected Health Information (EPHI)"** means individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

1.13 **"Employee"** means an individual that the Employer classifies as a common law employee and who is on the Employer's W-2 payroll, but does not include temporary or leased employees, casual employees, seasonal employees, contract workers or independent contractors.

1.14 **"Employer"** means the County of Jackson and any successor which shall maintain this Plan. Any Affiliate which elects to participate in the Plan, and receives the consent of its Board of Directors to do so, shall also be deemed the Employer with respect to its eligible Employees.

1.15 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time. References in the Plan to any ERISA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section. This Plan is exempt as a "governmental plan" from the provisions of ERISA. Any reference to ERISA within this document is for informational purposes only and does not cause this Plan to become subject to ERISA.

1.16 **"FMLA"** means the Family and Medical Leave Act of 1993, as amended from time to time. References in the Plan to any FMLA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.17 **"GINA"** means the Genetic Information Nondiscrimination Act of 2008, as amended from time to time.

1.18 **"Grandfathered Plan"** means a group health plan or health insurance coverage which had an individual enrolled in it on March 23, 2010 (and for as long as it maintains that status under the PPACA and its implementing regulations). This Plan is not a Grandfathered Plan.

1.19 **"Health Care Component"** means the components of this Plan which are subject to HIPAA's Privacy Rules and Security Rules. Specifically, the Health Care Components within this Plan and which, if separate entities, would also be covered entities under HIPAA, are the following:

- Medical and prescription benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")
- Dental and vision benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")

1.20 **"Highly Compensated Individual"** means an individual defined under Code section 105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

1.21 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time. References in the Plan to any HIPAA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.22 **"Individually Identifiable Health Information"** means the information that is a subset of health information, including demographic information collected from an individual, and: (a) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (b) relates to the past, present or future physical or mental health or condition, the provision of health care, or payment for the provision of health care to an individual and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

1.23 **"Insurance Contracts"** means any insurance contracts, certificates of coverage, certificates of insurance, benefit booklets, policies or other contracts between the Employer and Contract Administrators providing and/or administering benefits under the applicable Component Benefit Programs to Participants and their eligible Dependents.

1.24 **"MHPA"** means the Mental Health Parity Act, as amended from time to time. References in the Plan to any MHPA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.25 **"MHPAEA"** means the Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time. References in the Plan to any MHPAEA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.26 **"Named Fiduciary"** means the Plan Sponsor and Plan Administrator. For purposes of self-funded benefit appeals, the Named Fiduciaries are:

County of Jackson
120 West Michigan Avenue
Jackson, Michigan 49201
(517) 768-6602

1.27 **"NMHPA"** means the Newborns' and Mothers' Health Protection Act of 1996, as amended from time to time. References in the Plan to any NMHPA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.28 **"Participant"** means an Employee or Retiree who has satisfied the eligibility requirements of Article 2 and who is participating in the Plan pursuant to the terms of the Plan or any continuation requirements of State or Federal law.

1.29 **"PHSA"**means the Public Health Service Act of 1944, as amended. References in the Plan to any PHSA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.30 **"Plan"** means the County of Jackson Amended and Restated Group Health Plan for POAM Employees set forth in this document and all subsequent amendments.

1.31 **"Plan Sponsor"** means the County of Jackson.

1.32 **"Plan Year"** means the 12-month period ending on each December 31; however, there may be different plan years for each individual underlying benefit as set forth in the Component Benefit Programs.

1.33 **"PPACA"** means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and as may be further amended from time to time. References in the Plan to any PPACA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.34 **"Privacy Rules"** means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E , as amended from time to time.

1.35 **"Protected Health Information (PHI)"** means individually identifiable health information, except as provided below in this definition, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.

Protected health information excludes individually identifiable health information in Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and employment records held by a covered entity in its role as employer.

1.36 **"Qualified Beneficiary"** means those beneficiaries entitled to COBRA coverage under Article 5.

1.37 **"Qualifying Event"** means those events specified in Section 5.3.

1.38 **"Retiree"** means an Employee who has retired from full-time employment with Employer and is no longer an Employee.

1.39 **"Security Rules"** means the Security Standards and Implementation Specifications at 45 CFR Part 160 and Part 164, subpart C, as amended from time to time.

1.40 **"Spouse"** means an individual who is legally married to a Participant as determined under applicable Michigan state law and who is treated as a spouse under the Code.

1.41 **"Summary Health Information (SHI)"** means information that may be individually identifiable health information, as defined by the HIPAA Privacy Rules as amended from time to time, and (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and (b) from which names and geographic subdivisions smaller than a State has been deleted, except that such geographic information need only be aggregated to the level of a five-digit zip code.

1.42 **"USERRA"** means the Uniform Services Employment and Reemployment Rights Act, as amended from time to time. References in the Plan to any USERRA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

1.43 **"WHCRA"** means the Women's Health and Cancer Rights Act of 1998, as amended from time to time. References in the Plan to any WHCRA section shall include any comparable or succeeding provisions of any legislation which amends, supplements, or replaces the section.

Article 2

Eligibility and Participation

2.1 **Eligibility and Participation Requirements.** The eligibility requirements for this Plan and requirements for commencing participation are governed by the terms and conditions of the Component Benefit Programs, attached as Exhibit A, by the Employer's policies or directives and/or by any collective bargaining agreements between the Employer and any union representing Employees.

Employee Coverage

Unless otherwise provided, each Employee who meets all of the following requirements shall be eligible to participate in the Plan:

(a) The Employee is regularly scheduled to work at least 20 hours per week and will normally be scheduled to work more than six months during the Plan Year; and

(b) The Employee is a part-time or full-time Employee of Employer, is included in the Police Officers Association of Michigan ("POAM") collective bargaining unit which bargained in good faith for employee benefits, and the collective bargaining agreement provides that the Employee shall be eligible to participate in the Plan. In such case, the Employee may only participate in the Plan to the extent that the collective bargaining agreement provides.

The Employee may be responsible for the cost of coverage under this Plan as provided within the collective bargaining agreements, employee handbooks, benefit summaries, and/or enrollment materials.

Some of the Component Benefit Programs may require the Employee to make an annual election to enroll for coverage. The details of such annual elections are described in the underlying documents. In certain circumstances, enrollment may occur outside the open enrollment period.

Retiree Eligibility and Coverage for Medical and Prescription Benefits Only

Eligibility factors for Retiree Health for Employees / Retirees covered by collective bargaining agreements are set for in those agreements.

Retirees and their Dependents are not eligible for any dental or vision coverage under this Plan.

The Retiree may be responsible for the cost of coverage under this Plan as provided within the collective bargaining agreements, employee handbooks, benefit summaries, and/or enrollment materials.

Some of the Component Benefit Programs may require an annual election to enroll for coverage. The details of such annual elections are described in the underlying documents. In certain circumstances, enrollment may occur outside the open enrollment period.

Dependent Eligibility and Coverage in General

Coverage may also be provided to Dependents who are eligible to participate in the underlying Component Benefit Programs. Dependents may or may not be eligible to participate in certain Benefits within the Component Benefit Programs. Please see the underlying Component Benefit Programs for more information on Dependent eligibility.

Dependent Coverage Under BCBSM Plan

Effective January 1, 2011, coverage for Dependent children will be available for an adult child until the day prior to the date the child turns 26 years of age. A "child" for this purpose is defined as a son, daughter, stepson, stepdaughter, or eligible foster child of the Participant as defined in Code section 152(f)(1). The definition of "child" for this purpose shall not include a child of the Participant's child.

However, an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical disability may be covered to any age if such physical or mental disability occurred before the child turned 26 years of age, the child is chiefly dependent on the Participant for support and maintenance, and the Participant has submitted proof (medical certification) of the child's incapacity to the carrier prior to the child turning age 26 or within 31 days thereafter.

NOTE: The Participant shall be required to present, upon request, to the employer certified documentation providing proof of parentage, spousal and/or dependent relationships, proof of the physically or mentally disabled, and proof of dependent eligibility status. This required documentation may be requested at any time to determine eligibility status.

NOTE: If full-time student status is required for coverage of any Dependent children, this Plan will comply with Michelle's Law, Code section 9813. Michelle's Law provides for continued coverage if the Dependent would otherwise lose coverage due to loss of full-time student status at a postsecondary educational institution because of a medically necessary leave of absence that begins while the Dependent is suffering from a serious illness or injury. Coverage may continue for up to one year after the first day of the medically necessary leave of absence, ending earlier only if coverage under the Plan would otherwise terminate (such as reaching the maximum age requirement). Written certification by the Dependent's treating physician is required stating that the leave is medically necessary and that the child is suffering from a serious illness or injury as defined in Michelle's Law.

Coverage for a Dependent will be effective on the date the Employee's coverage becomes effective if he applies for Dependent coverage when he enrolls in the Plan. In no event will the Employee's Dependents be covered before the date the Employee's coverage begins. An Employee without a Dependent on the date he becomes eligible for coverage who later acquires a Dependent may enroll his Dependent in this Plan by written application within 30 days after he acquires that Dependent.

A newborn child, adopted child, or child placed for adoption will be covered if enrolled within the 30 day period following birth, adoption, or adoption placement. This Plan is intended to comply with OBRA '93 with respect to dependent child eligibility and Qualified Medical Child Support Orders. If coverage for a Dependent (including newborns, adopted children, or children placed for adoption) is applied for more than 30 days following the date that Dependent becomes eligible for coverage, the Dependent may only be able to enroll during the open enrollment/election period.

Additionally, for purposes of the BCBSM Plans, if two (2) Employees under this Plan are married and both want coverage, they may choose to both be covered as Employees, or one of

them may be covered as the Employee and the other may be covered as a Dependent. However, eligible Dependent children of two (2) parents who are both covered under this Plan may be enrolled as Dependents of only one (1) of the Employees. In the event that one (1) Employee's coverage should terminate, his/her eligible covered Dependents will be eligible to become covered Dependents under the remaining parent's Employee coverage.

2.2 **Election Periods.**

Initial Election Period

An Employee who does not apply for coverage within thirty (30) days of the date he or she becomes eligible for coverage may only be able to enroll during the open enrollment / election period, unless otherwise required by law.

Open Enrollment / Election Period

An Employee and/or Dependent who wishes to make an election change, or who does not apply for coverage when initially eligible but later wishes to apply, may do so only during the open enrollment / election period in the Fall for an effective date of January 1. However, an election change may be made before the open enrollment/election period if a special enrollment event occurs such as marital status change, change in number of Dependents or dependent status, other eligibility change, involuntary loss of coverage from another Plan, or another event legally requiring mid-year enrollment, as long as the proper notice is provided within the required 30 day time period from the date of the special enrollment event.

2.3 **Date of Participation**

Unless otherwise provided in the Component Benefit Programs or the collective bargaining agreements, and as long as all required enrollment materials are completed and submitted, an Employee or Retiree will become a Participant on the later of the Effective Date of this Plan or the date the Employee or Retiree becomes eligible to participate pursuant to this Article.

2.4 **HIPAA Special Enrollment**. An Employee or Participant may revoke an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f). Unless otherwise provided, such change shall take place on a prospective basis.

(a) As required by HIPAA, a 30-day special enrollment right will arise if:

(1) A current Employee is eligible for, but declined enrollment in, this group health plan coverage (or a Dependent of such Employee is eligible for, but was not enrolled in, this group health plans coverage) because the Employee or Dependent was covered under another group health plan or had other health insurance coverage when this group health plan coverage was previously offered and the other coverage was lost due to either: (i) if the other coverage was COBRA continuation coverage, that coverage has been exhausted; or (ii) if the other coverage was not COBRA continuation coverage, either the coverage was terminated as a result of loss of eligibility for the coverage (including, but not limited to, as a result of legal

separation, judgment of separate maintenance, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment; in the case of an HMO, the individual no longer resides, lives or works in the service area where the HMO provides benefits and, in cases of the group market, no other package is available to the individual; an individual incurs a claim meeting or exceeding a lifetime limit on all benefits; or the plan no longer offers any benefits to the class of similarly situated individuals that includes the individual), or employer contributions towards such coverage were terminated. Unless otherwise provided in the Component Benefit Programs, the eligible Employee must request enrollment not later than 30 days after the loss of other coverage (or after a claim is denied due to the operation of a lifetime limit on all benefits). Any eligible Dependent may only enroll if that Dependent (or the Employee) meets the above requirements; or

(2) A new Dependent is acquired as a result of marriage, birth, or adoption or placement for adoption, and the group health plan makes coverage available with respect to a Dependent of a Participant or an Employee who has met any waiting period requirements and is eligible to participate under that plan. Unless otherwise provided in the Component Benefit Programs, these election changes to add coverage must be made within 30 days of the date of the marriage, birth or adoption or placement for adoption (or the date dependent coverage is made available, if later). An election to add the following individuals (if otherwise eligible for coverage under the Plan) as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption is consistent with the special enrollment right: (i) a current Employee who is eligible but not enrolled; (ii) a current Employee who is eligible but not enrolled, and the Spouse of such Employee; (iii) a current Employee who is eligible but not enrolled, and the newly acquired Dependent of such Employee; (iv) the Spouse of a Participant; (v) a current Employee who is eligible but not enrolled, and the Spouse and newly acquired Dependent; and (vi) a newly acquired Dependent of a Participant.

Enrollment applications received after the special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Unless otherwise provided in the Component Benefit Programs, coverage under the special enrollment period for timely submitted requests must be effective no later than the first day of the month after the plan or issuer receives the request for special enrollment. However, with regard to enrollment requests made within 30 days on behalf of a new Dependent acquired due to birth, adoption, or placement for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for adoption (or the date the plan makes dependent coverage available, if later).

(b) As required by HIPAA, effective April 1, 2009, a 60-day special enrollment right will arise if the Employee or Dependent is eligible for, but not enrolled in, the Plan and either:

(1) loses coverage under Medicaid, specifically, if the Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for coverage; or

(2) becomes eligible for a Medicaid subsidy, specifically, if the

Employee or Dependent becomes eligible for premium assistance, with respect to coverage under the Plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Employee or Dependent with the special enrollment right under subsection (b) must request enrollment within the first 60 days from the date of termination of such coverage under (b)(1) or 60 days from the date the applicant is determined to be eligible for premium assistance under (b)(2). Enrollment applications received after the 60-day special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Coverage under this Plan shall take effect on the same date coverage for this HIPAA special enrollment right takes effect in the underlying Component Benefit Programs.

This Section only applies to group health plan coverage covering two or more Employees within the Component Benefit Programs. This Section does not apply to retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, specified disease or fixed indemnity coverage or health flexible spending accounts that qualify as "excepted benefits," as defined in Treasury Regulations section 54.9831-1(c).

2.5 **PPACA Special Enrollment.**

(a) As required by the PPACA, effective the first day of the first plan year beginning on or after September 23, 2010, a 30-day special enrollment right will be available to any child (i) whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26; and (ii) who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010. The plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage shall take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(b) As required by the PPACA, effective the first day of the first plan year beginning on or after September 23, 2010, a 30-day special enrollment right will be available to any individual (i) whose coverage or benefits under a group health plan or group health insurance coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits for any individual; and (ii) who becomes eligible (or is required to become eligible) for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010. The plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. If the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including

written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage shall take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(c) This Section only applies to group health plan coverage covering two or more Employees within the Component Benefit Programs. This subsection does not apply to retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c).

2.6 **Cessation of Participation and Loss of Benefits.** Unless provided otherwise in the Component Benefit Programs or collective bargaining agreements, a Participant's participation in the Plan will automatically cease at 11:59 p.m. on the earliest of the following dates:

(a) date the Participant terminates employment with Employer or is laid off;

(b) date the Participant ceases to be in a class of employees eligible for coverage;

(c) date the Participant fails to make any required contribution for coverage;

(d) date the Plan is terminated;

(e) date Employer terminates coverage;

(f) (1) the original effective date of coverage if coverage is rescinded due to misrepresentation on the Participant's enrollment application; (2) however, effective January 1, 2011, a group health plan or a health insurance issuer offering group health plan coverage (the "plan") shall not rescind (i.e., cancel or discontinue coverage retroactively when such cancellation or discontinuance is not attributable to a failure to timely pay required premiums towards the cost of coverage) coverage under the plan, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan, unless the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded. This subsection (f)(2) shall only apply for group health plan coverage covering two or more Employees within the Component Benefit Programs (but not for retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c).

(g) the date of the Participant's death; however, upon a Retiree's death, coverage for the Retiree's Spouse who was covered under this Plan on the date of the Retiree's death, spousal coverage continues for the life of the surviving Spouse (unless the Retiree had selected a Straight Life retirement option);

(h) the date the Participant otherwise lose eligibility under the Plan;

(i) the date the Participant revokes his or her election as permitted under the terms of the relevant Component Benefit Program; or

(j) for Retirees, the date the Retiree becomes entitled to Medicare, at which time the Retiree will be enrolled in the HUMANA Medicare Advantage Plan; any medical and prescription coverage for Dependents at the time of the Retiree's Medicare entitlement will continue under this BCBSM Plan as long as the Retiree is enrolled in HUMANA, until such coverage is otherwise terminated as specified below.

Cessation of Dependent Coverage

Generally, Dependents will lose coverage under the Component Benefit Programs as of the earlier of the date they are no longer eligible or at the same time the Participant loses coverage for any of the events listed above. Please see the Component Benefit Programs for more details.

With regard to coverage under the BCBSM Plans, Dependents will lose coverage as of the same time the Participant loses coverage for any of the events listed above, unless otherwise provided for Retirees.

Additionally, and unless otherwise provided in the Component Benefit Programs, coverage of any Dependent under the BCBSM Plans will automatically cease at 11:59 p.m. on the earliest of the following dates, unless coverage is otherwise required to continue by law:

(a) for Spouses:

(1) upon judgment of separate maintenance or legal separation (if applicable within the applicable State); or

(2) upon divorce.

(b) beginning January 1, 2011, for Dependent children:

(1) the day prior to the date the child reaches age 26; or

(2) in the case of a disabled Dependent, upon the Dependent being medically certified as no longer incapable of self-sustaining employment by reason of mental retardation of physical disability.

Other circumstances can result in the termination, reduction or denial of benefits. The Participant should consult the Component Benefit Program documents for additional information. Termination of participation will automatically revoke elections and benefits as of

the dates specified in the Component Benefit Programs. The Participant may also be entitled to continue certain benefits pursuant to state and federal law after participation ends. Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), a former Participant (or his or her covered Spouse or Dependent children) may be able to elect to continue certain group medical benefits provided under this Plan for a limited period of time by paying the cost of the benefits.

2.7 **May Benefits Be Continued During a Leave of Absence?** In addition to the rights provided under COBRA, FMLA and USERRA as described in this Plan, benefit coverage under the Component Benefit Programs may be continued if an Employee is on an approved leave of absence. Please see the Employer's policies for further information.

2.8 **USERRA Leave of Absence.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, as applicable, the Employer will continue to maintain the Participant's health benefits on the same terms and conditions as if the Participant were still an active Employee. These rights apply only to Participant-Employees and their Dependents covered under the Plan before the Employee left for military service. To be entitled to USERRA rights, the Participant must give the Employer advance notice of the Participant's absence from employment for uniformed service, unless precluded by military necessity or if it is otherwise impossible or unreasonable under all the circumstances. Additionally, subject to certain exceptions, the Participant's absence from work may not exceed five years.

USERRA rights include up to 24 months of continued health care coverage. For periods of leave less than 31 days, the Participant only needs to pay his or her normal portion of the premium. For periods of leave 31 days or more, coverage will only be extended upon payment of the entire cost of coverage plus a reasonable administration fee.

Moreover, if coverage was terminated due to an Participant's service in the uniformed services, and the Participant is reemployed under USERRA, the Participant is entitled to reinstatement in the Plan. No preexisting conditions limitations will be applied in the Plan upon return from service. However, Plan exclusions and waiting periods may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

USERRA rights terminate if the Participant's discharge from the uniformed service was a result of "dishonorable" or other undesirable conduct, the Participant fails to report back to work or apply for reemployment within the time period required under USERRA, or if the Participant fails to pay coverage premiums.

The time periods within which to elect and pay for USERRA continuation of coverage shall be the same time periods within which to elect and pay for COBRA coverage under the Plan. If both USERRA and COBRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage.

This Section only applies to health plan coverage within the Component Benefit Programs.

2.9 **Family and Medical Leave Act (FMLA).** If the Employer is subject to FMLA, this Plan shall at all times comply with applicable requirements of the Family and Medical Leave Act of 1993 and its implementing regulation. During any leave taken under the Family and Medical Leave Act, the Employer will maintain health coverage under this Plan on the same conditions as coverage would have been provided if the Employee had been continuously employed during the entire leave period. Benefit coverage may be continued for all benefits up to the time limit allowed for an approved leave of absence that qualifies under FMLA.

If, during FMLA leave, the Employee does not wish to receive some or all of the coverage that he or she was receiving just prior to leave, the Employee must inform the Plan Administrator prior to the start of leave of which coverages will be dropped. If the Employee decides not to receive some or all of the covered medical benefits during FMLA leave, he or she may reinstate the same coverages upon return to work at the conclusion of FMLA leave.

If the Employee wishes to continue participation in the Plan, he or she must make arrangements with the Plan Administrator to pay for the coverages (in which the Employee is currently enrolled) that he or she wishes to maintain during the course of leave. Eligibility to continue any coverage, which requires payments from the Employee, may be cancelled if he or she does not make the required payments during the period of FMLA leave.

If the Plan Administrator advances money by making any or all of these required payments for the Employee, it can recoup the amounts advanced through payroll deductions and by other means upon the Employee's return to employment following FMLA leave, to the extent permitted by law.

If the Employee fails to return from FMLA leave, and the reasons for failure are not beyond the Employee's control, the Employee is indebted to the Plan Administrator for the full amount of the cost of health coverage provided during FMLA leave. Employer intends to deduct any such amounts owed by an Employee from any compensable time payments owed to such Employee upon termination for failure to return from an FMLA leave, to the extent permitted by law. Employer may also use other means necessary to recoup these health care coverage costs.

An Employee should consult with the Plan Administrator before embarking on any FMLA qualified leave.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

This Section only applies to group health plan coverage within the Component Benefit Programs.

Article 3

Benefits Offered and Method of Funding

3.1 **Employer-Funded Benefits.** Additionally, the Plan offers Participants with the opportunity to participate in certain self-funded benefits:

- Medical and prescription benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")
- Dental and vision benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")

Summaries of these benefits are attached at Exhibit A. Any Insurance Contracts between the Employer and Contract Administrators providing and/or administering benefit coverage to Participants are incorporated by reference. The rights and conditions with respect to the benefits payable under these documents shall be determined from the terms of those documents. This Plan is not intended to expand or in any way increase the benefits available under those contracts.

3.2 **Contributions.** The cost of the benefits provided through the component benefit programs will be funded as provided in the underlying governing documents and collective bargaining agreements, including Employer contributions and/or pre-tax or after-tax employee contributions. Special rules apply with regard to pre-tax contributions, irrevocability of elections, and possible forfeitures as specified in the County of Jackson Second Amended and Restated Section 125 Cafeteria Plan, as amended from time to time. The Employee is also responsible for any deductible, co-payment, and coinsurance that may be required under the terms of the benefit programs. Unless provided otherwise in the collective bargaining agreements, the Employer will determine and periodically communicate the employee's cost of the benefits provided through each Component Benefit Program, and it may change that determination at any time.

3.3 **Funding**. Unless otherwise required by law, contributions to the self-funded portions of the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. The self-funded benefits are funded by the Employer and are not insured by an insurance company, with the exception of stop-loss insurance. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

3.4 **Reimbursements to Highly Compensated Individuals.** It is the intent of this Plan not to discriminate in violation of the Code and the Treasury Regulations thereunder. Therefore, reimbursements under any self-funded plan to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code section 105(h), as may be determined by the Administrator in its sole discretion. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

3.5 **Applicable Laws.** With respect to component benefit plans that are group health plans, the Plan will provide benefits in accordance with COBRA, FMLA, GINA, HIPAA, MHPA, MHPAEA, NMHPA, USERRA, WHCRA, PPACA and other group health plan laws to the extent required by such laws.

Article 4

HIPAA Privacy and Security Health Information for Self Insured Group Health Plans

4.1 **Permitted and Required Uses and Disclosures of Summary Health Information.** Unless otherwise permitted by law, the Plan may disclose SHI to the Plan sponsor, provided the Plan sponsor uses or discloses such SHI only for the following purposes:

(a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(b) Modifying, amending or terminating the Plan.

4.2 **Permitted and Required Uses and Disclosure of Protected Health Information.** Unless otherwise permitted by law, the Plan may disclose PHI to the Plan sponsor, provided the Plan sponsor uses or discloses such PHI only for the purpose of performing Plan administration functions.

4.3 **Permitted Disclosure of Enrollment/Disenrollment Information.** Unless otherwise permitted by law, the Plan may disclose information to the Plan sponsor, provided the Plan sponsor uses or discloses such PHI only for the purpose of determining whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

4.4 **Obligations of Plan Sponsor.** The Plan sponsor agrees that with respect to any PHI and EPHI, as applicable, disclosed to it by the Plan or any other covered entity, the Plan sponsor shall:

(a) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law.

(b) Ensure that any agents, including a subcontractor, to whom it provides PHI or EPHI received from the Plan agree to the same restrictions and conditions that apply to the Plan sponsor with respect to such information.

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make PHI available to the individual in accordance with the disclosure and timing requirements of the Privacy Rule.

(f) Make PHI available for amendment by the individual and incorporate any amendments to PHI in accordance with the Privacy Rule.

(g) Make information available to the individual to provide an accounting of disclosures in accordance with the Privacy Rule.

(h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule.

(i) If feasible, return or destroy all PHI received from the Plan that the Plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, 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 not feasible.

(j) Ensure that the adequate separation required by the Privacy Rule and Security Rule is established.

(k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Plan; and

(l) Report to the Plan any security incident, as defined by the HIPAA Security Rule, of which it becomes aware.

4.5 **Adequate Separation.** The Plan sponsor shall only allow employees with specific classifications/designations access to PHI and EPHI. The Plan sponsor shall designate these employees from time to time. These specified employees shall only have access to and use PHI and EPHI to the extent necessary to perform Plan administration functions that the Plan sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Article, that employee shall be subject to disciplinary action by the Plan sponsor for noncompliance pursuant to the discipline and termination procedures of the Plan sponsor.

4.6 **Certification of Plan Sponsor.** The Plan (or health insurance issuers or HMO with respect to the Plan) shall disclose PHI to the Plan sponsor only upon receipt of a certification by the Plan sponsor that the Plan has been amended to incorporate the provisions of Section 164.504(f)(2)(ii) of the Privacy Rule and that the Plan sponsor agrees to the conditions of the disclosures set forth in this Article.

4.7 **Miscellaneous Interpretive Provision.** The following provisions apply to limit and further define the operation of HIPAA to the Plan:

(a) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan sponsor be permitted to use or disclose health information in a manner that is inconsistent with HIPAA. Any ambiguity in this Article shall be resolved in favor of a meaning that permits the Plan and Plan sponsor to comply with HIPAA. Additionally, under no circumstances does this Section extend the rights and obligations of HIPAA to benefits that would otherwise be outside the scope of HIPAA. This Section does not create any contractual rights or obligations between the Plan and other parties to Plan benefits that would otherwise be outside the scope of HIPAA. This Article does not extend application of HIPAA to create any obligations for the Plan (or any part or component within the Plan) or the Plan sponsor that they would not otherwise have under HIPAA.

(b) This Article does not apply and has no legal effect on the Plan if the Plan does not meet the definition of "Health Plan" or "Group Health Plan" as defined by 45 CFR 160.103. Under HIPAA, a "Group Health Plan" is defined as an employee welfare benefit plan including insured and self-insured plans, to the extent that the plan provides medical care including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that: (1) has 50 or more participants; or (2) is administered by an entity other than the employer that established and maintains the plan.

(c) When permitted, it is the intention of the Plan (or any part or component within the Plan) to qualify as an exempted group health plan under 45 CFR 164.520(a)(2) and 164.530(k), or qualify under any exemption of any requirement under HIPAA.

4.8 **Effective Date and Applicability of this Article.** The requirements of the Privacy Rule within this Article shall be effective as of April 14, 2004, and the requirements of the Security Rule within this Article shall be effective as of April 20, 2005, and shall only apply to benefits provided and information received which pertain to health care and medical coverage. However, if this Plan should qualify as a "small plan" under HIPAA, the Security Rule aspects of this Article will instead become effective on April 20, 2006. In no event will this Article become effective prior to the Effective Date of this Plan.

4.9 **HITECH Act**. This Plan shall comply with the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), 42 USC 17930 et seq. as of the dates reflected within the HITECH Act.

This Article only applies to health plan coverage within the Component Benefit Programs.

Article 5

Continuation of Coverage for Group Health Plan Benefits

5.1 **In General.** The following provisions may apply to benefits provided to eligible Participants and their Qualified Beneficiaries under the Plan, but only to the extent that the benefits selected pertain to health care and medical coverage pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA).

This Article shall be applicable to Retirees only for purposes of the Component Benefit Programs which provide benefits to Retirees.

Importantly, this Article only applies to group health plan coverage within the Component Benefit Programs. It does not apply to non-health benefits.

5.2 **Continuation of Coverage.** To the extent required by Section 5.1 above, a covered Employee/Retiree or Qualified Beneficiary who would lose coverage under this Plan as a result of a Qualifying Event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a covered Employee/Retiree or Qualified Beneficiary who is a spouse of the covered Employee/Retiree will be deemed to include an election for continuation coverage under this provision on behalf of any other Qualified Beneficiary who would lose coverage by reason of a Qualifying Event.

If this Plan provides a choice among the types of coverage under this Plan, each Qualified Beneficiary is entitled to make a separate selection among such types of coverage. However, the Qualified Beneficiary may only be able to continue that type of coverage which he or she would have lost as a result of the Qualifying Event.

5.3 **Qualifying Event.** The term "Qualifying Event" means any of the following events which, but for COBRA continuation coverage, would result in the loss of coverage of a covered Employee/Retiree or Qualified Beneficiary:

(a) death of the eligible Employee/Retiree;

(b) termination (other than by reason of such Employee's gross misconduct) or reduction of hours of the eligible Employee's employment;

(c) divorce, judgment of separate maintenance, or legal separation of the eligible Employee/Retiree from the Employee's/Retiree's spouse (or loss of coverage caused by the Employee/Retiree in anticipation of a divorce, judgment of separate maintenance, or legal separation which later occurs);

(d) eligible Employee/Retiree becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);

(e) a dependent child ceasing to be a dependent child under the generally applicable requirements of the Plan; or

(f) with regard to a covered Retiree, a bankruptcy proceeding under Title 11 of the United States Code, with respect to the Employer from whose employment the covered Retiree retired at any time. For purposes of an employer's bankruptcy proceedings, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary (spouse, surviving spouse, or covered Retiree who retired on or before the date coverage was substantially eliminated) within one year before or after the date the proceeding commenced.

An event described above is only a Qualifying Event if it causes a loss of coverage under the group health plan.

5.4 **Type of Coverage.** Continuation coverage under this provision is coverage which is identical to the coverage provided to similarly-situated beneficiaries under the group health plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under the plan is modified for any group of similarly-situated beneficiaries, the coverage shall also be modified in the same manner for all Qualified Beneficiaries under the plan in connection with such group.

5.5 **Duration of Coverage.** The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event listed below (unless otherwise provided) and ending not earlier than the earliest of the following:

(a) In the case of a terminated covered Employee (except for termination for gross misconduct) or a covered Employee whose hours have been reduced, and his or her Qualified Beneficiaries, the date which is 18 months after the Qualifying Event;

(b) In case of a loss of coverage due to bankruptcy proceeding under Title 11 of the United States Code, with respect to the Employer from whose employment the covered Retiree retired at any time, the lifetime of the Retiree or the Retiree's surviving spouse who is a Qualified Beneficiary; or for the surviving spouse and dependent children, 36 months after the date of the Retiree's death;

(c) In the case of any Qualifying Event except as described in Section 5.5(a) or (b), for the Qualified Beneficiaries, the date which is 36 months after the date of the Qualifying Event;

(d) In the case of a covered Employee or Qualified Beneficiary who is disabled at some point before the 61st day after the Qualifying Event as described in Section 5.5(a) and the disability lasts until the end of the 18-month period, the date which is 29 months after the Qualifying Event, provided the Administrator is given notice of the Social Security disability determination within 18 months of the Qualifying Event and within 60 days of the later of (i) the disability determination; (ii) the Qualifying Event; or (iii) the date coverage was lost as a result of the Qualifying Event;

(e) In the case of a second Qualifying Event (must be an event described in Section 5.5(c)) which occurs during the 18 months after the first Qualifying Event described in Section 5.5(a), for the Qualified Beneficiaries, the date which is 36 months after the date of the first Qualifying Event;

(f) In the case of a loss of coverage due to termination (except for gross misconduct) or reduction in hours of a covered Employee which occurs within 18 months after the Employee's entitlement to Medicare, for the Qualified Beneficiaries, the date which is 36 months from date of entitlement to Medicare;

(g) The date on which the participating Employer ceases to provide any group health plan to any Employee/Retiree;

(h) The date on which coverage ceases under the Plan by reason of failure to make timely payment of the required contribution pursuant to this provision;

(i) The date on which the covered Employee/Retiree or Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan (as an employee or otherwise), or becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the plan will not cease while such preexisting condition limitation under the other group plan remains in effect, subject to the maximum period of coverage limitations set forth in this Section;

(j) The first day of the month beginning more than 30 days after the date on which the disabled covered Employee or Qualified Beneficiary is determined by the Social Security Administration to be no longer disabled; or

(k) COBRA may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

5.6 **Payment of Premium.**

(a) A covered Employee/Retiree or Qualified Beneficiary shall only be entitled to continuation coverage provided the Qualified Beneficiary or covered Employee/Retiree pays the applicable premium required by the Employer in full and in advance, except as provided in (b) below. Such premium shall not exceed the requirements of applicable federal law. A Qualified Beneficiary or covered Employee/Retiree may elect to pay such premium in monthly installments.

(b) Except as provided in (c) below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.

(c) Notwithstanding (a) and (b) above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

5.7 **Qualified Beneficiary Must Notify Plan Administrator of Certain Qualifying Events.**

(a) It is the responsibility of the covered Employees/Retirees and Qualified Beneficiaries to provide the following notices to the Plan Administrator:

(1) Notice of the occurrence of a Qualifying Event that is a divorce, judgment of separate maintenance, or legal separation of a covered Employee/Retiree from his or her spouse;

(2) Notice of occurrence of a Qualifying Event that is a Qualified Beneficiary ceasing to be covered under the Plan as a dependent child;

(3) Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a covered Employee or Qualified Beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(5) Notice that a covered Employee/Retiree or Qualified Beneficiary: (i) with respect to whom a notice described in paragraph (a)(4) of this section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled, or (ii) subsequently becomes covered under Medicare or under other group health coverage (but only after any preexisting condition exclusions of the other plan have been exhausted or satisfied).

(b) Notice to the Plan Administrator must be made in writing and must be mailed or hand-delivered to:

Human Resources Department
County of Jackson
120 West Michigan Avenue
Jackson, Michigan 49201

Oral notice or electronic notice (by e-mail or facsimile) is not acceptable. If mailed, the notice must be postmarked no later than the deadline described below. If hand-delivered, notice must be received by the individual at the address above no later than the deadline described below.

(c) **Required Contents of Notice**. The notice must at a minimum contain the following information:

(1) the name of the Plan;

(2) the name and address of the Employee or former Employee who is or was covered under the Plan;

(3) the nature of the Qualifying Event, and, if applicable, the nature of the initial Qualifying Event that started the COBRA coverage, including any verifying documentation which may be required by the Employer;

(4) the date of this Qualifying Event, and, if applicable, the initial Qualifying Event;

(5) the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event or initial Qualifying Event, and, if applicable, whether those individuals are receiving COBRA coverage at the time of this notice;

(6) if the notice is for a disability extension, the name and address of the disabled covered Employee or Qualified Beneficiary;

(7) if the notice is for a disability extension, the date that the covered Employee or Qualified Beneficiary became disabled;

(8) if the notice is for a disability extension, the date that the Social Security Administration made its determination of disability. Additionally, a copy of the Social Security Administration's disability determination letter must be attached;

(9) if the notice is regarding (a) the Social Security Administration subsequently determining that the covered Employee or Qualified Beneficiary is no longer disabled or (b) subsequent entitlement of Medicare or coverage under another group health plan, the initial Qualifying Event and the subsequent event terminating coverage and the dates they occurred; and

(10) the signature, name, and contact information of the individual sending the notice.

Furthermore, the Plan requires that the following documents, if relevant to the particular Qualifying Event, be provided with the notice: Death Certificate; Divorce Decree, Judgment of Separate Maintenance or Legal Separation Agreement; Birth Certificate or Order of Adoption; Marriage Certificate; Social Security Administration's Disability Determination Letter; Spouse's Notice of Employment Termination or Proof of Loss of Coverage; Qualified Domestic Relations Order.

Any notice that does not contain all of the information required by the Plan must be supplemented in writing within 15 business days with the additional information necessary to meet the Plan's reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this section.

(d) **Time Periods To Provide Notice**. If written notice is not provided within the time periods provided below, the covered Employee/Retiree and Qualified Beneficiaries will lose the right to elect COBRA.

(1) Time limits for notices of Qualifying Events. The notice described in Section 5.7(a)(1), (2), or (3) must be furnished within 60 days after the latest of:

(A) the date on which the relevant Qualifying Event occurs; or

(B) the date on which the covered Employee or Qualified Beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event.

(2) Time limits for notice of disability determination. A notice described in Section 5.7(a)(4) must be furnished before the end of the first 18 months of continuation coverage and within 60 days after the latest of:

(A) the date of the disability determination by the Social Security Administration;

(B) the date on which the Qualifying Event occurs; or

(C) the date on which the covered Employee or Qualified Beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event.

(3) Time limits for notice of change in disability status, subsequent Medicare eligibility, or coverage under another group health plan. The notice described in Section 5.7(a)(5) must be furnished within 30 days after the date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the covered Employee or Qualified Beneficiary is no longer disabled or the date the covered Employee or Qualified Beneficiary becomes entitled to Medicare or covered under other group health coverage.

(e) **Person to Provide Notice**. With respect to each of the notice requirements of this section, any individual who is either the covered Employee/Retiree, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee/Retiree or Qualified Beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

5.8 **Notification to Qualified Beneficiary.**

(a) The Plan Administrator (or entity which it has hired) shall provide written notice to each covered Employee/Retiree and spouse of such covered Employee/Retiree of his/her right to continuation coverage under this provision as required by federal law.

(b) The Plan Administrator (or entity which it has hired) shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the Qualifying Event is the divorce, judgment of separate maintenance, or legal separation of the covered Employee/Retiree from the covered Employee's/Retiree's spouse or a dependent child ceasing to be a dependent under the terms of this Plan, the Plan Administrator shall only be required to notify a covered Employee/Retiree or Qualified Beneficiary of his/her right to elect continuation coverage if the covered Employee/Retiree or the Qualified Beneficiary notifies the Employer of such Qualifying Event as previously stated. Additionally, the right to extend COBRA coverage may only be provided upon the Plan Administrator receiving proper notice.

(c) Notification of the requirements of this provision to a Qualified Beneficiary who is the spouse of a covered Employee/Retiree shall be treated as notification to all other Qualified Beneficiaries residing with such spouse at the time notification is made.

5.9 **Special Election Period.** Special COBRA rights apply to certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts

for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible Employee or former Employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If the Employee qualifies for TAA or ATAA, he/she must contact the Employer promptly or the Employee will lose the right to elect COBRA during a special second election period.

5.10 **Interaction with FMLA.** If the Employer is subject to the Family and Medical Leave Act and the Employee does not return to work from the FMLA leave, the Employee and Qualified Beneficiaries may be entitled to continuation coverage under COBRA. A Qualifying Event under COBRA will occur if:

(a) the Employee and Qualified Beneficiaries are covered under the Employer's group health plan on the day before the first day of FMLA leave;

(b) the Employee does not return to work with the Employer at the end of the FMLA leave, and

(c) the Employee and Qualified Beneficiaries would, in the absence of COBRA, lose coverage under the group health plan before the end of the maximum coverage period.

The Qualifying Event would occur on the last day of the FMLA leave. The last day of FMLA leave may be the date the Employee notifies the Employer that the Employee will not be returning to work, if the notification was given before the FMLA was set to expire.

Article 6

Named Fiduciary Provisions

6.1 **Named Fiduciary.** The Named Fiduciaries shall have only those specific powers, duties, responsibilities, and obligations as are specifically given them under the Plan including, but not limited to, any agreement allocation or delegating their responsibilities, the terms of which are incorporated herein by reference. In general, the Employer shall have the sole authority to appoint and remove the Administrator; and to amend Plan provisions or terminate, in whole or in part, the Plan. The Administrator shall have the sole responsibility for the administration of the Plan, which responsibility is specifically described in the Plan. Furthermore, each Named Fiduciary may rely upon any such direction, information or action of another Named Fiduciary as being proper under the Plan, and is not required under the Plan to inquire into the propriety of any such direction, information or action. It is intended under the Plan that each Named Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan. Any person or group may serve in more than one Fiduciary capacity.

6.2 **General Fiduciary Responsibilities.** The Administrator and any other fiduciary shall discharge its duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan.

Article 7

Record Keeping and Administration

7.1 **Administrator.** The Administrator shall be designated by the Board of Commissioners and shall carry out the duties assigned to the Administrator under the Plan. The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

7.2 **Applicability of Article and Power and Authority of Contract Administrators.** This Article shall only apply to this Plan and to the underlying Component Benefit Programs which are self-funded and administered by the Plan Administrator. For all other Component Benefit Programs, this Article does not apply, and the Contract Administrators shall administer the Component Benefit Programs as provided in the Insurance Contracts and other governing documents, and the Plan Administrator shall retain no responsibility for such acts. Moreover, the Contract Administrators for the non-self-funded Component Benefit Programs are responsible for (1) paying claims; (2) determining eligibility for and the amount of any benefits payable under their respective component benefit plans; and (3) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective Component Benefit Program.

7.3 **Powers of the Administrator.** The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, subject to the pertinent provisions of the Code and Treasury Regulations. All determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(a) to make and enforce rules and regulations necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan;

(c) to approve reimbursement requests and to authorize the payment of Benefits;

(d) to prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Administrator determines to be appropriate;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

(f) to allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities in writing.

(g) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan; and

(h) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal.

The Plan Administrator, and other fiduciaries of the Plan (including any named fiduciary for claim appeals), have the requisite discretionary authority and control over the Plan to require deferential judicial review of its decisions, as set forth by the U.S. Supreme Court in Firestone Tire & Rubber Co. v. Bruch.

7.4 **Examination of Records.** The Administrator will make records available to each Participant for examination at reasonable times during normal business hours.

7.5 **Reliance on Participant, Tables, etc.** The Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

7.6 **Nondiscriminatory Exercise of Authority.** Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall also be consistent with the intent that the plan shall continue to comply with the terms of Code section 105(h) and the Treasury Regulations thereunder.

7.7 **Indemnification of Administrator.** The Employer agrees to indemnify and to defend, to the fullest extent permitted by law, any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission in connection with the Plan, if such act or omission is in good faith.

7.8 **Bonding.** The Administrator shall be bonded to the extent required by law.

7.9 **Records.** The Administrator shall keep records containing all relevant data pertaining to the administration of the Plan.

7.10 **Assurance of Receipt of Benefits.** The Administrator shall take all necessary action to ensure that Participants receive the Benefits to which they are entitled under the Plan.

7.11 **Conflict of Interest.** The Administrator may not decide any matter relating solely to the Administrator's rights or benefits under the Plan. These decisions shall be made by an individual appointed by the Board of Commissioners.

7.12 **Exercise of Discretion on a Uniform Basis.** In those instances where the Administrator is granted discretion in making its determinations, and the decision of the Administrator affects the benefits, rights or privileges of Participants, such discretion shall be exercised uniformly so that all Participants similarly situated are similarly treated.

7.13 **Timely Filing of Reports.** The Administrator shall cause to have prepared and filed or furnished, as the case may be, in a timely fashion, such information and reports as are required by applicable law and regulations to be filed or furnished by the Plan.

7.14 **Employment of Agents.** The Administrator has the right to employ agents and advisors to assist the Administrator in the performance of its duties.

7.15 **Provision for Third-Party Plan Service Providers.** The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

7.16 **Insurance Contracts.** The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan and to replace any such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

7.17 **Reliance Upon Information and Advice.** The Administrator may rely upon the written information, opinions or certificates supplied by any agent, counsel, actuary, investment manager, physician or fiduciary.

7.18 **Administration of Claims.** The Administrator shall administer all claims procedures under the Plan, except as otherwise provided.

7.19 **Compensation of Administrator**. The Administrator, if not an Employee of Employer, shall be paid a reasonable compensation for services on behalf of the Plan as may be agreed upon from time to time by Employer and the Administrator. Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee

of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

7.20 **Liability Limitations**. The Administrator is not liable or responsible for the acts or omissions of another fiduciary, unless:

(a) the Administrator knowingly participated or knowingly attempted to conceal the act or omission of another fiduciary and the Administrator knew the act or omission was a breach of fiduciary responsibility by the other fiduciary,

(b) the Administrator had knowledge of a breach by the other fiduciary and did not make reasonable efforts to remedy the breach, or

(c) the Administrator's breach of the Administrator's fiduciary responsibility permitted the other fiduciary to commit a breach.

7.21 **Resignation of Administrator.** The Administrator may resign by giving written notice to Employer not less than fifteen days before the effective date of the resignation.

7.22 **Removal of Administrator; Filling Vacancy.** The Administrator may be removed at any time, without cause, by the Board of Commissioners. In such case, the Board of Commissioners shall fill the vacancy as soon as reasonably possible after the vacancy occurs. Until a new Administrator is appointed, the Board of Commissioners has full authority to act as the Administrator.

Article 8

Claims Procedure and Appeal

8.1 **Applicability of Article and Claims for Fully-Insured Benefits.** The term "Administrator" shall also mean "Contract Administrator" for purposes of this Article only. Specifically, the term "Administrator" shall mean the relevant Administrator or Contract Administrator who is administering benefits under the particular Component Benefit Program.

Claims procedures and appeals set forth in the Insurance Contracts for the Component Benefit Programs control; this Article supplements those documents to the extent required by the PPACA and to impose the limitations period for filing suit.

For purposes of determination of the amount of, and entitlement to, benefits of the fully-insured Component Benefit Programs provided under the Insurance Contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the plan as they relate to the benefits provided under the applicable Insurance Contract.

To obtain benefits from the insurer of a Component Benefit Program, the Participant must follow the claims procedures under the applicable Insurance Contract, which may require the participant to complete, sign and submit a written claim on the insurer's form. The insurance company will decide a participant's claim in accordance with its reasonable claims procedures, as required by the PPACA.

The insurance company may have the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company denies a claim in whole or in part, then the participant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the participant may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claims procedures, as required by the PPACA. If the participant does not appeal on time, then he or she will lose his or her right to file suit in a state or federal court, as he or she will not have exhausted his or her internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

The Insurance Contract (including the certificate of insurance booklet) provides more information about how to file a claim and details regarding the insurance company's claims procedures.

8.2 **Application for Self-Funded Benefits**. A Claimant shall make a claim for benefits by making a request pursuant to the procedures specified for each benefit in the underlying Component Benefit Programs. Any claims not submitted within the specified time requirements will not be considered. Claims for benefits will be reviewed in accordance with the procedures contained in the Insurance Contracts.

Generally, the provider will file all claims. However, in some circumstances, nonparticipating providers may not file a claim. In those cases, a Claimant shall make a claim for benefits by making a request pursuant to the procedures specified in the claim forms provided by the Administrator. For purposes of determining the amount of, and entitlement to, benefits provided through the Employer's general assets, the relevant Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

The Administrator will decide claims in accordance with reasonable claims procedures, as required by the PPACA. The Administrator may have the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the Administrator denies a claim in whole or in part, then the claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the claimant may appeal to the Administrator for a review of the denied claim. The Administrator will decide the appeal in accordance with reasonable claims procedures, as required by the PPACA. If the claimant does not appeal on time, he or she will lose the right to file suit in a state or federal court, because he or she will not have exhausted the internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

8.3 **Timing of Notification of Initial Benefit Determination.**

(a) **General Rule For Benefits Other Than Group Health Benefits.** The Administrator, with respect to benefits other than group health benefits, shall notify the

Claimant of the benefit determination within 90 days after receipt of a claim by the Plan, unless the Administrator determines that special circumstances require an extension of time up to an additional 90 days for processing the claim. If an extension is necessary, the Administrator will provide the Claimant with written notice of the extension, before the end of the initial 90-day period, explaining the reason for the extension and the date the Administrator expects to make a decision. The extension will not exceed 90 days from the end of the initial 90-day period. Unless otherwise provided for within this Plan, if the Claimant fails to provide the Administrator with sufficient information to make a determination, the Administrator shall notify the Claimant of the specific information necessary to complete the claim and the Claimant shall be afforded 45 days to provide the specified information.

(b) **Pre-service Determinations.** In the case of pre-service determinations, the Administrator shall notify the Claimant of the Plan's benefit determination within a reasonable time, but no later than 15 days after receipt of the claim by the Plan if no further information is required. This period may be extended one time for 15 additional days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan. The Administrator will provide the Claimant with written notice of the extension before the end of the initial 15-day period, explaining the reason for the extension and the date the Administrator expects to make a decision. If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, but communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Administrator will provide oral notice (and in writing if requested) of the failure and the proper procedure to complete the claim, within five days of the failure. If the extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the Claimant shall have 45 days to provide the information. Failure to respond in a timely and complete manner will result in a benefit denial.

(c) **Post-service Decisions.** In the case of post-service claims, the Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable time, but no later than 30 days after receipt of the claim by the Plan if no further information is required. This period may be extended one time for 15 additional days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and the Administrator notifies the Claimant prior to expiration of the initial 30-day period of the reasons for the extension of time and the date by which the Administrator expects to render a decision. If the extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the Claimant shall have at least 45 days to provide the information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

(d) **Concurrent Care Decisions.**

(1) In the case of a reduction or termination of an ongoing course of treatment which the Administrator had previously approved, the Administrator shall notify the Claimant of the Plan's benefit determination within a reasonable time sufficiently in advance of

the reduction or termination to allow the Claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

(2) In the case of a request of a Claimant to extend the course of treatment which the Administrator had previously approved, the Administrator shall notify the Claimant of the Plan's benefit determination within 24 hours after receipt of the claim by the Plan, provided the claim is made at least 24 hours before the expiration of the period of time or number of treatments.

(e) **Urgent Care Decisions.** In the case of urgent care claims, the Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. However, if the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, but communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Administrator will provide notice of the failure and the proper procedure to complete the claim as soon as possible, but not later than 24 hours of the failure. The Claimant shall be afforded at least 48 hours to provide the specified information. The Administrator will notify the Claimant of the benefit determination as soon as possible, but not later than 48 hours of the earlier of receipt of the specified information or the end of the period in which the Claimant must provide the additional information.

8.4 **Content of Notification of Initial Benefit Determination.** A notice of benefit determination will be sent to the Claimant in written or electronic format in a manner calculated to be understood by the Claimant. In the case of urgent care decisions, the Claimant may be informed orally and will be sent a written or electronic notification within three days of the oral notification. The notification to the Claimant of an adverse determination will generally include:

(a) the specific reason or reasons for the adverse determination;

(b) reference to the specific Plan provisions on which the determination is based;

(c) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an adverse benefit determination on review;

(e) If the claim involves a decision by a group health plan:

(1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criteria, or a statement that such was relied upon in making the adverse benefit determination, will be provided free of charge to the Claimant upon request; and

(2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances, or a statement of such explanation, will be provided free of charge upon request.

(f) if the claim involves an urgent care decision, a description of the expedited review process for such claims.

8.5 **Appeal of Adverse Benefits Determinations.**

(a) Appealing Adverse Determination not Pertaining to Group Health Plan Benefits.

(1) A Claimant shall have 60 days following receipt of a notification of an adverse benefit determination not pertaining to group health plan benefits within which to appeal the determination to the appropriate named fiduciary of the plan.

(2) A Claimant may submit written comments, documents, records and other information relating to the claim for benefits.

(3) A Claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant's claim for benefits.

(4) The review will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) Appealing Adverse Determination Pertaining to Group Health Plan Benefits.

(1) A Claimant shall have 180 days following receipt of a notification of an adverse benefit determination pertaining to group health plan benefits within which to appeal the determination to the appropriate named fiduciary of the plan.

(2) The Plan must comply with items (2) through (4) under "Appealing Adverse Determination not Pertaining to Group Health Plan Benefits."

(3) The review will not give deference to the original determination and will be conducted by an appropriate name fiduciary of the plan who is neither the person who made the original determination subject to appeal, nor the subordinate of such individual.

(4) If the determination was based on medical judgment, including determinations of whether a particular drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary shall consult with an appropriate health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment.

(5) Medical or vocational experts consulted on behalf of the Plan in connection with the determination must be identified, whether or not the advice was relied upon in the determination.

(6) The health care professional consulted under (4) shall be an individual not consulted for the original determination, nor the subordinate of such individual.

(7) If the claim involves urgent care, an expedited review will occur, which may be requested orally or in writing by the Claimant and all necessary information, including the determination on review, shall be transmitted between the Administrator and the Claimant by telephone, facsimile or other available similarly expeditious method.

8.6 **Timing of Notification of Benefits Determination on Review.**

(a) **Generally.** Unless otherwise provided for within this Plan, the Administrator shall notify the Claimant of the benefit determination on review within 60 days after receipt of Claimant's request of review, unless the Administrator determines that special circumstances require an extension of time up to an additional 60 days for processing the claim. If the Administrator determines an extension is necessary, written notice will be provided to the Claimant before the end of the initial 60-day period. The notice shall indicate the reasons for the extension and the date by which the Administrator expects to render a decision.

(b) **Pre-service Decisions.** The Administrator shall notify the Claimant of the benefit determination on review concerning pre-service determinations within 30 days after receipt of Claimant's request of review.

(c) **Post-service Decisions.** The Administrator shall notify the Claimant of the benefit determination on review concerning post-service determinations within 60 days after receipt of Claimant's request of review.

(d) **Urgent Care Decisions.** The Administrator shall notify the Claimant of the benefit determination on review concerning urgent care determinations within 72 hours after receipt of Claimant's request of review.

8.7 **Content of Notification of Benefit Determination on Review.** A notice of benefit determination on review will be sent to the Claimant in written or electronic format in a manner calculated to be understood by the Claimant. The notification to the Claimant will generally include:

(a) the specific reason or reasons for the adverse determination;

(b) reference to the specific Plan provisions on which the benefit determination is based;

(c) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant's claim for benefits;

(d) if any voluntary appeal right exist, a statement describing any voluntary appeal procedures offered by the plan and the Claimant's right to obtain the information about such procedures and a statement of the Claimant's right to bring an action;

(e) if the claim involves a decision by a group health plan:

(1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the determination, will be provided free of charge to the Claimant upon request;

(2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances, or a statement of such explanation, will be provided free of charge upon request.

(f) a statement of the Claimant's other voluntary alternative dispute resolution options, if any. However, if Claimant should initiate a lawsuit, it shall be brought within three years after exhaustion of the claims procedures.

Article 9

PPACA Claims Procedure and Appeal

9.1 **Application.** This Article 9 shall apply to non-Grandfathered Plans providing group health plan coverage covering two or more Employees within the Component Benefit Programs (but not for retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c)) for plan years beginning on or after September 23, 2010. This Plan is a non-Grandfathered Plan.

9.2 **Minimum Internal Claims and Appeals Standards.** A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503-1 and Article 8, except to the extent those requirements are modified or expanded by Article 9.

9.3 **Additional Internal Claims and Appeals Standards.** In addition to the applicable requirements set forth in Section 9.2, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the following requirements:

(a) Full and fair review. A plan and issuer must allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements set forth in Section 8.5:

(i) The plan or issuer must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under Section 8.6 to give the claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date of which the notice of final internal adverse benefit determination is required to be provided under Section 8.6 to give the Claimant a reasonable opportunity to respond prior to that date;

(b) Avoiding conflicts of interest. In addition to the requirements of 29 CFR 2560.503-1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits;

(c) Notice. Effective the first day of the first plan year beginning on or after January 1, 2012, a plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as set forth in 29 C.F.R. 2590.715-2719(e) with respect to applicable non-English languages) that complies with the requirements of 29 C.F.R. 2560.503-1(g) and (j). Effective the first day of the first plan year beginning on or after July 1, 2011 (unless a different effective date is set forth below in this paragraph), the plan and issuer must also comply with the following requirements:

(i) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable)).

(ii) Effective the first day of the first plan year beginning on or after January 1, 2012, the plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(iii) The plan and issuer must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under Sections 9.2, 9.3, or 9.4, or an external review under Section 9.5.

(iv) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(v) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(d) Deemed exhaustion of internal claims and appeals processes. Effective the first day of the first plan year beginning on or after January 1, 2012,

(i) In the case of a plan or issuer that fails to adhere to all the requirements of Sections 9.2, 9.3, and 9.4 with respect to a claim, the Claimant is deemed to have exhausted the internal claims and appeals process of this Article 9 except as provided in subparagraph (ii) of this paragraph (d). Accordingly, the Claimant may initiate an external review under Section 9.5. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(ii) Notwithstanding subparagraph (i) of this paragraph (d), the internal claims and appeals process of this Article 9 will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. The Claimant may request a written explanation of the violation from the plan or issuer, and the plan or issuer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this Article 9 to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under subparagraph (i) of this paragraph (d) on the basis that the plan met the standards for the exception under this subparagraph (ii) of this paragraph (d), the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

9.4 **Provision of Continued Coverage Pending the Outcome of an Appeal.** A plan or issuer subject to the requirements of Sections 9.2 and 9.3 are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of Section 8.3(d), which generally provides that benefits for an ongoing

course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

9.5 **External Review Process**

(a) In general. A Claimant may have the right to file a request for an external review of an adverse determination or final adverse determination with the plan. The Claimant may contact the Plan Administrator for more detailed information related to the external review process. The plan can be reached at (517) 768-6602 or 120 West Michigan Avenue, 5th Floor, Jackson, Michigan 49201.

(b) For fully-insured plans and self-insured nonfederal governmental plans,

(1) Through December 31, 2011, an applicable State external review process is binding on the issuer or plan. If there is no applicable State external review process, the issuer or plan is required to comply with the requirements set forth in paragraph (c) of this Section 9.5. For final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided on or after January 1, 2012, the external review process set forth in paragraph (c) of this Section 9.5 will apply unless the Department of Health and Human Services determines that a State law meets all temporary standards set forth in subparagraph (2) of this paragraph (b).

(2) Beginning January 1, 2012, and until the earlier of January 1, 2014, or the date an applicable State enacts an NAIC-parallel process, issuers and self-insured nonfederal governmental plans shall comply with an applicable State external review process that meets the following temporary standards (as set forth in Department of Labor Technical Release 2011-02):

(A) The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(B) The process provides for external review of adverse benefit determinations (and final internal adverse benefit determinations) involving experimental or investigational treatments or services and must have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(C) Issuers (or plans) are required to provide effective written notice to Claimants of their rights to external review in their summary plan descriptions and plan materials and on each notice of adverse benefit determination. These notice requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.

(D) If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (1) the internal appeal process timelines are not met; or (2) in an urgent care situation, the Claimant files for an external review without

having exhausted the internal appeal process. These requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.

(E) The cost of an external review must be borne by the issuer (or plan), and the Claimant cannot be charged a filing fee in excess of $25 per external review.

(F) There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.

(G) The Claimant must have at least 60 days to file for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.

(H) The IRO must be assigned impartially. The Claimant and issuer (or plan) should have no discretion as to the IRO that is chosen.

(I) If the State contracts with, or otherwise identifies one or more IROs to provide external review, the State must have a process in place for quality assurance of IROs.

(J) If the State contracts with, or otherwise identifies one or more IROs to conduct external reviews, the State must ensure conflict of interest protections on the part of the IRO when it participates in external review decisions.

(K) The IRO decision is binding and must be enforceable by the State.

(L) For standard external reviews (those not involving urgent care), the IRO must inform the issuer and the Claimant, in writing, of its decision within 60 days from receipt of the request for external review.

(M) The process must provide for expedited external review of urgent care claims. In such cases, the IRO must inform the issuer and the Claimant of an urgent care decision within four business days or less (depending on medical exigencies of the case) from receipt of the request for review. If the IRO's decision was given orally, the IRO must provide written notice of its decision within 48 hours of the oral notification.

(3) Once an applicable State enacts an NAIC-parallel process (as determined by the Department of Health and Human Services), the external review process of that State law shall apply, unless the health insurance issuer or self-insured nonfederal governmental plan elects to follow a Federally administered external review process as permitted in subparagraph (5) of this paragraph (b).

(4) Beginning January 1, 2012, if a State process does not meet the standards set forth in subparagraphs (2) or (3) of this paragraph (b), health insurance issuers

(and, if applicable, self-insured nonfederal governmental plans) in the State will be subject to the external review process set forth in paragraph (c) of this Section 9.5. Additionally, if a State-administered process reduces consumer protections below the level that applies at the time the Department of Health and Human Services makes its finding, plans and issuers in the State will be required to participate in the external review process set forth in paragraph (c) of this Section 9.5.

(5) Health insurance issuers and self-insured nonfederal governmental plans may elect to use a Federally administered external review process instead of the State process; specifically, such plans or issuers can elect to use the process set forth in paragraphs (b)(2) or (c) of this Section 9.5 by timely submitting appropriate information to the Department of Health and Human Services.

(c) ERISA and/or IRC self-insured plans will comply with the external review requirements under the PPACA if the following procedures are adhered to: Subject to the suspension provision set forth in subparagraph (1) of this paragraph (c) (and except to the extent provided otherwise by the Secretary of the Department of Labor in guidance) the external review process set forth in subparagraphs (2) and (3) of this paragraph (c) (i.e., the procedures set forth in Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-02) shall apply to any adverse benefit determination of final internal adverse benefit determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for external review process set forth in subparagraphs (2) and (3) of this paragraph (c).

(1) Unless or until this suspension is revoked in guidance by the Secretary of Labor, with respect to claims for which external review has not been initiated before September 20, 2011, the external review process set forth in subparagraphs (2) and (3) of this paragraph (c) applies only to: (i) an adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (ii) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(2) Standard external review for self-insured group health plans. This subparagraph (2) sets forth procedures for standard external review for self-insured group health plans. Standard external review is external review that is not considered expedited (as described in subparagraph (3) of this paragraph (c)).

(A) Request for external review. A group health plan must allow a Claimant to file a request for an external review with the plan if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last

filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(B) Preliminary review. Within five business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

(ii) The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

(iii) The Claimant has exhausted the plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the plan must issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(C) Referral to Independent Review Organization. The group health plan must assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan must take action against bias and to ensure independence. Accordingly, plans must contract with at least two (2) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between a plan and an IRO must provide the following:

(i) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.

(ii) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a

statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(iii) Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the Claimant and the plan.

(iv) Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the Claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

(v) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

A. The Claimant's medical records;

B. The attending health care professional's recommendation;

C. Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;

D. The terms of the Claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with the applicable law;

E. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

F. Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

G. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(vi) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claimant and the plan.

(vii) The assigned IRO's decision notice will contain:

A. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

B. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

C. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

D. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

E. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;

F. A statement that judicial review may be available to the Claimant; and

G. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(viii) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(D) Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

(3) Expedited external review for self-insured group health plans.

(A) Request for expedited external review. A group health plan must allow a Claimant to make a request for an expedited external review with the plan at the time the Claimant receives:

(i) An adverse benefit determination if the adverse benefit determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(B) Preliminary review. Immediately upon receipt of the request for expedited external review, the plan must determine whether the request meets the reviewability requirements set forth in subparagraph (2)(B) above for standard external review. The plan must immediately send a notice that meets the requirements set forth in paragraph (2)(B) above for standard external review to the Claimant of its eligibility determination.

(C) Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO pursuant to the requirements set forth in subparagraph (2)(C) above for standing review. The plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must

review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

(D) Notice of final external review decision. The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in subparagraph (2)(C) above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the plan.

(d) To the extent that benefits under a group health plan are provided through health insurance coverage, the health insurance issuer has primary responsibility to comply with the external review process set forth in this Section 9.5.

Article 10

Amendment and Termination of the Plan

10.1 **Amendment and Termination.** Although Employer intends to maintain this Plan indefinitely, it reserves the right to amend or terminate the Plan at any time. Employer further reserves the right to change insurers and/or modify the terms of any contracts with insurers who are providing benefits pursuant to this Plan. The amendment or termination shall be made by a written instrument and shall be communicated to all Participants. Any decision to amend or terminate the Plan and any and all benefits provided under the Plan shall be made either by the Board of Commissioners of County of Jackson or by any person or persons authorized by the Board of Commissioners to take such action.

Unless otherwise provided in the Component Benefit Programs, no Employee, Participant, Dependent or any other person shall have any further right, title, interest or claim, legal or equitable, in or to any reimbursement or benefit payable under such Plan beyond the date in which such Plan or benefit is terminated. Assets remaining in the Plan upon termination arising from employer contributions will revert to the Employer.

Article 11

Miscellaneous Provisions

11.1 **Gender and Number.** Except where otherwise indicated by the context, as used in this agreement the masculine gender includes the feminine and neuter, and words used in the singular include the plural.

11.2 **Headings.** The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

11.3 **Controlling Law.** This Plan shall be construed, administered and enforced according to applicable state laws, to the extent not superseded by the Code, PHSA or any other federal law.

11.4 **Participation in Plan Not Contract of Employment.** The establishment of the Plan, the creation of any account, or the payment of any benefit does not create in any Employee, Participant, or other party a right to continuing employment with Employer. This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be consideration or an inducement for the employment of any Participant.

11.5 **Participants' Rights.** Except as may be required by law, the existence of the Plan shall not give any Participant or beneficiary any equity or other interest in the assets, business or affairs of the Employer; the right to challenge any action taken by the Employer's officers, directors or stockholders, or any policy adopted or followed by the Employer; or the right to examine any of the books and records of the Employer. The rights of all Participants and their beneficiaries shall be limited to their right to receive payment of their benefits from the Plan when due and payable in accordance with the terms of the Plan.

11.6 **Insurance Contract or Governing Document Controls.** Benefits are provided under the Plan pursuant to the Insurance Contracts or other governing document of the underlying Component Benefit Programs. If the terms of this document conflict with the terms of such other contracts or documents, then the terms of the Insurance Contract or governing document will control, rather than this Plan, unless otherwise required by law.

11.7 **Information to be Furnished by Participants.** Participants shall provide the Employer and Administrator with information and evidence, and shall sign documents, as may be reasonably requested from time to time for the purpose of administration of the Plan.

11.8 **Non-Assignability of Rights.** The right of any Participant to receive any Benefit under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant’s creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

11.9 **Children Placed for Adoption.** This Plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries under the Plan, irrespective of whether the adoption has become final. Restrictions based on preexisting conditions at time of placement for adoption are prohibited. The term “placement,” or being “placed” for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

11.10 **National Medical Support Notices**. With respect to component benefit plans that are group health plans, the Plan will also provide benefits in accordance with the applicable requirements of any National Medical Support Notice conforming with section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105-200). In any case in which

an appropriately completed National Medical Support Notice is issued in the case of a child of a Participant who is a noncustodial parent of the child, the Administrator, within 40 business days after the date of the National Medical Support Notice shall (1) notify the State agency issuing the National Medical Support Notice with respect to such child whether coverage of the child is available under the terms of the Plan and, if so, whether such child is covered under the Plan and either the effective date of the coverage or any steps necessary to be taken by the custodial parent (or by any official of a State or political subdivision thereof substituted in the National Medical Support Notice for the name of such child) to effectuate the coverage; and (2) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage. Nothing in the Section shall be construed as requiring the Plan, upon receipt of a National Medical Support Notice, to provide benefits under the plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such National Medical Support Notice.

11.11 **State Recovery of Medicaid Payments**. Notwithstanding any other provision of this Plan to the contrary, if this Plan provides benefit payments on behalf of a covered person who is also covered by a state's Medicaid program, the Plan shall be subject to the state's right to reimbursement for benefits the state has paid on behalf of the covered person, provided that the state has an assignment of rights made by or on behalf of the covered person, or the covered person's beneficiary, as may be required by the state medical assistance plan.

11.12 **Coordination with Medicaid**. Notwithstanding any other provisions of this Plan to the contrary, this Plan shall not take into account, with respect to Plan enrollment or the payment of benefits to a covered person or covered person's beneficiary, that such covered person or covered person's beneficiary qualifies for medical assistance under a state Medicaid plan.

11.13 **Honor of State Subrogation Rights**. Notwithstanding any other provision of this Plan to the contrary, the Plan will honor any subrogation rights that a state may have gained from a Medicare-eligible beneficiary covered by the Plan by virtue of the state's having paid Medicare benefits, provided that the Plan has a legal liability for coverage.

11.14 **Subrogation, Reimbursement and Third Party Recovery Provision.** Unless otherwise provided in the Component Benefit Programs, the Plan shall have the following rights:

(a) Benefits under the Plan shall be paid second to other rights of recovery and will be paid only if the Participant fully adheres to the terms and conditions of the Plan. The Plan shall have the right to recover from the Participant or beneficiary any payment for benefits paid by the Plan to which the Participant or beneficiary is entitled to recover from a third person, including but not limited to any liability insurance, uninsured/underinsured motorist proceeds, or other health plan. Specifically, the Plan has a first lien upon any recovery, whether by settlement, judgment or otherwise that the Participant or beneficiary receives from a third person, not to exceed the amounts of benefits paid by the Plan or the amount received by the Participant or beneficiary for such treatment. Any settlement or recovery shall first be applied to reimbursement of medical expenses paid by the Plan.

(b) If benefits are paid or payable by this Plan as the result of an action of a third party, this Plan shall be subrogated to all rights of recovery of any participant or beneficiary under this Plan in respect to such action. No Plan benefits shall be provided unless the Participant provides all information, documentation, and agreements required by the Plan or its agents to process a claim, including but not limited to, reimbursement and subrogation agreements as the Plan or its agents may request. Failure or refusal to execute such agreements or furnish such information does not preclude the Plan from exercising its rights to subrogation or obtaining full reimbursement. Participants receiving benefits under this Plan are obligated to avoid doing anything that would prejudice the Plan's rights, including but not limited to reimbursement.

(c) If any suit is filed, the Participant shall retain an attorney who will not assert the common fund, make-whole, or other apportionment actions in contravention of the Plan's reimbursement terms and that reimbursement shall be made immediately upon collection of any sum recovered regardless of its legal, financial or other sufficiency.

(d) If a suit is filed, the Plan may cause to be recorded a notice of payment of benefits, and such will constitute a lien on any judgment recovered less a pro rata share of court costs.

(e) If suit is filed against the Participant to enforce this provision, the Participant agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

(f) If a person to whom benefits are paid or payable under this Plan fails to bring suit promptly against a third party, the Plan may institute suit against such third party in its own name or in the name of such person and the Plan shall be entitled to retain from any judgment the amount of benefits paid or to be paid to such person without reduction for court costs, attorney fees, comparative negligence, limits of collectability or responsibility, or otherwise. The remainder of any recovery shall be paid to such person or as the court directs.

(g) If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of applicable state law and whether the minor's representative has access or control of any recovery funds.

(h) The Plan Administrator has sole discretion to interpret the terms and conditions of this provision in its entirety and reserves the right to make changes as it deems necessary.

11.15 **Coordination of Benefits**. Benefits shall be coordinated as set forth in the Component Benefit Programs as outlined in the Summary Plan Description.

11.16 **Exclusive Benefit**. This Plan shall be maintained for the exclusive benefit of the Participants who participate in the Plan.

11.17 **Action by the Employer**. Whenever the Employer, under the terms of the Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.18 **No Guarantee of Tax Consequences**. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant'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. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Administrator if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.19 **Indemnification of Employer by Participants**. If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax, plus any penalties, that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.20 **Expenses.** All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

11.21 **Code and PHSA Compliance.** It is intended that this Plan meet all applicable requirements of the Code and PHSA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or PHSA, the provisions of the Code and PHSA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

11.22 **Plan Provisions Controlling.** Except as provided in Section 11.6, in the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

11.23 **COBRA Continuation of Coverage.** Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the continuation coverage requirement of Code section 4980B (the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X, as amended, (COBRA)), the Plan will be operated in accordance with Code section 4980B and any regulations and guidance thereunder.

11.24 **Uniform Services Employment and Reemployment Rights Act (USERRA)**. Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service

credit with respect to qualified military service shall be provided in accordance with USERRA and any regulations thereunder.

11.25 **Family and Medical Leave Act (FMLA)**. Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act, this Plan shall be operated in accordance with the FMLA and any regulations thereunder.

11.26 **Health Insurance Portability and Accountability Act (HIPAA)**. Notwithstanding anything in this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of HIPAA, this Plan shall be operated in accordance with HIPAA and any regulations thereunder.

11.27 **Newborns' and Mothers' Health Protection Act (NMHPA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of NMHPA, this Plan shall be operated in accordance with NMHPA and any regulations thereunder.

11.28 **Mental Health Parity Act (MHPA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of MHPA, this Plan shall be operated in accordance with MHPA and any regulations thereunder.

11.29 **Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of MHPA and/or the MHPAEA, this Plan shall be operated in accordance with MHPA and/or the MHPAEA and any regulations thereunder.

11.30 **Genetic Information Nondiscrimination Act of 2008 (GINA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of GINA, this Plan shall be operated in accordance with GINA and any regulations thereunder.

11.31 **Women's Health and Cancer Rights Act of 1998 (WHCRA)**. Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of WHCRA, this Plan shall be operated in accordance with WHCRA and any regulations thereunder.

11.32 **Patient Protection and Affordable Care Act of 2010 (PPACA)** Notwithstanding any provision of this Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of PPACA, this Plan shall be operated in accordance with the PPACA and any regulations thereunder.

11.33 **Conformity with Statutes** This Plan is intended to conform with any and all applicable state and federal statutes. Any reference to any federal, state, local, or foreign statute or law shall be deemed also to refer to all rules and regulations promulgated thereunder, unless the context requires otherwise.

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

Executed this _____ day of _____, 2011.

County of Jackson

By:_____
Michael Overton
County Administrator/Controller

County of Jackson Amended and Restated Group Health Plan for POAM Employees

Drafted By:
Elizabeth H. Latchana
Fraser Trebilcock Davis & Dunlap, P.C.
124 West Allegan, Suite 1000
Lansing, Michigan 48933
(517) 377-0826

Exhibit A

Component Benefit Program Information

County of Jackson

Amended and Restated Group Health Plan

SUMMARY PLAN DESCRIPTION

Non-POAM Employees

Prepared by:
Fraser Trebilcock Davis & Dunlap, P.C.
124 West Allegan, Suite 1000
Lansing, Michigan 48933
Telephone: (517) 482-5800
Facsimile: (517) 482-0887

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County of Jackson
Amended and Restated Group Health Plan for Non-POAM Employees

Summary Plan Description

The County of Jackson ("Employer") has adopted a Welfare Benefit Plan ("Plan") for its Employees. This Plan is the overall plan by Employer to provide you with certain benefits through contracts with various insurance companies, administrative service organizations and/or through the Employer's programs. Specifically, the Plan incorporates medical and other benefits, depending on employee eligibility and other employer and insurer requirements and is treated as a single employee welfare benefit plan.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company or third-party administrator, a summary plan description or another governing document prepared by the Employer or authorized representatives. This document, along with the accompanying governing documents, constitutes the summary plan description for each of the component plans.

This Summary Plan Description ("SPD") has been prepared to generally explain the provisions of the various plans included in the Plan; it does not give the full details of each plan. It is not meant to interpret, extend or change the underlying plans in any way. In case of a conflict between this SPD and the actual provisions of the formal plan documents, the provisions of the plan documents will control, unless otherwise required by law.

It is important that you know your legal rights and responsibilities as well as the benefits that are available to you. The County of Jackson encourages you to read through this SPD thoroughly. If for any reason you do not understand the information provided, contact the Plan Administrator for assistance.

A. GENERAL PLAN INFORMATION

A-1. **Name of Plan:** County of Jackson Amended and Restated Group Health Plan for Non-POAM Employees.

A-2. **Name, Address and Telephone Number of Plan Sponsor**: County of Jackson, 120 West Michigan Avenue, Jackson, Michigan, (517) 768-6602.

A-3. **Plan Sponsor / Employer Identification Number**: 38-6004845.

A-4. **Type of Plan:** Welfare benefit plan, which incorporates the following benefits:

- Medical and prescription benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")
- Dental and vision benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")

Collectively, these benefits are called the "Component Benefit Programs."

A-5. **Name, Address and Telephone Number of Plan Administrator and Named Fiduciary:** County of Jackson, 120 West Michigan Avenue, Jackson, Michigan, (517) 768-6602.

The Plan has granted the Named Fiduciary final discretionary authority in determining eligibility for benefits or to interpret the terms of the Plan for claims purposes.

A-6. **Name and Address of Contract Administrator and Named Fiduciary (for self-funded benefits and benefit appeals):**

Blue Cross Blue Shield of Michigan
PO Box 2888
Detroit, Michigan 48231
(800) 645-BLUE

The Plan has granted the Named Fiduciary final discretionary authority in determining eligibility for benefits for which it administers or to interpret the terms of the Plan for claims purposes.

A-7. **Plan Number:** The Plan is a group benefit plan document which incorporates several different insurance contracts, third-party administration contracts and benefit booklets issued by the Employer and the various insurers, Contract Administrators and Named Fiduciaries described above. The Plan Number is 501.

A-8. **Effective Date:** The effective date of this Plan is January 1, 2011.

A-9. **Agent for Service of Legal Process:** County Administrator, County of Jackson, 120 West Michigan Avenue, Jackson, Michigan 49201.

Note: Service of legal process may also be made on the Plan Administrator.

A-10. **Type of Administration of the Plan:** The administration of the Plan is under the supervision of the Plan Administrator, and the Plan Administrator shall have full power to administer the plan, subject to any applicable requirements of law. The Plan Administrator, and other fiduciaries of the Plan (including any named fiduciary for claim appeals), have the requisite discretionary authority and control over the Plan to require deferential judicial review of its decisions, as set forth by the U.S. Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The medical, prescription, dental and vision benefits offered by the County of Jackson are self-funded by the Employer and are administered by BCBSM.

To the extent the Plan allocates to the Contract Administrators the responsibility for administering the Component Benefit Programs and for exercising other fiduciary functions described in those Programs, the Plan Administrator shall retain no responsibility for such acts.

If you have any general questions regarding the Plan or regarding your eligibility for or the amount of any benefit payable under the self-funded component benefit plans, please contact the Human Resources Department, who acts on behalf of the Plan Administrator.

A-11. **Funding Medium:** As described above, the benefits under the Plan are self-funded. The self-funded benefits are funded by the Employer and are not insured by an insurance company, with the exception of stop-loss insurance. If for any reason the Plan Administrator does not ultimately pay expenses under this Plan, the individuals covered by the Plan will be liable for those expenses.

Benefits under the Plan for employees and their eligible family members are paid as provided in the underlying governing documents and collective bargaining agreements, including by the Employer out of its general assets and/or by employees' pre-tax or after-tax payroll deductions. Unless provided otherwise in the collective bargaining agreements, the Employer will determine and periodically communicate your cost of benefits provided through each Component Benefit Program, and it may change that determination at any time. Special rules apply with regard to pre-tax contributions, irrevocability of elections, and possible forfeitures. Please see your underlying Summary Plan Description for the County of Jackson Second Amended and Restated Section 125 Cafeteria Plan, as amended from time to time, for more details. You are also responsible for any deductible, co-payment, and coinsurance that may be required under the terms of the benefit programs. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the Component Benefit Programs, as applicable.

A-12. **Plan Year:** The Plan Year starts on January 1 and ends on December 31; however, there may be different plan years for each individual underlying benefit as set forth within each respective insurance contract or other plan document.

A-13. **Grandfather Status:** This Plan believes it is a Grandfathered Plan under the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and as may be further amended from time to time (the "PPACA"). "Grandfathered Plan" or "grandfathered health plan" means a group health plan or health insurance coverage which had an individual enrolled in it on March 23, 2010 (and for as long as it maintains that status under the PPACA and its implementing regulations).

As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health

services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections of the PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the address and phone number listed in Section A-5. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

B. ELIGIBILITY AND BENEFITS

B-1. **When am I Eligible to Participate in the Plan?** The eligibility and participation requirements for this Plan are governed by the terms and conditions of the Component Benefit Program documents, collective bargaining agreements, and by the Employer's policies or directives. Please refer to these documents for details regarding your eligibility for benefits offered under this Plan. Unless otherwise provided, you will be eligible to participate in the Plan if you meet all of the following requirements:

Employee Eligibility

(a) You are an "Employee," which means an individual that the Employer classifies as a common law employee and who is on the Employer's W-2 payroll, but does not include temporary or leased employees, casual employees, seasonal employees, contract workers or independent contractors;

(b) You are regularly scheduled to work at least 20 hours per week and will normally be scheduled to work more than six months during the Plan Year; and

(c) You are either:

(1) a non-union part-time or full-time Employee of Employer; or

(2) a part-time or full-time Employee of Employer, are included in a collective bargaining unit which bargained in good faith for employee benefits, and the collective bargaining agreement provides that you shall be eligible to participate in the Plan. In such case, you may only participate in the Plan to the extent that the collective bargaining agreement provides.

(d) You are not included in a collective bargaining unit of the Police Officers Association of Michigan ("POAM").

You may be responsible for the cost of coverage under this Plan. Please see your collective bargaining agreement, employee handbooks, benefit summaries, and/or enrollment materials for more information.

Some of the Component Benefit Programs may require you to make an annual election to enroll for coverage. The details of such annual elections are described in the underlying documents. In certain circumstances, enrollment may occur outside the open enrollment period. Please see the underlying documents for more details.

Retiree Eligibility and Coverage for Medical and Prescription Benefits Only

Except as otherwise provided in a collective bargaining agreement, you will be eligible to participate in the medical and prescription coverage portions of this Plan as a Retiree if you meet each of the following requirements:

(a) You are a "Retiree," which means an individual who has retired from the full-time employment of Employer and is no longer an Employee (however, you were not a POAM Employee);

(b) You were eligible for Employer's group health plan at the time of your retirement;

(c) You are not eligible for Medicare;

(d) With regard to non-union Retirees and Retirees who retired under the APA collective bargaining agreement, you were hired as an Employee of Employer prior to December 1, 2010; and

(e) With regard to non-union Retirees, you have met certain service requirements, specifically:

(i) For full-time Employees hired on or after August 20, 2008, you must have 21 years of service actually worked with Employer at the time you retire.

(ii) For full-time Employees hired on or after January 1, 2008 and on or before August 19, 2008, you must have 10 years of service actually worked with Employer at the time you retire.

(iii) For full-time Employees hired on or after January 1, 2006 and prior to January 1, 2008, at the time of retirement you must have actually worked:

i. 30 years of service with Employer;

ii. 25 years of service with Employer and attained the age of 55; or

iii. 10 years of service with Employer and attained the age of 60.

(iv) Except as indicated in subsection (v) below, for full-time Employees hired prior to January 1, 2006, at the time of retirement you must have actually worked:

i. 25 years of service with Employer;

ii. 10 years of service with Employer and attained the age of 55; or

iii. 8 years of service with Employer and attained the age of 60.

(v) For full-time Employees who have four (4) or more years of service actually worked as of December 31, 1999, you have eight (8) or more years of service actually worked with Employer at the time you retire.

Eligibility factors for Retiree Health for Employees / Retirees covered by collective bargaining agreements are set for in those agreements.

Retirees and their Dependents are not eligible for any dental or vision coverage under this Plan.

You may be responsible for the cost of coverage under this Plan. Please contact Human Resources for verification of your financial responsibility; also see your collective bargaining agreement, employee handbooks, benefit summaries, and/or enrollment materials for more information.

Some of the Component Benefit Programs may require you to make an annual election to enroll for coverage. The details of such annual elections are described in the underlying documents. In certain circumstances, enrollment may occur outside the open enrollment period. Please see the underlying documents for more details.

Dependent Eligibility and Coverage in General

Coverage may also be provided to your Dependents who are eligible to participate in the underlying Component Benefit Programs. The term "Dependent" generally means a Participant's Spouse and any person who is a dependent of the Participant within the meaning of Internal Revenue Code (the "Code") section 152; however, for health benefits, a Dependent generally means any person who is a dependent as set forth in Code sections 105(b), 106 and the regulations and other authority thereunder. The term "Spouse" means an individual who is legally married to a Participant as determined under applicable Michigan state law and who is treated as a spouse under the Code. Dependents may or may not be eligible to participate in

certain Benefits within the Component Benefit Programs. Please review the Component Benefit Program eligibility materials for more information.

Dependent Eligibility and Coverage

Effective January 1, 2011, coverage for Dependent children will be available for an adult child until the day prior to the date the child turns 26 years of age. However, for plan years beginning before January 1, 2014, coverage for Dependent children shall not be made available to an adult child who is eligible to enroll in an eligible employer-sponsored health plan (as defined in Code section 5000A(f)(2)) other than a group health plan of a parent for as long as this Plan is deemed a Grandfathered Plan. A "child" for this purpose is defined as your son, daughter, stepson, stepdaughter, or eligible foster child as defined in Code section 152(f)(1). The definition of "child" for this purpose shall not include a child of your child.

However, an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical disability may be covered to any age if such physical or mental disability occurred before the child turned 26 years of age, the child is chiefly dependent on the Participant for support and maintenance, and the Participant has submitted proof (medical certification) of the child's incapacity to the carrier prior to the child turning age 26 or within 31 days thereafter.

NOTE: The employee shall be required to present, upon request, to the employer certified documentation providing proof of parentage, spousal and/or dependent relationships, proof of the physically or mentally disabled, and proof of dependent eligibility status. This required documentation may be requested at any time to determine eligibility status.

NOTE: If full-time student status is required for coverage of any Dependent children, this Plan will comply with Michelle's Law, Code section 9813. Michelle's Law provides for continued coverage if the Dependent would otherwise lose coverage due to loss of full-time student status at a postsecondary educational institution because of a medically necessary leave of absence that begins while the Dependent is suffering from a serious illness or injury. Coverage may continue for up to one year after the first day of the medically necessary leave of absence, ending earlier only if coverage under the Plan would otherwise terminate (such as reaching the maximum age requirement). Written certification by the Dependent's treating physician is required stating that the leave is medically necessary and that the child is suffering from a serious illness or injury as defined in Michelle's Law.

Coverage for a Dependent will be effective on the date the Employee's coverage becomes effective if s/he applies for Dependent coverage when s/he enrolls in the Plan. In no event will the Employee's Dependents be covered before the date the Employee's coverage begins. An Employee without a Dependent on the date s/he becomes eligible for coverage who later acquires a Dependent may enroll his/her Dependent in this Plan by written application within 30 days after s/he acquires that Dependent.

A newborn child, adopted child, or child placed for adoption will be covered if enrolled within the 30 day period following birth, adoption, or adoption placement. This Plan is intended

to comply with OBRA '93 with respect to dependent child eligibility and Qualified Medical Child Support Orders. If coverage for a Dependent (including newborns, adopted children, or children placed for adoption) is applied for more than 30 days following the date that Dependent becomes eligible for coverage, the Dependent may only be able to enroll during the open enrollment/election period.

Additionally, for purposes of the BCBSM Plans, if two (2) Employees under this Plan are married and both want coverage, they may choose to both be covered as Employees, or one of them may be covered as the Employee and the other may be covered as a Dependent. However, eligible Dependent children of two (2) parents who are both covered under this Plan may be enrolled as Dependents of only one (1) of the Employees. In the event that one (1) Employee's coverage should terminate, his/her eligible covered Dependents will be eligible to become covered Dependents under the remaining parent's Employee coverage.

B-2. **When Must I Elect Coverage Under the Plan?**

Initial Election Period

An Employee who does not apply for coverage within thirty (30) days of the date he or she becomes eligible for coverage may only be able to enroll during the open enrollment / election period, unless otherwise required by law.

Open Enrollment / Election Period

An Employee and/or Dependent who wishes to make an election change, or who does not apply for coverage when initially eligible but later wishes to apply, may do so only during the open enrollment / election period in the Fall for an effective date of January 1. However, an election change may be made before the open enrollment/election period as provided in Section B-4 if a special enrollment event occurs such as marital status change, change in number of Dependents or dependent status, other eligibility change, involuntary loss of coverage from another Plan, or another event legally requiring mid-year enrollment and if the change in election request is timely submitted.

B-3. **When Will My Participation Begin?** Unless otherwise provided in the Component Benefit Programs or the collective bargaining agreements, and as long as all required enrollment materials are completed and submitted by you, your participation in the Plan as an Employee or Retiree will begin on the later of the Effective Date of this Plan or the date you become eligible to participate, at which time you will become a "Participant."

B-4. **HIPAA Special Enrollment.** An Employee or Participant may revoke an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f). Unless otherwise provided, such change shall take place on a prospective basis.

(a) As required by HIPAA, a 30-day special enrollment right will arise if:

(1) A current Employee is eligible for, but declined enrollment in, this group health plan coverage (or a Dependent of such Employee is eligible for, but was not enrolled in, this group health plans coverage) because the Employee or Dependent was covered under another group health plan or had other health insurance coverage when this group health plan coverage was previously offered and the other coverage was lost due to either: (i) if the other coverage was COBRA continuation coverage, that coverage has been exhausted; or (ii) if the other coverage was not COBRA continuation coverage, either the coverage was terminated as a result of loss of eligibility for the coverage (including, but not limited to, as a result of legal separation, judgment of separate maintenance, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment; in the case of an HMO, the individual no longer resides, lives or works in the service area where the HMO provides benefits and, in cases of the group market, no other package is available to the individual; an individual incurs a claim meeting or exceeding a lifetime limit on all benefits; or the plan no longer offers any benefits to the class of similarly situated individuals that includes the individual), or employer contributions towards such coverage were terminated. Unless otherwise provided in the Component Benefit Programs, the eligible Employee must request enrollment not later than 30 days after the loss of other coverage (or after a claim is denied due to the operation of a lifetime limit on all benefits). Any eligible Dependent may only enroll if that Dependent (or the Employee) meets the above requirements; or

(2) A new Dependent is acquired as a result of marriage, birth, or adoption or placement for adoption, and the group health plan makes coverage available with respect to a Dependent of a Participant or an Employee who has met any waiting period requirements and is eligible to participate under that plan. Unless otherwise provided in the Component Benefit Programs, these election changes to add coverage must be made within 30 days of the date of the marriage, birth or adoption or placement for adoption (or the date dependent coverage is made available, if later). An election to add the following individuals (if otherwise eligible for coverage under the Plan) as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption is consistent with the special enrollment right: (i) a current Employee who is eligible but not enrolled; (ii) a current Employee who is eligible but not enrolled, and the Spouse of such Employee; (iii) a current Employee who is eligible but not enrolled, and the newly acquired Dependent of such Employee; (iv) the Spouse of a Participant; (v) a current Employee who is eligible but not enrolled, and the Spouse and newly acquired Dependent; and (vi) a newly acquired Dependent of a Participant.

Enrollment applications received after the special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Unless otherwise provided in the Component Benefit Programs, coverage under the special enrollment period for timely submitted requests must be effective no later than the first day of the month after the plan or issuer receives the request for special enrollment. However, with regard to enrollment requests made within 30 days on behalf of a new Dependent acquired due to birth, adoption, or placement for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for adoption (or the date the plan makes dependent coverage available, if later).

(b) As required by HIPAA, effective April 1, 2009, a 60-day special enrollment right will arise if the Employee or Dependent is eligible for, but not enrolled in, the Plan and either:

(1) loses coverage under Medicaid, specifically if the Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for coverage; or

(2) becomes eligible for a Medicaid subsidy, specifically, if the Employee or Dependent becomes eligible for premium assistance, with respect to coverage under the Plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Employee or Dependent with the special enrollment right under subsection (b) must request enrollment within the first 60 days from the date of termination of such coverage under (b)(1) or 60 days from the date the applicant is determined to be eligible for premium assistance under (b)(2). Enrollment applications received after the 60-day special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Coverage under this Plan shall take effect on the same date coverage for this HIPAA special enrollment right takes effect in the underlying Component Benefit Programs.

This Section only applies to group health plan coverage covering two or more Employees within the Component Benefit Programs. This Section does not apply to retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, specified disease or fixed indemnity coverage or health flexible spending accounts that qualify as "excepted benefits," as defined in Treasury Regulations section 54.9831-1(c).

B-5. **PPACA Special Enrollment**

(a) As required by the PPACA, effective the first day of the first plan year beginning on or after September 23, 2010, a 30-day special enrollment right will be available to any child (i) whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26; and (ii) who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010. The plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage shall take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(b) As required by the PPACA, effective the first day of the first plan year beginning on or after September 23, 2010, a 30-day special enrollment right will be available to any individual (i) whose coverage or benefits under a group health plan or group health insurance coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits for any individual; and (ii) who becomes eligible (or is required to become eligible) for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010. The plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. If the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage shall take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(c) This Section only applies to group health plan coverage covering two or more Employees within the Component Benefit Programs. This subsection does not apply to retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c).

B-6. **When Will My Participation End?** Unless otherwise provided in the Component Benefit Program documents or collective bargaining agreements, your participation in the Plan will automatically cease at 11:59 p.m. on the earliest of the following dates:

(a) date you terminate employment with Employer or are laid off;

(b) date you cease to be in a class of employees eligible for coverage;

(c) date you fail to make any required contribution for coverage;

(d) date the Plan is terminated;

(e) date Employer terminates coverage;

(f) (1) the original effective date of coverage if coverage is rescinded due to misrepresentation on your enrollment application; (2) however, effective January 1, 2011, a group health plan or a health insurance issuer offering group health plan coverage (the “plan”) shall not rescind (i.e., cancel or discontinue coverage retroactively when such cancellation or discontinuance is not attributable to a failure to timely pay required premiums towards the cost of coverage) coverage under the plan, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan, unless the individual (or person seeking coverage on behalf

of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded. This subsection (f)(2) shall only apply for group health plan coverage covering two or more Employees within the Component Benefit Programs (but not for retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c);

(g) the date of your death. However, upon a Retiree's death, coverage for the Retiree's Spouse who was covered under this Plan on the date of the Retiree's death, spousal coverage continues for the life of the surviving Spouse (unless the Retiree had selected a Straight Life retirement option);

(h) the date you otherwise lose eligibility under the Plan;

(i) the date you revoke your election as permitted under the terms of the relevant Component Benefit Program; or

(j) for Retirees, the date you become entitled to Medicare, at which time you will be enrolled in the HUMANA Medicare Advantage Plan; any medical and prescription coverage for your Dependents at the time of your Medicare entitlement will continue under this BCBSM Plan as long as you are enrolled in HUMANA, until such coverage is otherwise terminated as specified below.

Other circumstances can result in the termination, reduction or denial of benefits. You should consult the Component Benefit Program documents for additional information. Termination of participation will automatically revoke your elections and benefits as of the dates specified in the Component Benefit Program documents. You may also be entitled to continue certain benefits pursuant to state and federal law after your participation ends. Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), a former Participant (or his or her covered Spouse or Dependent children) may be able to elect to continue certain group medical benefits provided under this Plan for a limited period of time by paying the cost of the benefits.

<u>When Dependent Coverage is Terminated:</u>

Generally, your Dependents will lose coverage under the Component Benefit Programs as of the earlier of the date they are no longer eligible or at the same time you lose coverage for any of the events listed above. Please see the Component Benefit Program documents for more details.

With regard to the BCBSM Plans, your Dependents will lose coverage as of the same time you lose coverage for any of the events listed above, unless otherwise provided for Retirees.

Additionally, and unless otherwise provided in the Component Benefit Programs, coverage of any Dependent under the BCBSM Plans will automatically cease at 11:59 p.m. on the date your Dependent loses his/her eligible status as defined below, unless coverage is otherwise required to continue by law:

(a) for Spouses:

(1) upon judgment of separate maintenance or legal separation (if applicable within your State); or

(2) upon divorce.

(b) beginning January 1, 2011, for Dependent children:

(1) the day prior to the date the child reaches age 26;

(2) in the case of a disabled Dependent, upon the Dependent being medically certified as no longer incapable of self-sustaining employment by reason of mental retardation of physical disability; or

(3) for plan years beginning before January 1, 2014 and to the extent this Plan has maintained its status as a Grandfathered Plan, upon becoming eligible to enroll in an eligible employer-sponsored health plan (as defined in Code section 5000A(f)(2)) other than a group health plan of a parent.

B-7. **How May Benefits Be Continued under the BCBSM Plan?** In addition to the rights provided under COBRA, FMLA and USERRA as described in Article D, benefit coverage under the BCBSM Plan may be continued if an Employee is on an approved leave of absence. Please see the Employer's policies for further information.

B-8. **Procedure for Obtaining Certificate of Creditable Coverage**. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any exclusion periods for pre-existing conditions that might otherwise apply when changing coverage.

When your coverage through your employer ends, you will receive a certificate of creditable coverage which states that amount of time that you had coverage with your employer. You also may request a certificate for health coverage periods on and after July 1, 1996, at any time during your coverage or within 24 months after loss of coverage. To request a certificate of creditable coverage, please contact the following:

- For medical benefits:

  Blue Cross Blue Shield of Michigan
  PO Box 2888
  Detroit, Michigan 48231
  (800) 645-BLUE

C. BENEFITS

C-1. **Benefits**. This Plan offers the benefits set forth in Section A-4 through the Component Benefit Programs to Participants in this Plan and their eligible Dependents as provided under the terms of the Component Benefit Programs. Each of these Component Benefit Programs is summarized in a benefit booklet or CD issued by an insurance company or third-party administrator, a summary plan description or another governing document prepared by the Employer or authorized representative. All documents describing the Component Benefit Programs are incorporated by reference. (Please contact third-party insurers directly for information regarding network providers, if applicable). You must review these materials to understand your benefits.

Benefit summaries are attached to this Plan at Exhibit A. You can access further information regarding your benefits at www.bcbsm.com. You may also contact the Blue Cross customer service at 1-800-645-BLUE. Please contact Human Resources for more information.

The rights and conditions with respect to the benefits payable under the Component Benefit Programs shall be determined from the terms of those contracts and programs. This Summary Plan Description is not intended to expand or in any way increase the benefits available under those Programs. Any Participant (or Dependent of a Participant) who is receiving coverage under a fully insured program shall not have any claim against the Employer for any benefits provided. The Participant (and/or his or her Dependents) shall only have a right to recover from the particular insurer providing benefits. With respect to Component Benefit Programs that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws.

C-2. **National Medical Support Notices.** With respect to component benefit plans that are group health plans, the Plan will also provide benefits in accordance with the applicable requirements of any National Medical Support Notice conforming with section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105-200). The Plan has detailed procedures for determining whether a National Medical Support Notice is appropriately completed. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

D. CONTINUATION OF COVERAGE FOR GROUP HEALTH PLAN BENEFITS

D-1. **COBRA**. You may have the right to continue your group health plan benefits pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. Generally, this means you may be able to continue the same group health plan coverage that you had immediately before the Qualifying Event. It can also become available to your Spouse and Dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. Importantly, this Section only applies to group health plan coverage within the Component Benefit Programs (i.e., medical, prescription, dental, vision). It does not apply to non-health benefits.

If you are or were provided coverage under your Employer's group health plan, you are considered a "covered employee" or "covered retiree." The terms "covered employee," "covered retiree," and "you" are used interchangeably for purposes of this Section. Your Spouse and Dependent children who are covered under the same plan before the date of the Qualifying Event are considered to be "qualified beneficiaries." A qualified beneficiary also includes a child who is born to or placed for adoption with the covered employee during the COBRA coverage. These terms will be used throughout the remainder of this Section. The continuation coverage will not be conditioned on a physical examination or other evidence of insurability and will be identical to the coverage provided to similarly-situated employees or family members.

Unless otherwise provided in the insurance contracts or other governing documents, the following provisions shall apply.

(a) **Qualifying Event**. You are entitled to elect COBRA if you lose your group health plan coverage because your hours of employment are reduced or your employment ends for any reason other than your gross misconduct.

Additionally, if you are receiving coverage under this Plan as a retiree, you are entitled to COBRA continuation coverage under this Plan in the event you experience a loss of coverage resulting from the employer's bankruptcy proceeding under Title 11 of the United States Code. For this purpose, a loss of coverage includes a substantial elimination of coverage on or after the date of your retirement and within one year before or after the commencement of the employer's bankruptcy proceeding. Your spouse, surviving spouse and dependent children will also become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

Your spouse or eligible dependent children covered under the plan shall have the right to continuation coverage for themselves if they lose coverage under the plan for any of the following reasons:

(1) your death;

(2) the termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment;

(3) your divorce, judgment of separate maintenance, or legal separation (or if your spouse's group health coverage is reduced or eliminated by the employee in anticipation of a divorce, judgment of separate maintenance or legal separation which later occurs);

(4) you become entitled to Medicare; or

(5) your dependent child ceases to be a covered dependent.

An event described above is only a "Qualifying Event" if it causes a loss of coverage under the group health plan.

(b) **Type of Coverage**. Continuation coverage under this provision is coverage which is identical to the coverage provided to similarly-situated beneficiaries under the group health plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under the plan is modified for any group of similarly-situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under the plan in connection with such group.

(c) **Duration of Coverage**. The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event listed below (unless otherwise provided) and ending not earlier than the earliest of the following:

(1) In the case of a terminated covered employee (except for termination for gross misconduct) or a covered employee whose hours have been reduced, and his or her qualified beneficiaries, the date which is 18 months after the Qualifying Event;

(2) In the case of retiree coverage where there is a loss of coverage due to bankruptcy proceeding under Title 11 of the United States Code, with respect to the employer from whose employment the covered retiree retired at any time, the lifetime of the retiree or the retiree's surviving spouse who is a qualified beneficiary; or for the surviving spouse and dependent children, 36 months after the date of the retiree's death;

(3) In the case of any Qualifying Event except as described in (c)(1) or (2) above, for the qualified beneficiaries, the date which is 36 months after the date of the Qualifying Event;

(4) In the case of a covered employee or qualified beneficiary who is disabled at some point before the 61st day after the Qualifying Event as described in (c)(1) and the disability lasts until the end of the 18-month period, the date which is 29 months after the Qualifying Event, provided the Administrator is given proper notice of the Social Security disability determination within 18 months of the Qualifying Event and within 60 days of the later

of (i) the disability determination; (ii) the Qualifying Event; or (iii) the date coverage was lost as a result of the Qualifying Event;

(5) In the case of a second Qualifying Event (must be an event described in (c)(3)) which occurs during the 18 months after the first Qualifying Event described in (c)(1), for the qualified beneficiaries, the date which is 36 months after the date of the first Qualifying Event;

(6) In the case of a loss of coverage due to termination (except for gross misconduct) or reduction in hours of a covered employee which occurs within 18 months after the employee's entitlement to Medicare, for the qualified beneficiaries, the date which is 36 months from date of entitlement to Medicare;

(7) The date on which the participating Employer ceases to provide any group health plan to any employee/retiree;

(8) The date on which coverage ceases under the plan by reason of failure to make timely payment of the required contribution pursuant to this provision;

(9) The date on which the covered employee/retiree or qualified beneficiary first becomes, after the date of the election, covered under any other group health plan, (as an employee or otherwise) or becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the plan will not cease while such preexisting condition limitation under the other group plan remains in effect, subject to the maximum period of coverage limitations set forth in this Section;

(10) The first day of the month beginning more than 30 days after the date on which the disabled covered employee or qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(11) COBRA may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

(d) **Cost of Coverage**. The law permits the Employer to charge any person who elects to continue coverage 102 percent of the full cost to the plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. If coverage is continued due to a disability, the law permits the Employer to charge 150 percent of the full cost of the plan for the last 11 months of the 29-month period during which coverage may continue.

(e) **Payment of Premium.**

(1) A covered employee/retiree or qualified beneficiary shall only be entitled to continuation coverage provided that he or she pays the applicable premium required

by the Employer in full and in advance, except as provided in (2) below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary or covered employee/retiree may elect to pay such premium in monthly installments.

(2) Except as provided in (3) below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under the plan.

(3) Notwithstanding (1) and (2) above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

(f) You Must Notify Plan Administrator of Certain Qualifying Events.

(1) The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. It is the responsibility of the covered employees/retirees and qualified beneficiaries to provide the following notices to the Plan Administrator:

(A) Notice of the occurrence of a Qualifying Event that is a divorce, judgment of separate maintenance, or legal separation of a covered employee/retiree from his or her spouse;

(B) Notice of the occurrence of a Qualifying Event that is a qualified beneficiary ceasing to be covered under the Plan as a dependent child;

(C) Notice of the occurrence of a second Qualifying Event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(D) Notice that a covered employee or qualified beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(E) Notice that a covered employee/retiree or qualified beneficiary: (i) with respect to whom a notice described in paragraph (1)(D) of this section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled, or (ii) subsequently becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of the other plan have been exhausted or satisfied).

(2) Notice to the Plan Administrator must be made in writing and must be mailed or hand-delivered to:

Human Resources Department
County of Jackson
120 West Michigan Avenue
Jackson, Michigan 49201

Oral notice or electronic notice (by e-mail or facsimile) is not acceptable. If mailed, the notice must be postmarked no later than the deadline described below. If hand-delivered, your notice must be received by the individual at the address above no later than the deadline described below.

(3) Required Contents of Notice. The notice must at a minimum contain the following information:

(A) the name of the Plan;

(B) the name and address of the employee or former employee who is or was covered under the Plan;

(C) the nature of this Qualifying Event, and, if applicable, the nature of the initial Qualifying Event that started your COBRA coverage, including any verifying documentation which may be required by the Plan Administrator;

(D) the date of this Qualifying Event, and, if applicable, the initial Qualifying Event;

(E) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the Qualifying Event or initial Qualifying Event, and, if applicable, whether those individuals are receiving COBRA coverage at the time of this notice;

(F) if the notice is regarding a disability extension, the name and address of the disabled covered employee or qualified beneficiary;

(G) if the notice is regarding a disability extension, the date that the covered employee or qualified beneficiary became disabled;

(H) if the notice is regarding a disability extension, the date that the Social Security Administration made its determination of disability. Additionally, a copy of the Social Security Administration's disability determination letter must be attached;

(I) if the notice is regarding (a) the Social Security Administration subsequently determining that the covered Employee or Qualified Beneficiary is no longer disabled or (b) subsequent entitlement of Medicare or coverage under another group health plan, the initial Qualifying Event and the subsequent event terminating coverage and the dates they occurred; and

(J) the signature, name, and contact information of the individual sending the notice.

Furthermore, the Plan requires that the following documents, if relevant to the particular Qualifying Event, be provided with the notice: Death Certificate; Divorce Decree, Judgment of Separate Maintenance or Legal Separation Agreement; Birth Certificate or Order of Adoption; Marriage Certificate; Social Security Administration's Disability Determination Letter; Spouse's Notice of Employment Termination or Proof of Loss of Coverage; Qualified Domestic Relations Order.

Any notice that does not contain all of the information required by the plan must be supplemented in writing within 15 business days upon request with the additional information necessary to meet the plan's reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this section. Otherwise, you will lose your right to elect COBRA.

(4) Time Periods To Provide Notice. If you do not provide notice in writing within the time period provided below, you will lose your right to elect COBRA:

(A) Time limits for notices of Qualifying Events. The notice described in paragraph (f)(1)(A), (B), or (C) of this section must be furnished within 60 days after the latest of: (i) the date on which the relevant Qualifying Event occurs; or (ii) the date on which the covered employee/retiree or qualified beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event.

(B) Time limits for notice of disability determination. A notice described in paragraph (f)(1)(D) of this section must be furnished before the end of the first 18 months of continuation coverage and within 60 days after the latest of: (i) the date of the disability determination by the Social Security Administration; (ii) the date on which the Qualifying Event occurs; or (iii) the date on which the covered employee or qualified beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event.

(C) Time limits for notice of change in disability status, subsequent Medicare entitlement or coverage under another group health plan. The notice described in paragraph (f)(1)(E) of this section must be furnished within 30 days after the date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the covered employee or qualified beneficiary is no longer disabled or the date the covered employee or qualified beneficiary becomes entitled to Medicare or covered under other group health plan coverage.

(5) Person to Provide Notice. With respect to each of the notice requirements of this section, any individual who is either the covered employee/retiree, a qualified beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered employee/retiree or qualified beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the Qualifying Event.

(g) **Employer Must Notify Plan Administrator of Certain Qualifying Events**. When the qualifying event is the end of employment or reduction of hours of

employment, death of the covered employee/retiree, enrollment of the covered employee/retiree in Medicare (Part A, Part B, or both), or commencement of a bankruptcy proceeding of the employer, the employer must notify the Plan Administrator within 30 days of the Qualifying Event.

(h) **Notification to Qualified Beneficiary**. The Plan Administrator has 14 days (or 44 days in the case where the Employer is the Administrator and the Employer had to furnish a notice of a Qualifying Event to the Plan Administrator) to send you and your spouse notification of your COBRA rights and the cost, if any, for continuation coverage.

(i) **Election of COBRA**. You and your qualified beneficiaries each will have an independent right to elect COBRA continuation coverage and shall have 60 days to elect COBRA from the date of notice or the date of the event, whichever is later. Covered employees/retirees and spouses who are qualified beneficiaries may elect COBRA coverage on behalf of all other beneficiaries, and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA coverage.

You then shall have 45 days to pay for any required premium. Thereafter, payment is timely if made within the time periods of the Plan or 30 days of the due date.

(j) **Special Election Period**. Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Employer promptly or you will lose the right to elect COBRA during a special second election period.

(k) **Interaction with FMLA**. If your employer is subject to the Family and Medical Leave Act and you do not return to work from your FMLA leave, you and your qualified beneficiaries may be entitled to continuation coverage under COBRA. A qualifying event under COBRA will occur if (1) you and your qualified beneficiaries are covered under your employer's group health plan on the day before the first day of FMLA leave; (2) you do not return to work with the employer at the end of the FMLA leave, and (3) you and your qualified beneficiaries would, in the absence of COBRA, lose coverage under the group health plan before the end of the maximum coverage period. The Qualifying Event would occur on the last day of the FMLA leave. The last day of FMLA leave may be the date you notify the employer that you will not be returning to work, if the notification was given before the FMLA was set to expire.

D-2. **What Happens to My Coverage if I Take Leave Under the Family and Medical Leave Act (FMLA)?** If your employer is subject to the Family and Medical Leave Act, this Plan shall at all times comply with applicable requirements of that Act and its underlying regulations. During any leave taken under the FMLA, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the Employee had been continuously employed during the entire leave period. Benefit coverage may be continued for all benefits up to the time limit allowed for an approved leave of absence that qualifies under FMLA.

If, during FMLA leave, the Employee does not wish to receive some or all of the coverage that he or she was receiving just prior to leave, the Employee must inform the Plan Administrator prior to the start of leave of which coverage will be dropped. If the Employee decides not to receive some or all of the covered medical benefits during FMLA leave, he or she may reinstate the same coverages upon return to work at the conclusion of FMLA leave.

If the Employee wishes to continue participation in the Plan, he or she must make arrangements with the Plan Administrator to pay for the coverages (in which the Employee is currently enrolled) that he or she wishes to maintain during the course of leave. Eligibility to continue any coverage, which requires payments from the Employee, may be cancelled if he or she does not make the required payments during the period of FMLA leave.

If the Plan Administrator advances money by making any or all of these required payments for the Employee, it can recoup the amounts advanced through payroll deductions and by other means upon the Employee's return to employment following FMLA leave, to the extent permitted by law.

If the Employee fails to return from FMLA leave, and the reasons for failure are not beyond the Employee's control, the Employee is indebted to Employer for the full amount of the cost of health coverage provided during FMLA leave. Employer intends to deduct any such amounts owed by an Employee from any compensable time payments owed to such Employee upon termination for failure to return from an FMLA leave, to the extent permitted by law. Employer may also use other means necessary to recoup these health care coverage costs.

An Employee should consult with the Plan Administrator before embarking on any FMLA qualified leave.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

This Section only applies to group health plan coverage within the Component Benefit Programs.

D-3. **What Happens to My Coverage if I Take Leave Under the Uniformed Services Employment and Reemployment Rights Acts (USERRA)?** Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you take leave under USERRA, to the extent required by USERRA, your Employer may continue to maintain your benefits on the same terms and conditions as if you were still an active Employee.

Employees going into or returning from service in the uniformed services may have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to Employees and their Dependents covered under the Plan before the Employee left for military service. To be entitled to USERRA rights, the Employee must give the Employer advance notice of the Employee's absence from employment for uniformed service, unless precluded by military necessity or if it is otherwise impossible or unreasonable under all the circumstances. Additionally, subject to certain exceptions, the Employee's absence from work may not exceed five years.

USERRA rights include up to 24 months of continued health care coverage. For periods of leave less than 31 days, the Employee only needs to pay his or her normal portion of the premium. For periods of leave 31 days or more, coverage will only be extended upon payment of the entire cost of coverage plus a reasonable administration fee.

Moreover, if coverage was terminated due to an Employee's service in the uniformed services, and the Employee is reemployed under USERRA, the Employee is entitled to reinstatement in the Plan. No preexisting conditions limitations will be applied in the Plan upon return from service. However, Plan exclusions and waiting periods may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

USERRA rights terminate if the Employee's discharge from the uniformed service was a result of "dishonorable" or other undesirable conduct, the Employee fails to report back to work or apply for reemployment within the time period required under USERRA, or if the Employee fails to pay coverage premiums. More information about coverage available pursuant to USERRA is included in the Component Benefit Program documents, or posted at your worksite.

The time periods within which to elect and pay for USERRA continuation of coverage shall be the same time periods within which to elect and pay for COBRA coverage under the Plan. If both USERRA and COBRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage.

This Section only applies to health plan coverage within the Component Benefit Programs.

E. CLAIMS REVIEW PROCEDURE IN GENERAL

E-1. **Applicability of Article.** The term "Administrator" shall also mean "Contract Administrator" for purposes of this Article only. Specifically, the term "Administrator" shall mean the relevant Administrator or Contract Administrator who is administering benefits under the particular Component Benefit Program.

Claims procedures and appeals set forth in the Component Benefit Programs control; this Article supplements those documents to the extent required by the PPACA for non-Grandfathered Plans and to impose the limitations period for filing suit.

Claims for benefits incorporated in this Plan shall be submitted to the relevant Administrator. For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Programs provided through the Employer's general assets, the Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

If you think an error has been made in determining your benefits, then you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Administrator. If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

Please review your Component Benefit Program documents for more information. The remainder of this Article E applies to non-Grandfathered Plans.

E-2. **How do I Make a Claim**? Generally, the provider will file all claims. However, in some circumstances, nonparticipating providers may not file a claim. In those cases, a claimant shall make a claim for benefits by making a request pursuant to the procedures specified in the claim forms provided by the Administrator. The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim. The Administrator will decide your claim in accordance with reasonable claims procedures, as required by the PPACA. If the Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Administrator for a review of the denied claim. The Administrator will decide your appeal in accordance with reasonable claims procedures, as required by the PPACA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). See the Component Benefit Plan documents for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

E-3. **What if My Benefits are Denied**?

(a) In general, your request for Plan benefits will be considered a claim for Plan benefits and will be subject to a full and fair review. If your claim is wholly or partially denied, the Administrator will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Administrator, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines that an extension is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

(b) A pre-service non-urgent care claim is one where the receipt of the benefit is conditioned on approval before the service is rendered. If your claim involves a pre-service determination, the Administrator shall notify you of the benefit determination within a reasonable time, but no later than 15 days after receipt of your claim if no further information is required. This period may be extended one time for 15 additional days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan. The Administrator will provide you with written notice of the extension before the end of the initial 15-day period explaining the reason for the extension and the date the Administrator expects to make a decision. If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, but communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Administrator will provide oral notice (and in writing if requested) of the failure and the proper procedure to complete the claim, within five days of the failure. If the extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and you shall have 45 days to provide the information. Failure to respond in a timely and complete manner will result in a benefit denial.

(c) A post-service care claim is one that may be filed and approved after the service is rendered. If your claim involves a post-service claim, the Administrator shall notify you of the adverse benefit determination within a reasonable time, but no later than 30 days after receipt of your claim, if no further information is required. This period may be extended one time for 15 additional days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you prior to expiration of the initial 30-day period of the reason for the extension of time and the date by which the Administrator expects to render a decision. If the extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and you shall have at least 45 days to provide the information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

(d) A concurrent care decision is one where the Plan has approved an ongoing course of treatment and then the Plan reduces or terminates coverage for that course of treatment

(other than by amendment or plan termination) before the end of the pre-approved course of treatment. This is an adverse benefit determination that can be appealed as a concurrent care claim. If your claim involves a reduction or termination of an ongoing course of treatment which the Plan had previously approved, the Administrator shall notify you of the benefit determination within a reasonable time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

(e) In the case of a concurrent care claim, if your claim involves a request to extend the course of treatment which the Plan had previously approved, the Administrator shall notify you of the benefit determination within 24 hours after receipt of the claim by the Plan, provided the claim is made at least 24 hours before the expiration of the period of time or number of treatments.

(f) An urgent care claim is any claim for which the application of the standard time periods for determining claims a prudent layperson would consider, or the patient's physician determines, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or for which delayed treatment would cause the patient severe pain. If your claim involves an urgent care decision, the Administrator shall notify you of the benefit determination as soon as possible, but not later than 72 hours after receipt of your claim. However, if you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, but communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Administrator will provide notice of the failure and the proper procedure to complete the claim as soon as possible, but not later than 24 hours of the failure. You shall be afforded at least 48 hours to provide the specified information. The Administrator will notify you of the benefit determination as soon as possible, but not later than 48 hours of the earlier of receipt of the specified information or the end of the period in which you must provide the additional information.

(g) The Administrator's written or electronic notification of any adverse benefit determination must contain the following information:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the determination is based;

(3) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

(4) Appropriate information as to the steps to be taken if you or your beneficiary want to submit your claim for review, including a statement of your right to bring a civil action.

(h) In the case of a decision by a group health plan:

(1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the adverse benefit determination, will be provided free of charge to you upon request; and

(2) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances, or a statement of such explanation, will be provided free of charge upon request.

(i) In the case of an urgent care decision, you may be informed orally and will be sent a written notification within 3 days of the oral notification. You will also receive a description of the expedited review process for such claims.

(j) If your claim has been denied and you want to submit your claim for review, you must follow the Claims Review Procedure.

E-4. **What is the Claims Review Procedure**?

(a) Upon denial of your claim for benefits you may file your claim for review, in writing, with the Administrator.

(1) You must file the claim for review to the appropriate named fiduciary of the plan no later than 60 days after you have received written or electronic notification of an adverse benefit determination.

However, if your claim is for group health plan benefits, then instead of the above, you must file the claim for review to the appropriate named fiduciary of the plan no later than 180 days following receipt of notification of an adverse benefit determination.

(2) You may submit written comments, documents, records and other information relating to the claim for benefits.

(3) You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

(4) Your claim for review will be given a full and fair review. This review will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) In addition to the Claims Review Procedure above, if your claim is for group health benefits, then under the Claims Review Procedure:

(1) Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named

fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

(2) In deciding an appeal of any adverse benefit determination that is based in whole or part on medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(3) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in the determination.

(4) The health care professional engaged for purposes of a consultation under (2) above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(c) If your claim involves an urgent care decision, an expedited review will occur, which you may request orally or in writing. All necessary information, including the determination on review, shall be transmitted between you and the Administrator by telephone, facsimile or other available similarly expeditious method.

(d) The Administrator will provide you with written or electronic notification of the benefit determination on review. The Administrator must provide you with notification of this denial within 60 days after the Administrator's receipt of your written claim for review, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review. If your claim involves the following types of care, the corresponding time periods will apply:

(1) The Administrator shall notify you of the benefit determination on review concerning pre-service determinations within 30 days after receipt of your request of review.

(2) The Administrator shall notify you of the benefit determination on review concerning post-service determinations within 60 days after receipt of your request of review.

(3) The Administrator shall notify you of the benefit determination on review concerning the urgent care determinations within 72 hours after receipt of your request for review.

(e) In the case of an adverse benefits determination, the written or electronic notification will set forth:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the benefit determination is based;

(3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;

(4) If any voluntary appeal right exists, a statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures and a statement of your right to bring an action;

(5) In the case of a claim for group health benefits:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the adverse determination, will be provided to you free of charge upon request;

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances, or a statement of such explanation, will be provided free of charge upon request.

(f) If you have a claim for benefits which is denied upon review, in whole or in part, you may file suit in a state or federal court; however, such suit must be brought within three years of the denial upon review.

F. PPACA CLAIMS PROCEDURE AND APPEAL

This Article F shall apply to non-Grandfathered Plans providing group health plan coverage covering two or more Employees within the Component Benefit Programs (but not for retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c)) for plan years beginning on or after September 23, 2010.

F-1. **Minimum Internal Claims and Appeals Standards.** A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503-1 and Article E, except to the extent those requirements are modified or expanded by this Article F.

F-2. **Additional Internal Claims and Appeals Standards.** In addition to the applicable requirements set forth in Section F-1, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the following requirements:

(a) Full and fair review. A plan and issuer must allow you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements set forth in Section E-4:

(1) The plan or issuer must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under Section E-4(d) to give you a reasonable opportunity to respond prior to that date; and

(2) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date of which the notice of final internal adverse benefit determination is required to be provided under Section E-4(d) to give you a reasonable opportunity to respond prior to that date;

(b) Avoiding conflicts of interest. In addition to the requirements of 29 CFR 2560.503-1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits;

(c) Notice. Effective the first day of the first plan year beginning on or after January 1, 2012, a plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as set forth in 29 C.F.R. 2590.715-2719(e) with respect to applicable non-English languages) that complies with the requirements of 29 C.F.R. 2560.503-1(g) and (j). Effective the first day of the first plan year beginning on or after July 1, 2011 (unless a different effective date is set forth below in this paragraph), the plan and issuer must also comply with the following requirements:

(1) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable);

(2) Effective the first day of the first plan year beginning on or after January 1, 2012, the plan and issuer must ensure that any notice of adverse benefit

determination or final internal adverse benefit determination includes a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(3) The plan and issuer must provide to you and your beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under Sections F-1, F-2, or F-3, or an external review under Section F-4;

(4) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(5) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(d) Deemed exhaustion of internal claims and appeals processes. Effective the first day of the first plan year beginning on or after January 1, 2012,

(i) In the case of a plan or issuer that fails to adhere to all the requirements of Sections F-1, F-2, and F-3 with respect to a claim, you are deemed to have exhausted the internal claims and appeals process of this Article F except as provided in subparagraph (ii) of this paragraph (d). Accordingly, you may initiate an external review under Section F-4. You are also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If you choose to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(ii) Notwithstanding subparagraph (i) of this paragraph (d), the internal claims and appeals process of this Article F will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and you. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. You may request a written explanation of the violation from the plan or issuer, and the plan or issuer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this Article F to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review under subparagraph (i) of this paragraph (d) on the basis that the plan met the

standards for the exception under this subparagraph (ii) of this paragraph (d), you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the plan shall provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

F-3. **Provision of Continued Coverage Pending the Outcome of an Appeal.** A plan or issuer subject to the requirements of Sections F-1 and F-2 are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of Sections E-3(d) and (e), which generally provide that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

F-4. **External Review Process**

(a) In general. You may have the right to file a request for an external review of an adverse determination or final adverse determination with the plan. You may contact the Plan Administrator for more detailed information related to the external review process. The plan can be reached at (517) 768-6602 or 120 West Michigan Avenue, 5th Floor, Jackson, Michigan 49201.

(b) For fully-insured plans and self-insured nonfederal governmental plans,

(1) Through December 31, 2011, an applicable State external review process is binding on the issuer or plan. If there is no applicable State external review process, the issuer or plan is required to comply with the requirements set forth in paragraph (c) of this Section F-4. For final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided on or after January 1, 2012, the external review process set forth in paragraph (c) of this Section F-4 will apply unless the Department of Health and Human Services determines that a State law meets all temporary standards set forth in subparagraph (2) of this paragraph (b).

(2) Beginning January 1, 2012, and until the earlier of January 1, 2014 or the date an applicable State enacts an NAIC-parallel process, issuers and self-insured nonfederal governmental plans shall comply with an applicable State external review process that meets the following temporary standards (as set forth in Department of Labor Technical Release 2011-02):

(A) The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(B) The process provides for external review of adverse benefit determinations (and final internal adverse benefit determinations) involving experimental or

investigational treatments or services and must have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(C) Issuers (or plans) are required to provide effective written notice to you of your right to external review in their summary plan descriptions and plan materials and on each notice of adverse benefit determination. These notice requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.

(D) If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (1) the internal appeal process timelines are not met; or (2) in an urgent care situation, you file for an external review without having exhausted the internal appeal process. These requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.

(E) The cost of an external review must be borne by the issuer (or plan), and you cannot be charged a filing fee in excess of $25 per external review.

(F) There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.

(G) You must have at least 60 days to file for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.

(H) The IRO must be assigned impartially. You and issuer (or plan) should have no discretion as to the IRO that is chosen.

(I) If the State contracts with, or otherwise identifies one or more IROs to provide external review, the State must have a process in place for quality assurance of IROs.

(J) If the State contracts with, or otherwise identifies one or more IROs to conduct external reviews, the State must ensure conflict of interest protections on the part of the IRO when it participates in external review decisions.

(K) The IRO decision is binding and must be enforceable by the State.

(L) For standard external reviews (those not involving urgent care), the IRO must inform the issuer and you, in writing, of its decision within 60 days from receipt of the request for external review.

(M) The process must provide for expedited external review of urgent care claims. In such cases, the IRO must inform the issuer and you of an urgent care decision within four business days or less (depending on medical exigencies of the case) from receipt of the request for review. If the IRO's decision was given orally, the IRO must provide written notice of its decision within 48 hours of the oral notification.

(3) Once an applicable State enacts an NAIC-parallel process (as determined by the Department of Health and Human Services), the external review process of that State law shall apply, unless the health insurance issuer or self-insured nonfederal governmental plan elects to follow a Federally administered external review process as permitted in subparagraph (5) of this paragraph (b).

(4) Beginning January 1, 2012, if a State process does not meet the standards set forth in subparagraphs (2) or (3) of this paragraph (b), health insurance issuers (and, if applicable, self-insured nonfederal governmental plans) in the State will be subject to the external review process set forth in paragraph (c) of this Section F-4. Additionally, if a State-administered process reduces consumer protections below the level that applies at the time the Department of Health and Human Services makes its finding, plans and issuers in the State will be required to participate in the external review process set forth in paragraph (c) of this Section F-4.

(5) Health insurance issuers and self-insured nonfederal governmental plans may elect to use a Federally administered external review process instead of the State process; specifically, such plans or issuers can elect to use the process set forth in paragraphs (b)(2) or (c) of this Section F-4 by timely submitting appropriate information to the Department of Health and Human Services.

(c) ERISA and/or IRC self-insured plans will comply with the external review requirements under the PPACA if the following procedures are adhered to: Subject to the suspension provision set forth in subparagraph (1) of this paragraph (c) (and except to the extent provided otherwise by the Secretary of the Department of Labor in guidance) the external review process set forth in subparagraphs (2) and (3) of this paragraph (c) (i.e., the procedures set forth in Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-02) shall apply to any adverse benefit determination of final internal adverse benefit determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for external review process set forth in subparagraphs (2) and (3) of this paragraph (c).

(1) Unless or until this suspension is revoked in guidance by the Secretary of Labor, with respect to claims for which external review has not been initiated before September 20, 2011, the external review process set forth in subparagraphs (2) and (3) of this paragraph (c) applies only to: (i) an adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its

determination that a treatment is experimental or investigational), as determined by the external reviewer; and (ii) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(2) Standard external review for self-insured group health plans. This subparagraph (2) sets forth procedures for standard external review for self-insured group health plans. Standard external review is external review that is not considered expedited (as described in subparagraph (3) of this paragraph (c)).

(A) Request for external review. A group health plan must allow you to file a request for an external review with the plan if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(B) Preliminary review. Within five business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:

(i) You are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;

(ii) The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

(iii) You have exhausted the plan's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations; and

(iv) You have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the plan must issue a notification in writing to you. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow you to perfect the request for external review

within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(C) Referral to Independent Review Organization. The group health plan must assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan must take action against bias and to ensure independence. Accordingly, plans must contract with at least two (2) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between a plan and an IRO must provide the following:

(i) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.

(ii) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(iii) Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify you and the plan.

(iv) Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

(v) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) Your medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, you, or your treating provider;

(D) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with the applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(G) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(vi) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to you and the plan.

(vii) The assigned IRO's decision notice will contain:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the

diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;

(F) A statement that judicial review may be available to you; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(viii) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the plan, or the State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(D) Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

(3) Expedited external review for self-insured group health plans.

(A) Request for expedited external review. A group health plan must allow you to make a request for an expedited external review with the plan at the time you receive:

(i) An adverse benefit determination if the adverse benefit determination involves a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of you or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(ii) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

(B) Preliminary review. Immediately upon receipt of the request for expedited external review, the plan must determine whether the request meets the reviewability requirements set forth in subparagraph (2)(B) above for standard external review. The plan must immediately send a notice that meets the requirements set forth in paragraph (2)(B) above for standard external review to you of its eligibility determination.

(C) Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO pursuant to the requirements set forth in subparagraph (2)(C) above for standing review. The plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

(D) Notice of final external review decision. The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in subparagraph (2)(C) above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the plan.

(d) To the extent that benefits under a group health plan are provided through health insurance coverage, the health insurance issuer has primary responsibility to comply with the external review process set forth in this Section F-4.

G. COORDINATION OF BENEFITS

Coordination of Benefits involves coordinating payments between two separate plans that both cover the Employee and/or Dependents. Unless otherwise provided in Component Benefit Programs, this Coordination of Benefits provision shall apply.

G-1. **Order of Payment**. According to the following section outlining the order of payment, one plan will be designated as the primary plan and succeeding plans will be designated as secondary plans. The primary plan must pay benefits as if the secondary plan did not exist. The secondary plan would then adjust and reduce its expense payments so that the total benefit payable by both plans will not exceed 100% of allowable expenses. This Plan will never pay more than it would without this coordination provision.

If two Employees are parents of the same eligible Dependent child(ren), whether or not the parents are, or have ever been, married, the Plan will not coordinate benefit payments. More specifically, only one Employee parents may cover the same eligible Dependent child(ren).

When a person is covered under two or more plans, the rules below will apply to decide which plan's benefits are payable first:

(a) If one plan does not have a coordination of benefits provision, then it will be the primary payer on the claim. The plan with the coordination of benefits provision, such as this one, will be the secondary payer.

(b) The plan that covers the insured as a nondependent (i.e., as an employee, member, subscriber, or retiree) is primary over a plan that covers the insured as a dependent.

(c) In cases of coverage for a dependent child, the plan of the parent whose birthday falls earlier in the year is primary if:

(1) The parents are married; or

(2) The parents are not separated (whether or not they have ever been married); or

(3) A court decree awards joint custody without specifying that one parents has the responsibility to provide health care coverage.

If both birthdays are the same, then the plan covering the parent longest is primary.

(d) If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses, if any, is as follows:

(1) The plan of the parent with custody;

(2) The plan of the custodial parent's spouse;

(3) The plan of the parent without custody;

(4) The plan of the noncustodial parent's spouse.

(e) If a court decree states that one of the parents must pay health coverage, then that parent's plan pays primary (as long as the plan has actual knowledge of the court decree and its terms). If that parent has no coverage for the child's health care services, then the plan of that parent's spouse is primary (as long as the plan has actual knowledge of the court decree and its terms). This paragraph shall not apply with respect to any claim determination period or plan year during which the benefits are paid or provided before the plan has actual knowledge. (If it is determined that another plan is primary due to the terms of the divorce decree after the secondary plan has paid as primary, the secondary plan will not retroactively seek refunds of the overpayments it previously issued as the primary plan.

(f) A plan that covers a person as a former employee (or dependent of a former employee) is secondary to the plan that covers the person as an active employee (or an active employee's dependent). However, if the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule is ignored.

(g) If none of the above rules can determine the order of benefits, then the plan that covered the insured the longest pays before the plan which covered the person for the shorter period of time. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within 24 hours after the first ended. The start of a new plan does not include (1) a change in the amount of scope of a plan's benefits; (2) a change in the entity that pays, provides, or administers the plan's benefits; or (3) a change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan). A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(h) With regard to COBRA, the plan covering the person as an employee, member, subscriber, or retiree (as their dependent) is primary. The COBRA plan is secondary, unless the plan that would be primary contains pre-existing condition limitations. However, this rule is ignored if only one plan follow the COBRA rules and the plans do not agree on the order of benefits.

(i) If another plan contains a provision whereby such plan considers their plan to be excess of other available benefits or considers their plan to be secondary only in normal coordination of benefits situations, this plan will coordinate to consider benefits payable on a 50%/50% basis, between this plan and the other plan.

(j) If none of the above rules apply, then the expenses must be shared equally between the plans.

The total maximum benefit limits under this Plan will only be reduced by the charges actually paid by this Plan. Any benefits coordinated and paid by other coverage providers will not be charged against the benefit limits of this Plan.

G-2. **Coordination With Medicare**. This Plan is intended to comply with Federal Regulations with respect to Medicare coverage and coordination of benefits. When determining Medicare benefits, the Plan will base its payment upon benefits that have been paid by Medicare under Parts A and B, whether or not the covered Participant and/or Dependent has enrolled for the full coverage. In the case of services and supplies for which Medicare makes direct reimbursement to the health care provider, this Plan will coordinate its benefits based on the amount approved by Medicare and not the amount of the charge.

G-3. **Coordination With Medicaid**. Notwithstanding any other provisions of this Plan to the contrary, this Plan shall not take into account, with respect to Plan enrollment or the payment of benefits to a covered Participant and/or Dependent, that such Participant and/or Dependent qualifies for medical assistance under a state Medicaid plan.

H. MISCELLANEOUS

H-1. **Amendment or Termination of the Plan.** Although the Employer intends to continue the Plan, it reserves the right to amend or terminate the Plan or to modify the Plan to reduce, increase or modify any and all of the benefits provided under the Plan. Any decision to amend, terminate or modify the Plan shall be made by a written instrument by the Board of Commissioners or other governing body of your Employer or by any person or persons authorized by the Board of Commissioners to take such action. This decision shall be communicated to all participants in writing.

When changes are made to Component Benefit Programs, they are made in the form of amendments and/or summaries of material modification. The procedure for amending a plan is as follows:

(a) The proposed amendment request by the Plan Sponsor is sent to the Plan Administrator of the plan.

(b) The Plan Administrator develops an amendment and/or summary of material modification in accordance with the amendment request from the Plan Sponsor. The authorized representative for the County of Jackson will then approve and sign the amendment and/or summary of material modification.

(c) The approved amendment and/or summary of material modification becomes part of the plan document and summary plan description and is available to the Department of Labor upon request. Adoption of an amendment and/or summary of material modification shall be effective as of the date indicated within the document (to the extent permitted by law) upon approval by the Plan Sponsor.

Unless otherwise provided in the Component Benefit Programs, no Employee, Participant, Dependent or any other person shall have any further right, title, interest or claim, legal or equitable, in or to any reimbursement or benefit payable under such Plan beyond the date in which such Plan or benefit is terminated. Assets remaining in the Plan upon termination arising from employer contributions will revert to the Employer. Information concerning asset

distribution after termination of the Plan shall be made available by the Plan Administrator at no cost upon written request.

H-2. **No Contract of Employment.** The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time.

H-3. **Subrogation, Reimbursement and Third Party Recovery Provision**. Unless otherwise provided in the Component Benefit Programs, the Plan shall have the following rights:

(a) Benefits under the Plan shall be paid second to other rights of recovery and will be paid only if the Participant fully adheres to the terms and conditions of the Plan. The Plan shall have the right to recover from the Participant or beneficiary any payment for benefits paid by the Plan to which the Participant or beneficiary is entitled to recover from a third person, including but not limited to any liability insurance, uninsured/underinsured motorist proceeds, or other health plan. Specifically, the Plan has a first lien upon any recovery, whether by settlement, judgment or otherwise that the Participant or beneficiary receives from a third person, not to exceed the amounts of benefits paid by the Plan or the amount received by the Participant or beneficiary for such treatment. This lien or right of reimbursement exists regardless of (1) whether the money or other valuable consideration is designated as economic or non-economic damages; (2) whether the recovery is partial or complete; and (3) who holds the money or other valuable consideration or where it is held. Any settlement or recovery shall first be applied to reimbursement of medical expenses paid by the Plan.

(b) If benefits are paid or payable by this Plan as the result of an action of a third party, this Plan shall be subrogated to all rights of recovery of any participant or beneficiary under this Plan in respect to such action. No Plan benefits shall be provided unless the Participant provides all information, documentation, and agreements required by the Plan or its agents to process a claim, including but not limited to, reimbursement and subrogation agreements as the Plan or its agents may request. Failure or refusal to execute such agreements or furnish such information does not preclude the Plan from exercising its rights to subrogation or obtaining full reimbursement. Participants receiving benefits under this Plan are obligated to avoid doing anything that would prejudice the Plan's rights, including but not limited to reimbursement.

(c) If any suit is filed, the Participant shall retain an attorney who will not assert the common fund, make-whole, or other apportionment actions in contravention of the Plan's reimbursement terms and that reimbursement shall be made immediately upon collection of any sum recovered regardless of its legal, financial or other sufficiency. The Plan shall be informed of when an attorney is hired to represent the Participant and the Participant shall inform his/her attorney of the Plan's rights.

(d) If a suit is filed, the Plan may cause to be recorded a notice of payment of benefits, and such will constitute a lien on any judgment recovered less a pro rata share of court costs.

(e) If suit is filed against the Participant to enforce this provision, the Participant agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

(f) If a person to whom benefits are paid or payable under this Plan fails to bring suit promptly against a third party, the Plan may institute suit against such third party in its own name or in the name of such person and the Plan shall be entitled to retain from any judgment the amount of benefits paid or to be paid to such person without reduction for court costs, attorney fees, comparative negligence, limits of collectability or responsibility, or otherwise. The remainder of any recovery shall be paid to such person or as the court directs.

(g) If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of applicable state law and whether the minor's representative has access or control of any recovery funds.

(h) The Plan Administrator has sole discretion to interpret the terms and conditions of this provision in its entirety and reserves the right to make changes as it deems necessary.

H-4. **Applicable Laws.** This Plan shall be construed, administered and enforced according to applicable state laws, to the extent not superseded by the Code, the Public Health Service Act ("PHSA"), or any other applicable federal law, including, but not limited to, COBRA, NMHPA, USERRA, the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, ("PPACA"), the Mental Health Parity Act, as amended ("MHPA"); the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"); the Genetic Information Nondiscrimination Act of 2008 ("GINA"); the Family and Medical Leave Act of 1993, as amended ("FMLA"); the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"); and the Women's Health and Cancer Rights Act of 1998, as amended ("WHCRA") and other group health plan laws to the extent required by such laws.

H-5. **Mastectomy Related Benefits.** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related medical and surgical benefits under a group health plan and who elect breast reconstruction in connection with such mastectomy, coverage under that same group health plan will be provided in a manner determined in consultation with the attending physician and the patient, for:

(a) all stages of reconstruction of the breast on which the mastectomy was performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) prostheses and treatment of physical complications of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under that group health plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

H-6. **Newborns' and Mothers' Health Protection Act ("NMHPA").** Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

H-7. **ERISA Rights.** This Plan is exempt as a "governmental plan" from the provisions of ERISA. Any reference to ERISA within this document is for informational purposes only and does not cause this Plan to become subject to ERISA.

H-8. **Further Information**. You may obtain additional copies of the individual Plans or insurance contracts from the Employer's Human Resources Department. The Human Resources Department is also responsible for answering your questions relating to the individual Plans and insurance contracts under this document.

Exhibit A

Component Benefit Program Information

County of Jackson

Amended and Restated Group Health Plan

SUMMARY PLAN DESCRIPTION

POAM Employees

Prepared by:
Fraser Trebilcock Davis & Dunlap, P.C.
124 West Allegan, Suite 1000
Lansing, Michigan 48933
Telephone: (517) 482-5800
Facsimile: (517) 482-0887

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County of Jackson
Amended and Restated Group Health Plan for POAM Employees

Summary Plan Description

The County of Jackson ("Employer") has adopted a Welfare Benefit Plan ("Plan") for its Employees. This Plan is the overall plan by Employer to provide you with certain benefits through contracts with various insurance companies, administrative service organizations and/or through the Employer's programs. Specifically, the Plan incorporates medical and other benefits, depending on employee eligibility and other employer and insurer requirements and is treated as a single employee welfare benefit plan.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company or third-party administrator, a summary plan description or another governing document prepared by the Employer or authorized representatives. This document, along with the accompanying governing documents, constitutes the summary plan description for each of the component plans.

This Summary Plan Description ("SPD") has been prepared to generally explain the provisions of the various plans included in the Plan; it does not give the full details of each plan. It is not meant to interpret, extend or change the underlying plans in any way. In case of a conflict between this SPD and the actual provisions of the formal plan documents, the provisions of the plan documents will control, unless otherwise required by law.

It is important that you know your legal rights and responsibilities as well as the benefits that are available to you. The County of Jackson encourages you to read through this SPD thoroughly. If for any reason you do not understand the information provided, contact the Plan Administrator for assistance.

A. GENERAL PLAN INFORMATION

A-1. **Name of Plan:** County of Jackson Amended and Restated Group Health Plan for POAM Employees.

A-2. **Name, Address and Telephone Number of Plan Sponsor**: County of Jackson, 120 West Michigan Avenue, Jackson, Michigan, (517) 768-6602.

A-3. **Plan Sponsor / Employer Identification Number**: 38-6004845.

A-4. **Type of Plan:** Welfare benefit plan, which incorporates the following benefits:

- Medical and prescription benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")
- Dental and vision benefits, administered by Blue Cross Blue Shield of Michigan ("BCBSM")

Collectively, these benefits are called the "Component Benefit Programs."

A-5. **Name, Address and Telephone Number of Plan Administrator and Named Fiduciary:** County of Jackson, 120 West Michigan Avenue, Jackson, Michigan, (517) 768-6602.

The Plan has granted the Named Fiduciary final discretionary authority in determining eligibility for benefits or to interpret the terms of the Plan for claims purposes.

A-6. **Name and Address of Contract Administrator and Named Fiduciary (for self-funded benefits and benefit appeals):**

Blue Cross Blue Shield of Michigan
PO Box 2888
Detroit, Michigan 48231
(800) 645-BLUE

The Plan has granted the Named Fiduciary final discretionary authority in determining eligibility for benefits for which it administers or to interpret the terms of the Plan for claims purposes.

A-7. **Plan Number:** The Plan is a group benefit plan document which incorporates several different insurance contracts, third-party administration contracts and benefit booklets issued by the Employer and the various insurers, Contract Administrators and Named Fiduciaries described above. The Plan Number is 501.

A-8. **Effective Date:** The effective date of this Plan is January 1, 2011.

A-9. **Agent for Service of Legal Process:** County Administrator, County of Jackson, 120 West Michigan Avenue, Jackson, Michigan 49201.

Note: Service of legal process may also be made on the Plan Administrator.

A-10. **Type of Administration of the Plan:** The administration of the Plan is under the supervision of the Plan Administrator, and the Plan Administrator shall have full power to administer the plan, subject to any applicable requirements of law. The Plan Administrator, and other fiduciaries of the Plan (including any named fiduciary for claim appeals), have the requisite discretionary authority and control over the Plan to require deferential judicial review of its decisions, as set forth by the U.S. Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The medical, prescription, dental and vision benefits offered by the County of Jackson are self-funded by the Employer and are administered by BCBSM.

To the extent the Plan allocates to the Contract Administrators the responsibility for administering the Component Benefit Programs and for exercising other fiduciary functions described in those Programs, the Plan Administrator shall retain no responsibility for such acts.

If you have any general questions regarding the Plan or regarding your eligibility for or the amount of any benefit payable under the self-funded component benefit plans, please contact the Human Resources Department, who acts on behalf of the Plan Administrator.

A-11. **Funding Medium:** As described above, the benefits under the Plan are self-funded. The self-funded benefits are funded by the Employer and are not insured by an insurance company, with the exception of stop-loss insurance. If for any reason the Plan Administrator does not ultimately pay expenses under this Plan, the individuals covered by the Plan will be liable for those expenses.

Benefits under the Plan for employees and their eligible family members are paid as provided in the underlying governing documents and collective bargaining agreements, including by the Employer out of its general assets and/or by employees' pre-tax or after-tax payroll deductions. Unless provided otherwise in the collective bargaining agreements, the Employer will determine and periodically communicate your cost of benefits provided through each Component Benefit Program, and it may change that determination at any time. Special rules apply with regard to pre-tax contributions, irrevocability of elections, and possible forfeitures. Please see your underlying Summary Plan Description for the County of Jackson Second Amended and Restated Section 125 Cafeteria Plan, as amended from time to time, for more details. You are also responsible for any deductible, co-payment, and coinsurance that may be required under the terms of the benefit programs. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the Component Benefit Programs, as applicable.

A-12. **Plan Year:** The Plan Year starts on January 1 and ends on December 31; however, there may be different plan years for each individual underlying benefit as set forth within each respective insurance contract or other plan document.

B. ELIGIBILITY AND BENEFITS

B-1. **When am I Eligible to Participate in the Plan?** The eligibility and participation requirements for this Plan are governed by the terms and conditions of the Component Benefit Program documents, collective bargaining agreements, and by the Employer's policies or directives. Please refer to these documents for details regarding your eligibility for benefits offered under this Plan. Unless otherwise provided, you will be eligible to participate in the Plan if you meet all of the following requirements:

Employee Eligibility

(a) You are an "Employee," which means an individual that the Employer classifies as a common law employee and who is on the Employer's W-2 payroll, but does not include temporary or leased employees, casual employees, seasonal employees, contract workers or independent contractors;

(b) You are regularly scheduled to work at least 20 hours per week and will normally be scheduled to work more than six months during the Plan Year; and

(c) You are a part-time or full-time Employee of Employer, are included in the Police Officers Association of Michigan ("POAM") collective bargaining unit which bargained in good faith for employee benefits, and the collective bargaining agreement provides that you shall be eligible to participate in the Plan. In such case, you may only participate in the Plan to the extent that the collective bargaining agreement provides.

You may be responsible for the cost of coverage under this Plan. Please see your collective bargaining agreement, employee handbooks, benefit summaries, and/or enrollment materials for more information.

Some of the Component Benefit Programs may require you to make an annual election to enroll for coverage. The details of such annual elections are described in the underlying documents. In certain circumstances, enrollment may occur outside the open enrollment period. Please see the underlying documents for more details.

Retiree Eligibility and Coverage for Medical and Prescription Benefits Only

Eligibility factors for Retiree Health for Employees / Retirees covered by collective bargaining agreements are set for in those agreements. Please see your POAM collective bargaining agreement for more details.

Retirees and their Dependents are not eligible for any dental or vision coverage under this Plan.

You may be responsible for the cost of coverage under this Plan. Please contact Human Resources for verification of your financial responsibility; also see your collective bargaining agreement, employee handbooks, benefit summaries, and/or enrollment materials for more information.

Some of the Component Benefit Programs may require you to make an annual election to enroll for coverage. The details of such annual elections are described in the underlying documents. In certain circumstances, enrollment may occur outside the open enrollment period. Please see the underlying documents for more details.

Dependent Eligibility and Coverage in General

Coverage may also be provided to your Dependents who are eligible to participate in the underlying Component Benefit Programs. The term "Dependent" generally means a Participant's Spouse and any person who is a dependent of the Participant within the meaning of Internal Revenue Code (the "Code") section 152; however, for health benefits, a Dependent generally means any person who is a dependent as set forth in Code sections 105(b), 106 and the regulations and other authority thereunder. The term "Spouse" means an individual who is legally married to a Participant as determined under applicable Michigan state law and who is treated as a spouse under the Code. Dependents may or may not be eligible to participate in certain Benefits within the Component Benefit Programs. Please review the Component Benefit Program eligibility materials for more information.

Dependent Eligibility and Coverage

Effective January 1, 2011, coverage for Dependent children will be available for an adult child until the day prior to the date the child turns 26 years of age. A “child” for this purpose is defined as your son, daughter, stepson, stepdaughter, or eligible foster child as defined in Code section 152(f)(1). The definition of “child” for this purpose shall not include a child of your child.

However, an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical disability may be covered to any age if such physical or mental disability occurred before the child turned 26 years of age, the child is chiefly dependent on the Participant for support and maintenance, and the Participant has submitted proof (medical certification) of the child’s incapacity to the carrier prior to the child turning age 26 or within 31 days thereafter.

NOTE: The employee shall be required to present, upon request, to the employer certified documentation providing proof of parentage, spousal and/or dependent relationships, proof of the physically or mentally disabled, and proof of dependent eligibility status. This required documentation may be requested at any time to determine eligibility status.

NOTE: If full-time student status is required for coverage of any Dependent children, this Plan will comply with Michelle’s Law, Code section 9813. Michelle’s Law provides for continued coverage if the Dependent would otherwise lose coverage due to loss of full-time student status at a postsecondary educational institution because of a medically necessary leave of absence that begins while the Dependent is suffering from a serious illness or injury. Coverage may continue for up to one year after the first day of the medically necessary leave of absence, ending earlier only if coverage under the Plan would otherwise terminate (such as reaching the maximum age requirement). Written certification by the Dependent’s treating physician is required stating that the leave is medically necessary and that the child is suffering from a serious illness or injury as defined in Michelle’s Law.

Coverage for a Dependent will be effective on the date the Employee’s coverage becomes effective if s/he applies for Dependent coverage when s/he enrolls in the Plan. In no

event will the Employee's Dependents be covered before the date the Employee's coverage begins. An Employee without a Dependent on the date s/he becomes eligible for coverage who later acquires a Dependent may enroll his/her Dependent in this Plan by written application within 30 days after s/he acquires that Dependent.

A newborn child, adopted child, or child placed for adoption will be covered if enrolled within the 30 day period following birth, adoption, or adoption placement. This Plan is intended to comply with OBRA '93 with respect to dependent child eligibility and Qualified Medical Child Support Orders. If coverage for a Dependent (including newborns, adopted children, or children placed for adoption) is applied for more than 30 days following the date that Dependent becomes eligible for coverage, the Dependent may only be able to enroll during the open enrollment/election period.

Additionally, for purposes of the BCBSM Plans, if two (2) Employees under this Plan are married and both want coverage, they may choose to both be covered as Employees, or one of them may be covered as the Employee and the other may be covered as a Dependent. However, eligible Dependent children of two (2) parents who are both covered under this Plan may be enrolled as Dependents of only one (1) of the Employees. In the event that one (1) Employee's coverage should terminate, his/her eligible covered Dependents will be eligible to become covered Dependents under the remaining parent's Employee coverage.

B-2. **When Must I Elect Coverage Under the Plan?**

Initial Election Period

An Employee who does not apply for coverage within thirty (30) days of the date he or she becomes eligible for coverage may only be able to enroll during the open enrollment / election period, unless otherwise required by law.

Open Enrollment / Election Period

An Employee and/or Dependent who wishes to make an election change, or who does not apply for coverage when initially eligible but later wishes to apply, may do so only during the open enrollment / election period in the Fall for an effective date of January 1. However, an election change may be made before the open enrollment/election period as provided in Section B-4 if a special enrollment event occurs such as marital status change, change in number of Dependents or dependent status, other eligibility change, involuntary loss of coverage from another Plan, or another event legally requiring mid-year enrollment and if the change in election request is timely submitted.

B-3. **When Will My Participation Begin?** Unless otherwise provided in the Component Benefit Programs or the collective bargaining agreements, and as long as all required enrollment materials are completed and submitted by you, your participation in the Plan as an Employee or Retiree will begin on the later of the Effective Date of this Plan or the date you become eligible to participate, at which time you will become a "Participant."

B-4. **HIPAA Special Enrollment.** An Employee or Participant may revoke an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f). Unless otherwise provided, such change shall take place on a prospective basis.

(a) As required by HIPAA, a 30-day special enrollment right will arise if:

(1) A current Employee is eligible for, but declined enrollment in, this group health plan coverage (or a Dependent of such Employee is eligible for, but was not enrolled in, this group health plans coverage) because the Employee or Dependent was covered under another group health plan or had other health insurance coverage when this group health plan coverage was previously offered and the other coverage was lost due to either: (i) if the other coverage was COBRA continuation coverage, that coverage has been exhausted; or (ii) if the other coverage was not COBRA continuation coverage, either the coverage was terminated as a result of loss of eligibility for the coverage (including, but not limited to, as a result of legal separation, judgment of separate maintenance, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment; in the case of an HMO, the individual no longer resides, lives or works in the service area where the HMO provides benefits and, in cases of the group market, no other package is available to the individual; an individual incurs a claim meeting or exceeding a lifetime limit on all benefits; or the plan no longer offers any benefits to the class of similarly situated individuals that includes the individual), or employer contributions towards such coverage were terminated. Unless otherwise provided in the Component Benefit Programs, the eligible Employee must request enrollment not later than 30 days after the loss of other coverage (or after a claim is denied due to the operation of a lifetime limit on all benefits). Any eligible Dependent may only enroll if that Dependent (or the Employee) meets the above requirements; or

(2) A new Dependent is acquired as a result of marriage, birth, or adoption or placement for adoption, and the group health plan makes coverage available with respect to a Dependent of a Participant or an Employee who has met any waiting period requirements and is eligible to participate under that plan. Unless otherwise provided in the Component Benefit Programs, these election changes to add coverage must be made within 30 days of the date of the marriage, birth or adoption or placement for adoption (or the date dependent coverage is made available, if later). An election to add the following individuals (if otherwise eligible for coverage under the Plan) as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption is consistent with the special enrollment right: (i) a current Employee who is eligible but not enrolled; (ii) a current Employee who is eligible but not enrolled, and the Spouse of such Employee; (iii) a current Employee who is eligible but not enrolled, and the newly acquired Dependent of such Employee; (iv) the Spouse of a Participant; (v) a current Employee who is eligible but not enrolled, and the Spouse and newly acquired Dependent; and (vi) a newly acquired Dependent of a Participant.

Enrollment applications received after the special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Unless otherwise provided in the Component Benefit Programs, coverage under the special enrollment period for timely submitted requests must be effective no later than the first day of the month

after the plan or issuer receives the request for special enrollment. However, with regard to enrollment requests made within 30 days on behalf of a new Dependent acquired due to birth, adoption, or placement for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for adoption (or the date the plan makes dependent coverage available, if later).

(b) As required by HIPAA, effective April 1, 2009, a 60-day special enrollment right will arise if the Employee or Dependent is eligible for, but not enrolled in, the Plan and either:

(1) loses coverage under Medicaid, specifically if the Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for coverage; or

(2) becomes eligible for a Medicaid subsidy, specifically, if the Employee or Dependent becomes eligible for premium assistance, with respect to coverage under the Plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Employee or Dependent with the special enrollment right under subsection (b) must request enrollment within the first 60 days from the date of termination of such coverage under (b)(1) or 60 days from the date the applicant is determined to be eligible for premium assistance under (b)(2). Enrollment applications received after the 60-day special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Coverage under this Plan shall take effect on the same date coverage for this HIPAA special enrollment right takes effect in the underlying Component Benefit Programs.

This Section only applies to group health plan coverage covering two or more Employees within the Component Benefit Programs. This Section does not apply to retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, specified disease or fixed indemnity coverage or health flexible spending accounts that qualify as "excepted benefits," as defined in Treasury Regulations section 54.9831-1(c).

B-5. **PPACA Special Enrollment**

(a) As required by the PPACA, effective the first day of the first plan year beginning on or after September 23, 2010, a 30-day special enrollment right will be available to any child (i) whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26; and (ii) who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010. The plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice

of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage shall take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(b) As required by the PPACA, effective the first day of the first plan year beginning on or after September 23, 2010, a 30-day special enrollment right will be available to any individual (i) whose coverage or benefits under a group health plan or group health insurance coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits for any individual; and (ii) who becomes eligible (or is required to become eligible) for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010. The plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. If the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage shall take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(c) This Section only applies to group health plan coverage covering two or more Employees within the Component Benefit Programs. This subsection does not apply to retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c).

B-6. **When Will My Participation End?** Unless otherwise provided in the Component Benefit Program documents or collective bargaining agreements, your participation in the Plan will automatically cease at 11:59 p.m. on the earliest of the following dates:

(a) date you terminate employment with Employer or are laid off;

(b) date you cease to be in a class of employees eligible for coverage;

(c) date you fail to make any required contribution for coverage;

(d) date the Plan is terminated;

(e) date Employer terminates coverage;

(f) (1) the original effective date of coverage if coverage is rescinded due to misrepresentation on your enrollment application; (2) however, effective January 1, 2011, a group health plan or a health insurance issuer offering group health plan coverage (the “plan”)

shall not rescind (i.e., cancel or discontinue coverage retroactively when such cancellation or discontinuance is not attributable to a failure to timely pay required premiums towards the cost of coverage) coverage under the plan, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan, unless the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded. This subsection (f)(2) shall only apply for group health plan coverage covering two or more Employees within the Component Benefit Programs (but not for retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c);

(g) the date of your death. However, upon a Retiree's death, coverage for the Retiree's Spouse who was covered under this Plan on the date of the Retiree's death, spousal coverage continues for the life of the surviving Spouse (unless the Retiree had selected a Straight Life retirement option);

(h) the date you otherwise lose eligibility under the Plan;

(i) the date you revoke your election as permitted under the terms of the relevant Component Benefit Program; or

(j) for Retirees, the date you become entitled to Medicare, at which time you will be enrolled in the HUMANA Medicare Advantage Plan; any medical and prescription coverage for your Dependents at the time of your Medicare entitlement will continue under this BCBSM Plan as long as you are enrolled in HUMANA, until such coverage is otherwise terminated as specified below.

Other circumstances can result in the termination, reduction or denial of benefits. You should consult the Component Benefit Program documents for additional information. Termination of participation will automatically revoke your elections and benefits as of the dates specified in the Component Benefit Program documents. You may also be entitled to continue certain benefits pursuant to state and federal law after your participation ends. Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), a former Participant (or his or her covered Spouse or Dependent children) may be able to elect to continue certain group medical benefits provided under this Plan for a limited period of time by paying the cost of the benefits.

When Dependent Coverage is Terminated:

Generally, your Dependents will lose coverage under the Component Benefit Programs as of the earlier of the date they are no longer eligible or at the same time you lose coverage for any of the events listed above. Please see the Component Benefit Program documents for more details.

With regard to the BCBSM Plans, your Dependents will lose coverage as of the same time you lose coverage for any of the events listed above, unless otherwise provided for Retirees.

Additionally, and unless otherwise provided in the Component Benefit Programs, coverage of any Dependent under the BCBSM Plans will automatically cease at 11:59 p.m. on the date your Dependent loses his/her eligible status as defined below, unless coverage is otherwise required to continue by law:

(a) for Spouses:

(1) upon judgment of separate maintenance or legal separation (if applicable within your State); or

(2) upon divorce.

(b) beginning January 1, 2011, for Dependent children:

(1) the day prior to the date the child reaches age 26; or

(2) in the case of a disabled Dependent, upon the Dependent being medically certified as no longer incapable of self-sustaining employment by reason of mental retardation of physical disability.

B-7. **How May Benefits Be Continued under the BCBSM Plan?** In addition to the rights provided under COBRA, FMLA and USERRA as described in Article D, benefit coverage under the BCBSM Plan may be continued if an Employee is on an approved leave of absence. Please see the Employer's policies for further information.

B-8. **Procedure for Obtaining Certificate of Creditable Coverage**. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any exclusion periods for pre-existing conditions that might otherwise apply when changing coverage.

When your coverage through your employer ends, you will receive a certificate of creditable coverage which states that amount of time that you had coverage with your employer. You also may request a certificate for health coverage periods on and after July 1, 1996, at any time during your coverage or within 24 months after loss of coverage. To request a certificate of creditable coverage, please contact the following:

- For medical benefits:

Blue Cross Blue Shield of Michigan
PO Box 2888
Detroit, Michigan 48231
(800) 645-BLUE

C. BENEFITS

C-1. **Benefits**. This Plan offers the benefits set forth in Section A-4 through the Component Benefit Programs to Participants in this Plan and their eligible Dependents as provided under the terms of the Component Benefit Programs. Each of these Component Benefit Programs is summarized in a benefit booklet or CD issued by an insurance company or third-party administrator, a summary plan description or another governing document prepared by the Employer or authorized representative. All documents describing the Component Benefit Programs are incorporated by reference. (Please contact third-party insurers directly for information regarding network providers, if applicable). You must review these materials to understand your benefits.

Benefit summaries are attached to this Plan at Exhibit A. You can access further information regarding your benefits at www.bcbsm.com. You may also contact the Blue Cross customer service at 1-800-645-BLUE. Please contact Human Resources for more information.

The rights and conditions with respect to the benefits payable under the Component Benefit Programs shall be determined from the terms of those contracts and programs. This Summary Plan Description is not intended to expand or in any way increase the benefits available under those Programs. Any Participant (or Dependent of a Participant) who is receiving coverage under a fully insured program shall not have any claim against the Employer for any benefits provided. The Participant (and/or his or her Dependents) shall only have a right to recover from the particular insurer providing benefits. With respect to Component Benefit Programs that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws.

C-2. **National Medical Support Notices.** With respect to component benefit plans that are group health plans, the Plan will also provide benefits in accordance with the applicable requirements of any National Medical Support Notice conforming with section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105-200). The Plan has detailed procedures for determining whether a National Medical Support Notice is appropriately completed. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

C-3. **Patient Protection Disclosure.** The Jackson County Group Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the

participating primary care providers, contact the plan administrator at 120 West Michigan Avenue, Jackson, Michigan 49201 or by calling (517) 768-6602.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Jackson County Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator at 120 West Michigan Avenue, Jackson, Michigan 49201 or by calling (517) 768-6602.

D. CONTINUATION OF COVERAGE FOR GROUP HEALTH PLAN BENEFITS

D-1. **COBRA**. You may have the right to continue your group health plan benefits pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. Generally, this means you may be able to continue the same group health plan coverage that you had immediately before the Qualifying Event. It can also become available to your Spouse and Dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. Importantly, this Section only applies to group health plan coverage within the Component Benefit Programs (i.e., medical, prescription, dental, vision). It does not apply to non-health benefits.

If you are or were provided coverage under your Employer's group health plan, you are considered a "covered employee" or "covered retiree." The terms "covered employee," "covered retiree," and "you" are used interchangeably for purposes of this Section. Your Spouse and Dependent children who are covered under the same plan before the date of the Qualifying Event are considered to be "qualified beneficiaries." A qualified beneficiary also includes a child who is born to or placed for adoption with the covered employee during the COBRA coverage. These terms will be used throughout the remainder of this Section. The continuation coverage will not be conditioned on a physical examination or other evidence of insurability and will be identical to the coverage provided to similarly-situated employees or family members.

Unless otherwise provided in the insurance contracts or other governing documents, the following provisions shall apply.

(a) **Qualifying Event**. You are entitled to elect COBRA if you lose your group health plan coverage because your hours of employment are reduced or your employment ends for any reason other than your gross misconduct.

Additionally, if you are receiving coverage under this Plan as a retiree, you are entitled to COBRA continuation coverage under this Plan in the event you experience a loss of coverage resulting from the employer's bankruptcy proceeding under Title 11 of the United States Code. For this purpose, a loss of coverage includes a substantial elimination of coverage on or after the date of your retirement and within one year before or after the commencement of the employer's bankruptcy proceeding. Your spouse, surviving spouse and dependent children will also become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

Your spouse or eligible dependent children covered under the plan shall have the right to continuation coverage for themselves if they lose coverage under the plan for any of the following reasons:

(1) your death;

(2) the termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment;

(3) your divorce, judgment of separate maintenance, or legal separation (or if your spouse's group health coverage is reduced or eliminated by the employee in anticipation of a divorce, judgment of separate maintenance, or legal separation which later occurs);

(4) you become entitled to Medicare; or

(5) your dependent child ceases to be a covered dependent.

An event described above is only a "Qualifying Event" if it causes a loss of coverage under the group health plan.

(b) **Type of Coverage**. Continuation coverage under this provision is coverage which is identical to the coverage provided to similarly-situated beneficiaries under the group health plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under the plan is modified for any group of similarly-situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under the plan in connection with such group.

(c) **Duration of Coverage**. The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event listed below (unless otherwise provided) and ending not earlier than the earliest of the following:

(1) In the case of a terminated covered employee (except for termination for gross misconduct) or a covered employee whose hours have been reduced, and his or her qualified beneficiaries, the date which is 18 months after the Qualifying Event;

(2) In the case of retiree coverage where there is a loss of coverage due to bankruptcy proceeding under Title 11 of the United States Code, with respect to the employer from whose employment the covered retiree retired at any time, the lifetime of the retiree or the retiree's surviving spouse who is a qualified beneficiary; or for the surviving spouse and dependent children, 36 months after the date of the retiree's death;

(3) In the case of any Qualifying Event except as described in (c)(1) or (2) above, for the qualified beneficiaries, the date which is 36 months after the date of the Qualifying Event;

(4) In the case of a covered employee or qualified beneficiary who is disabled at some point before the 61st day after the Qualifying Event as described in (c)(1) and the disability lasts until the end of the 18-month period, the date which is 29 months after the Qualifying Event, provided the Administrator is given proper notice of the Social Security disability determination within 18 months of the Qualifying Event and within 60 days of the later of (i) the disability determination; (ii) the Qualifying Event; or (iii) the date coverage was lost as a result of the Qualifying Event;

(5) In the case of a second Qualifying Event (must be an event described in (c)(3)) which occurs during the 18 months after the first Qualifying Event described in (c)(1), for the qualified beneficiaries, the date which is 36 months after the date of the first Qualifying Event;

(6) In the case of a loss of coverage due to termination (except for gross misconduct) or reduction in hours of a covered employee which occurs within 18 months after the employee's entitlement to Medicare, for the qualified beneficiaries, the date which is 36 months from date of entitlement to Medicare;

(7) The date on which the participating Employer ceases to provide any group health plan to any employee/retiree;

(8) The date on which coverage ceases under the plan by reason of failure to make timely payment of the required contribution pursuant to this provision;

(9) The date on which the covered employee/retiree or qualified beneficiary first becomes, after the date of the election, covered under any other group health plan, (as an employee or otherwise) or becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the plan will not cease while such preexisting condition limitation under the other group plan remains in effect, subject to the maximum period of coverage limitations set forth in this Section;

(10) The first day of the month beginning more than 30 days after the date on which the disabled covered employee or qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(11) COBRA may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

(d) **Cost of Coverage**. The law permits the Employer to charge any person who elects to continue coverage 102 percent of the full cost to the plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. If coverage is continued due to a disability, the law permits the Employer to charge 150 percent of the full cost of the plan for the last 11 months of the 29-month period during which coverage may continue.

(e) **Payment of Premium.**

(1) A covered employee/retiree or qualified beneficiary shall only be entitled to continuation coverage provided that he or she pays the applicable premium required by the Employer in full and in advance, except as provided in (2) below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary or covered employee/retiree may elect to pay such premium in monthly installments.

(2) Except as provided in (3) below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under the plan.

(3) Notwithstanding (1) and (2) above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

(f) You Must Notify Plan Administrator of Certain Qualifying Events.

(1) The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. It is the responsibility of the covered employees/retirees and qualified beneficiaries to provide the following notices to the Plan Administrator:

(A) Notice of the occurrence of a Qualifying Event that is a divorce, judgment of separate maintenance, or legal separation of a covered employee/retiree from his or her spouse;

(B) Notice of the occurrence of a Qualifying Event that is a qualified beneficiary ceasing to be covered under the Plan as a dependent child;

(C) Notice of the occurrence of a second Qualifying Event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(D) Notice that a covered employee or qualified beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(E) Notice that a covered employee/retiree or qualified beneficiary: (i) with respect to whom a notice described in paragraph (1)(D) of this section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled, or (ii) subsequently becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of the other plan have been exhausted or satisfied).

(2) Notice to the Plan Administrator must be made in writing and must be mailed or hand-delivered to:

Human Resources Department
County of Jackson
120 West Michigan Avenue
Jackson, Michigan 49201

Oral notice or electronic notice (by e-mail or facsimile) is not acceptable. If mailed, the notice must be postmarked no later than the deadline described below. If hand-delivered, your notice must be received by the individual at the address above no later than the deadline described below.

(3) Required Contents of Notice. The notice must at a minimum contain the following information:

(A) the name of the Plan;

(B) the name and address of the employee or former employee who is or was covered under the Plan;

(C) the nature of this Qualifying Event, and, if applicable, the nature of the initial Qualifying Event that started your COBRA coverage, including any verifying documentation which may be required by the Plan Administrator;

(D) the date of this Qualifying Event, and, if applicable, the initial Qualifying Event;

(E) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the Qualifying Event or initial Qualifying Event, and, if applicable, whether those individuals are receiving COBRA coverage at the time of this notice;

(F) if the notice is regarding a disability extension, the name and address of the disabled covered employee or qualified beneficiary;

(G) if the notice is regarding a disability extension, the date that the covered employee or qualified beneficiary became disabled;

(H) if the notice is regarding a disability extension, the date that the Social Security Administration made its determination of disability. Additionally, a copy of the Social Security Administration's disability determination letter must be attached;

(I) if the notice is regarding (a) the Social Security Administration subsequently determining that the covered Employee or Qualified Beneficiary is no longer disabled or (b) subsequent entitlement of Medicare or coverage under another group health plan, the initial Qualifying Event and the subsequent event terminating coverage and the dates they occurred; and

(J) the signature, name, and contact information of the individual sending the notice.

Furthermore, the Plan requires that the following documents, if relevant to the particular Qualifying Event, be provided with the notice: Death Certificate; Divorce Decree, Judgment of Separate Maintenance, or Legal Separation Agreement; Birth Certificate or Order of Adoption; Marriage Certificate; Social Security Administration's Disability Determination Letter; Spouse's Notice of Employment Termination or Proof of Loss of Coverage; Qualified Domestic Relations Order.

Any notice that does not contain all of the information required by the plan must be supplemented in writing within 15 business days upon request with the additional information necessary to meet the plan's reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this section. Otherwise, you will lose your right to elect COBRA.

(4) Time Periods To Provide Notice. If you do not provide notice in writing within the time period provided below, you will lose your right to elect COBRA:

(A) Time limits for notices of Qualifying Events. The notice described in paragraph (f)(1)(A), (B), or (C) of this section must be furnished within 60 days after the latest of: (i) the date on which the relevant Qualifying Event occurs; or (ii) the date on which the covered employee/retiree or qualified beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event.

(B) Time limits for notice of disability determination. A notice described in paragraph (f)(1)(D) of this section must be furnished before the end of the first 18 months of continuation coverage and within 60 days after the latest of: (i) the date of the disability determination by the Social Security Administration; (ii) the date on which the

Qualifying Event occurs; or (iii) the date on which the covered employee or qualified beneficiary loses (or would lose) coverage under the plan as a result of the Qualifying Event.

(C) Time limits for notice of change in disability status, subsequent Medicare entitlement or coverage under another group health plan. The notice described in paragraph (f)(1)(E) of this section must be furnished within 30 days after the date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the covered employee or qualified beneficiary is no longer disabled or the date the covered employee or qualified beneficiary becomes entitled to Medicare or covered under other group health plan coverage.

(5) Person to Provide Notice. With respect to each of the notice requirements of this section, any individual who is either the covered employee/retiree, a qualified beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered employee/retiree or qualified beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the Qualifying Event.

(g) **Employer Must Notify Plan Administrator of Certain Qualifying Events**. When the qualifying event is the end of employment or reduction of hours of employment, death of the covered employee/retiree, enrollment of the covered employee/retiree in Medicare (Part A, Part B, or both), or commencement of a bankruptcy proceeding of the employer, the employer must notify the Plan Administrator within 30 days of the Qualifying Event.

(h) **Notification to Qualified Beneficiary**. The Plan Administrator has 14 days (or 44 days in the case where the Employer is the Administrator and the Employer had to furnish a notice of a Qualifying Event to the Plan Administrator) to send you and your spouse notification of your COBRA rights and the cost, if any, for continuation coverage.

(i) **Election of COBRA**. You and your qualified beneficiaries each will have an independent right to elect COBRA continuation coverage and shall have 60 days to elect COBRA from the date of notice or the date of the event, whichever is later. Covered employees/retirees and spouses who are qualified beneficiaries may elect COBRA coverage on behalf of all other beneficiaries, and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA coverage.

You then shall have 45 days to pay for any required premium. Thereafter, payment is timely if made within the time periods of the Plan or 30 days of the due date.

(j) **Special Election Period**. Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already

elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Employer promptly or you will lose the right to elect COBRA during a special second election period.

(k) **Interaction with FMLA**. If your employer is subject to the Family and Medical Leave Act and you do not return to work from your FMLA leave, you and your qualified beneficiaries may be entitled to continuation coverage under COBRA. A qualifying event under COBRA will occur if (1) you and your qualified beneficiaries are covered under your employer's group health plan on the day before the first day of FMLA leave; (2) you do not return to work with the employer at the end of the FMLA leave, and (3) you and your qualified beneficiaries would, in the absence of COBRA, lose coverage under the group health plan before the end of the maximum coverage period. The Qualifying Event would occur on the last day of the FMLA leave. The last day of FMLA leave may be the date you notify the employer that you will not be returning to work, if the notification was given before the FMLA was set to expire.

D-2. **What Happens to My Coverage if I Take Leave Under the Family and Medical Leave Act (FMLA)?** If your employer is subject to the Family and Medical Leave Act, this Plan shall at all times comply with applicable requirements of that Act and its underlying regulations. During any leave taken under the FMLA, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the Employee had been continuously employed during the entire leave period. Benefit coverage may be continued for all benefits up to the time limit allowed for an approved leave of absence that qualifies under FMLA.

If, during FMLA leave, the Employee does not wish to receive some or all of the coverage that he or she was receiving just prior to leave, the Employee must inform the Plan Administrator prior to the start of leave of which coverage will be dropped. If the Employee decides not to receive some or all of the covered medical benefits during FMLA leave, he or she may reinstate the same coverages upon return to work at the conclusion of FMLA leave.

If the Employee wishes to continue participation in the Plan, he or she must make arrangements with the Plan Administrator to pay for the coverages (in which the Employee is currently enrolled) that he or she wishes to maintain during the course of leave. Eligibility to continue any coverage, which requires payments from the Employee, may be cancelled if he or she does not make the required payments during the period of FMLA leave.

If the Plan Administrator advances money by making any or all of these required payments for the Employee, it can recoup the amounts advanced through payroll deductions and by other means upon the Employee's return to employment following FMLA leave, to the extent permitted by law.

If the Employee fails to return from FMLA leave, and the reasons for failure are not beyond the Employee's control, the Employee is indebted to Employer for the full amount of the cost of health coverage provided during FMLA leave. Employer intends to deduct any such amounts owed by an Employee from any compensable time payments owed to such Employee upon termination for failure to return from an FMLA leave, to the extent permitted by law. Employer may also use other means necessary to recoup these health care coverage costs.

An Employee should consult with the Plan Administrator before embarking on any FMLA qualified leave.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

This Section only applies to group health plan coverage within the Component Benefit Programs.

D-3. **What Happens to My Coverage if I Take Leave Under the Uniformed Services Employment and Reemployment Rights Acts (USERRA)?** Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you take leave under USERRA, to the extent required by USERRA, your Employer may continue to maintain your benefits on the same terms and conditions as if you were still an active Employee.

Employees going into or returning from service in the uniformed services may have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to Employees and their Dependents covered under the Plan before the Employee left for military service. To be entitled to USERRA rights, the Employee must give the Employer advance notice of the Employee's absence from employment for uniformed service, unless precluded by military necessity or if it is otherwise impossible or unreasonable under all the circumstances. Additionally, subject to certain exceptions, the Employee's absence from work may not exceed five years.

USERRA rights include up to 24 months of continued health care coverage. For periods of leave less than 31 days, the Employee only needs to pay his or her normal portion of the premium. For periods of leave 31 days or more, coverage will only be extended upon payment of the entire cost of coverage plus a reasonable administration fee.

Moreover, if coverage was terminated due to an Employee's service in the uniformed services, and the Employee is reemployed under USERRA, the Employee is entitled to reinstatement in the Plan. No preexisting conditions limitations will be applied in the Plan upon return from service. However, Plan exclusions and waiting periods may be imposed for any

illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

USERRA rights terminate if the Employee's discharge from the uniformed service was a result of "dishonorable" or other undesirable conduct, the Employee fails to report back to work or apply for reemployment within the time period required under USERRA, or if the Employee fails to pay coverage premiums. More information about coverage available pursuant to USERRA is included in the Component Benefit Program documents, or posted at your worksite.

The time periods within which to elect and pay for USERRA continuation of coverage shall be the same time periods within which to elect and pay for COBRA coverage under the Plan. If both USERRA and COBRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage.

This Section only applies to health plan coverage within the Component Benefit Programs.

E. CLAIMS REVIEW PROCEDURE IN GENERAL

E-1. **In General.** The term "Administrator" shall also mean "Contract Administrator" for purposes of this Article only. Specifically, the term "Administrator" shall mean the relevant Administrator or Contract Administrator who is administering benefits under the particular Component Benefit Program.

Claims procedures and appeals set forth in the Insurance Contracts and the Component Benefit Programs control; this Article supplements those documents to the extent required by the PPACA and to impose the limitations period for filing suit.

Claims for benefits incorporated in this Plan shall be submitted to the relevant Administrator. For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Programs provided through the Employer's general assets, the Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

If you think an error has been made in determining your benefits, then you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Administrator. If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

E-2. **How do I Make a Claim**? Generally, the provider will file all claims. However, in some circumstances, nonparticipating providers may not file a claim. In those cases, a claimant shall make a claim for benefits by making a request pursuant to the procedures specified in the claim forms provided by the Administrator. The Administrator has the right to

secure independent medical advice and to require such other evidence as it deems necessary to decide your claim. The Administrator will decide your claim in accordance with reasonable claims procedures, as required by the PPACA. If the Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Administrator for a review of the denied claim. The Administrator will decide your appeal in accordance with reasonable claims procedures, as required by the PPACA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). See the Component Benefit Plan documents for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

E-3. **What if My Benefits are Denied**?

(a) In general, your request for Plan benefits will be considered a claim for Plan benefits and will be subject to a full and fair review. If your claim is wholly or partially denied, the Administrator will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Administrator, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines that an extension is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

(b) A pre-service non-urgent care claim is one where the receipt of the benefit is conditioned on approval before the service is rendered. If your claim involves a pre-service determination, the Administrator shall notify you of the benefit determination within a reasonable time, but no later than 15 days after receipt of your claim if no further information is required. This period may be extended one time for 15 additional days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan. The Administrator will provide you with written notice of the extension before the end of the initial 15-day period explaining the reason for the extension and the date the Administrator expects to make a decision. If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, but communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Administrator will provide oral notice (and in writing if requested) of the failure and the proper procedure to complete the claim, within five days of the failure. If the extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and you shall have 45 days to provide the information. Failure to respond in a timely and complete manner will result in a benefit denial.

(c) A post-service care claim is one that may be filed and approved after the service is rendered. If your claim involves a post-service claim, the Administrator shall notify you of the adverse benefit determination within a reasonable time, but no later than 30 days after receipt of your claim, if no further information is required. This period may be extended one time for 15 additional days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you prior to expiration of the initial 30-day period of the reason for the extension of time and the date by which the Administrator expects to render a decision. If the extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and you shall have at least 45 days to provide the information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

(d) A concurrent care decision is one where the Plan has approved an ongoing course of treatment and then the Plan reduces or terminates coverage for that course of treatment (other than by amendment or plan termination) before the end of the pre-approved course of treatment. This is an adverse benefit determination that can be appealed as a concurrent care claim. If your claim involves a reduction or termination of an ongoing course of treatment which the Plan had previously approved, the Administrator shall notify you of the benefit determination within a reasonable time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

(e) In the case of a concurrent care claim, if your claim involves a request to extend the course of treatment which the Plan had previously approved, the Administrator shall notify you of the benefit determination within 24 hours after receipt of the claim by the Plan, provided the claim is made at least 24 hours before the expiration of the period of time or number of treatments.

(f) An urgent care claim is any claim for which the application of the standard time periods for determining claims a prudent layperson would consider, or the patient's physician determines, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or for which delayed treatment would cause the patient severe pain. If your claim involves an urgent care decision, the Administrator shall notify you of the benefit determination as soon as possible, but not later than 72 hours after receipt of your claim. However, if you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, but communicates at least the name of the Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Administrator will provide notice of the failure and the proper procedure to complete the claim as soon as possible, but not later than 24 hours of the failure. You shall be afforded at least 48 hours to provide the specified information. The Administrator will notify you of the benefit determination as soon as possible, but not later than 48 hours of the earlier of receipt of the specified information or the end of the period in which you must provide the additional information.

(g) The Administrator's written or electronic notification of any adverse benefit determination must contain the following information:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the determination is based;

(3) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

(4) Appropriate information as to the steps to be taken if you or your beneficiary want to submit your claim for review, including a statement of your right to bring a civil action.

(h) In the case of a decision by a group health plan:

(1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the adverse benefit determination, will be provided free of charge to you upon request; and

(2) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances, or a statement of such explanation, will be provided free of charge upon request.

(i) In the case of an urgent care decision, you may be informed orally and will be sent a written notification within 3 days of the oral notification. You will also receive a description of the expedited review process for such claims.

(j) If your claim has been denied and you want to submit your claim for review, you must follow the Claims Review Procedure.

E-4. **What is the Claims Review Procedure**?

(a) Upon denial of your claim for benefits you may file your claim for review, in writing, with the Administrator.

(1) You must file the claim for review to the appropriate named fiduciary of the plan no later than 60 days after you have received written or electronic notification of an adverse benefit determination.

However, if your claim is for group health plan benefits, then instead of the above, you must file the claim for review to the appropriate named fiduciary of the plan no later than 180 days following receipt of notification of an adverse benefit determination.

(2) You may submit written comments, documents, records and other information relating to the claim for benefits.

(3) You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

(4) Your claim for review will be given a full and fair review. This review will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) In addition to the Claims Review Procedure above, if your claim is for group health benefits, then under the Claims Review Procedure:

(1) Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

(2) In deciding an appeal of any adverse benefit determination that is based in whole or part on medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(3) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in the determination.

(4) The health care professional engaged for purposes of a consultation under (2) above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(c) If your claim involves an urgent care decision, an expedited review will occur, which you may request orally or in writing. All necessary information, including the determination on review, shall be transmitted between you and the Administrator by telephone, facsimile or other available similarly expeditious method.

(d) The Administrator will provide you with written or electronic notification of the benefit determination on review. The Administrator must provide you with notification of this denial within 60 days after the Administrator's receipt of your written claim for review, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review. If your claim involves the following types of care, the corresponding time periods will apply:

(1) The Administrator shall notify you of the benefit determination on review concerning pre-service determinations within 30 days after receipt of your request of review.

(2) The Administrator shall notify you of the benefit determination on review concerning post-service determinations within 60 days after receipt of your request of review.

(3) The Administrator shall notify you of the benefit determination on review concerning the urgent care determinations within 72 hours after receipt of your request for review.

(e) In the case of an adverse benefits determination, the written or electronic notification will set forth:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the benefit determination is based;

(3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;

(4) If any voluntary appeal right exists, a statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures and a statement of your right to bring an action;

(5) In the case of a claim for group health benefits:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon in making the adverse determination, will be provided to you free of charge upon request;

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances, or a statement of such explanation, will be provided free of charge upon request.

(f) If you have a claim for benefits which is denied upon review, in whole or in part, you may file suit in a state or federal court; however, such suit must be brought within three years of the denial upon review.

F. PPACA CLAIMS PROCEDURE AND APPEAL

This Article F shall apply to non-Grandfathered Plans providing group health plan coverage covering two or more Employees within the Component Benefit Programs (but not for retiree-only plans, limited-scope vision or limited-scope dental plans, accident or disability plans, life insurance, health flexible spending accounts, or other Component Benefit Programs that qualify as "excepted benefits," as defined in Treasury Regulation section 54.9831-1(c)) for plan years beginning on or after September 23, 2010. This Plan is a non-Grandfathered Plan.

F-1. **Minimum Internal Claims and Appeals Standards.** A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503-1 and Article E, except to the extent those requirements are modified or expanded by this Article F.

F-2. **Additional Internal Claims and Appeals Standards.** In addition to the applicable requirements set forth in Section F-1, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the following requirements:

(a) Full and fair review. A plan and issuer must allow you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements set forth in Section E-4:

(1) The plan or issuer must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under Section E-4(d) to give you a reasonable opportunity to respond prior to that date; and

(2) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date of which the notice of final internal adverse benefit determination is required to be provided under Section E-4(d) to give you a reasonable opportunity to respond prior to that date;

(b) Avoiding conflicts of interest. In addition to the requirements of 29 CFR 2560.503-1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits;

(c) Notice. Effective the first day of the first plan year beginning on or after January 1, 2012, a plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as set forth in 29 C.F.R. 2590.715-2719(e) with respect to applicable non-English languages) that complies with the requirements of 29 C.F.R. 2560.503-1(g) and (j). Effective the first day of the first plan year beginning on or after July 1, 2011 (unless a different effective date is set forth below in this paragraph), the plan and issuer must also comply with the following requirements:

(1) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable);

(2) Effective the first day of the first plan year beginning on or after January 1, 2012, the plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(3) The plan and issuer must provide to you and your beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under Sections F-1, F-2, or F-3, or an external review under Section F-4;

(4) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(5) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(d) Deemed exhaustion of internal claims and appeals processes. Effective the first day of the first plan year beginning on or after January 1, 2012,

(i) In the case of a plan or issuer that fails to adhere to all the requirements of Sections F-1, F-2, and F-3 with respect to a claim, you are deemed to have exhausted the internal claims and appeals process of this Article F except as provided in subparagraph (ii) of this paragraph (d). Accordingly, you may initiate an external review under Section F-4. You are also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If you choose to pursue remedies under section 502(a) of ERISA under such

circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(ii) Notwithstanding subparagraph (i) of this paragraph (d), the internal claims and appeals process of this Article F will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and you. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. You may request a written explanation of the violation from the plan or issuer, and the plan or issuer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this Article F to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review under subparagraph (i) of this paragraph (d) on the basis that the plan met the standards for the exception under this subparagraph (ii) of this paragraph (d), you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the plan shall provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

F-3. **Provision of Continued Coverage Pending the Outcome of an Appeal.** A plan or issuer subject to the requirements of Sections F-1 and F-2 are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of Sections E-3(d) and (e), which generally provide that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

F-4. **External Review Process**

(a) In general. You may have the right to file a request for an external review of an adverse determination or final adverse determination with the plan. You may contact the Plan Administrator for more detailed information related to the external review process. The plan can be reached at (517) 768-6602 or 120 West Michigan Avenue, Jackson, Michigan 49201.

(b) For fully-insured plans and self-insured nonfederal governmental plans,

(1) Through December 31, 2011, an applicable State external review process is binding on the issuer or plan. If there is no applicable State external review process, the issuer or plan is required to comply with the requirements set forth in paragraph (c) of this Section F-4. For final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided on or after January 1, 2012, the external review process set forth in paragraph (c) of this Section F-4

will apply unless the Department of Health and Human Services determines that a State law meets all temporary standards set forth in subparagraph (2) of this paragraph (b).

(2) Beginning January 1, 2012, and until the earlier of January 1, 2014 or the date an applicable State enacts an NAIC-parallel process, issuers and self-insured nonfederal governmental plans shall comply with an applicable State external review process that meets the following temporary standards (as set forth in Department of Labor Technical Release 2011-02):

(A) The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(B) The process provides for external review of adverse benefit determinations (and final internal adverse benefit determinations) involving experimental or investigational treatments or services and must have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(C) Issuers (or plans) are required to provide effective written notice to you of your right to external review in their summary plan descriptions and plan materials and on each notice of adverse benefit determination. These notice requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.

(D) If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (1) the internal appeal process timelines are not met; or (2) in an urgent care situation, you file for an external review without having exhausted the internal appeal process. These requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.

(E) The cost of an external review must be borne by the issuer (or plan), and you cannot be charged a filing fee in excess of $25 per external review.

(F) There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.

(G) You must have at least 60 days to file for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.

(H) The IRO must be assigned impartially. You and issuer (or plan) should have no discretion as to the IRO that is chosen.

(I) If the State contracts with, or otherwise identifies one or more IROs to provide external review, the State must have a process in place for quality assurance of IROs.

(J) If the State contracts with, or otherwise identifies one or more IROs to conduct external reviews, the State must ensure conflict of interest protections on the part of the IRO when it participates in external review decisions.

(K) The IRO decision is binding and must be enforceable by the State.

(L) For standard external reviews (those not involving urgent care), the IRO must inform the issuer and you, in writing, of its decision within 60 days from receipt of the request for external review.

(M) The process must provide for expedited external review of urgent care claims. In such cases, the IRO must inform the issuer and you of an urgent care decision within four business days or less (depending on medical exigencies of the case) from receipt of the request for review. If the IRO's decision was given orally, the IRO must provide written notice of its decision within 48 hours of the oral notification.

(3) Once an applicable State enacts an NAIC-parallel process (as determined by the Department of Health and Human Services), the external review process of that State law shall apply, unless the health insurance issuer or self-insured nonfederal governmental plan elects to follow a Federally administered external review process as permitted in subparagraph (5) of this paragraph (b).

(4) Beginning January 1, 2012, if a State process does not meet the standards set forth in subparagraphs (2) or (3) of this paragraph (b), health insurance issuers (and, if applicable, self-insured nonfederal governmental plans) in the State will be subject to the external review process set forth in paragraph (c) of this Section F-4. Additionally, if a State-administered process reduces consumer protections below the level that applies at the time the Department of Health and Human Services makes its finding, plans and issuers in the State will be required to participate in the external review process set forth in paragraph (c) of this Section F-4.

(5) Health insurance issuers and self-insured nonfederal governmental plans may elect to use a Federally administered external review process instead of the State process; specifically, such plans or issuers can elect to use the process set forth in paragraphs (b)(2) or (c) of this Section F-4 by timely submitting appropriate information to the Department of Health and Human Services.

(c) ERISA and/or IRC self-insured plans will comply with the external review requirements under the PPACA if the following procedures are adhered to: Subject to the suspension provision set forth in subparagraph (1) of this paragraph (c) (and except to the extent provided otherwise by the Secretary of the Department of Labor in guidance) the external review

process set forth in subparagraphs (2) and (3) of this paragraph (c) (i.e., the procedures set forth in Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-02) shall apply to any adverse benefit determination of final internal adverse benefit determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for external review process set forth in subparagraphs (2) and (3) of this paragraph (c).

(1) Unless or until this suspension is revoked in guidance by the Secretary of Labor, with respect to claims for which external review has not been initiated before September 20, 2011, the external review process set forth in subparagraphs (2) and (3) of this paragraph (c) applies only to: (i) an adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (ii) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(2) Standard external review for self-insured group health plans. This subparagraph (2) sets forth procedures for standard external review for self-insured group health plans. Standard external review is external review that is not considered expedited (as described in subparagraph (3) of this paragraph (c)).

(A) Request for external review. A group health plan must allow you to file a request for an external review with the plan if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(B) Preliminary review. Within five business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:

(i) You are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;

(ii) The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

(iii) You have exhausted the plan's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations; and

(iv) You have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the plan must issue a notification in writing to you. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow you to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(C) Referral to Independent Review Organization. The group health plan must assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan must take action against bias and to ensure independence. Accordingly, plans must contract with at least two (2) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between a plan and an IRO must provide the following:

(i) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.

(ii) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(iii) Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify you and the plan.

(iv) Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

(v) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) Your medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, you, or your treating provider;

(D) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with the applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(G) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(vi) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to you and the plan.

(vii) The assigned IRO's decision notice will contain:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;

(F) A statement that judicial review may be available to you; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(viii) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the plan, or the State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(D) Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

(3) Expedited external review for self-insured group health plans.

(A) Request for expedited external review. A group health plan must allow you to make a request for an expedited external review with the plan at the time you receive:

(i) An adverse benefit determination if the adverse benefit determination involves a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of you or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(ii) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

(B) Preliminary review. Immediately upon receipt of the request for expedited external review, the plan must determine whether the request meets the reviewability requirements set forth in subparagraph (2)(B) above for standard external review. The plan must immediately send a notice that meets the requirements set forth in paragraph (2)(B) above for standard external review to you of its eligibility determination.

(C) Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO pursuant to the requirements set forth in subparagraph (2)(C) above for standing review. The plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

(D) Notice of final external review decision. The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in subparagraph (2)(C) above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the plan.

(d) To the extent that benefits under a group health plan are provided through health insurance coverage, the health insurance issuer has primary responsibility to comply with the external review process set forth in this Section F-4.

G. COORDINATION OF BENEFITS

Coordination of Benefits involves coordinating payments between two separate plans that both cover the Employee and/or Dependents. Unless otherwise provided in Component Benefit Programs, this Coordination of Benefits provision shall apply.

G-1. **Order of Payment**. According to the following section outlining the order of payment, one plan will be designated as the primary plan and succeeding plans will be designated as secondary plans. The primary plan must pay benefits as if the secondary plan did not exist. The secondary plan would then adjust and reduce its expense payments so that the total benefit payable by both plans will not exceed 100% of allowable expenses. This Plan will never pay more than it would without this coordination provision.

If two Employees are parents of the same eligible Dependent child(ren), whether or not the parents are, or have ever been, married, the Plan will not coordinate benefit payments. More specifically, only one Employee parents may cover the same eligible Dependent child(ren).

When a person is covered under two or more plans, the rules below will apply to decide which plan's benefits are payable first:

(a) If one plan does not have a coordination of benefits provision, then it will be the primary payer on the claim. The plan with the coordination of benefits provision, such as this one, will be the secondary payer.

(b) The plan that covers the insured as a nondependent (i.e., as an employee, member, subscriber, or retiree) is primary over a plan that covers the insured as a dependent.

(c) In cases of coverage for a dependent child, the plan of the parent whose birthday falls earlier in the year is primary if:

(1) The parents are married; or

(2) The parents are not separated (whether or not they have ever been married); or

(3) A court decree awards joint custody without specifying that one parents has the responsibility to provide health care coverage.

If both birthdays are the same, then the plan covering the parent longest is primary.

(d) If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's

health care services or expenses, the order of benefit determination among the plans of the parents and their spouses, if any, is as follows:

(1) The plan of the parent with custody;

(2) The plan of the custodial parent's spouse;

(3) The plan of the parent without custody;

(4) The plan of the noncustodial parent's spouse.

(e) If a court decree states that one of the parents must pay health coverage, then that parent's plan pays primary (as long as the plan has actual knowledge of the court decree and its terms). If that parent has no coverage for the child's health care services, then the plan of that parent's spouse is primary (as long as the plan has actual knowledge of the court decree and its terms). This paragraph shall not apply with respect to any claim determination period or plan year during which the benefits are paid or provided before the plan has actual knowledge. (If it is determined that another plan is primary due to the terms of the divorce decree after the secondary plan has paid as primary, the secondary plan will not retroactively seek refunds of the overpayments it previously issued as the primary plan.

(f) A plan that covers a person as a former employee (or dependent of a former employee) is secondary to the plan that covers the person as an active employee (or an active employee's dependent). However, if the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule is ignored.

(g) If none of the above rules can determine the order of benefits, then the plan that covered the insured the longest pays before the plan which covered the person for the shorter period of time. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within 24 hours after the first ended. The start of a new plan does not include (1) a change in the amount of scope of a plan's benefits; (2) a change in the entity that pays, provides, or administers the plan's benefits; or (3) a change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan). A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(h) With regard to COBRA, the plan covering the person as an employee, member, subscriber, or retiree (as their dependent) is primary. The COBRA plan is secondary, unless the plan that would be primary contains pre-existing condition limitations. However, this rule is ignored if only one plan follow the COBRA rules and the plans do not agree on the order of benefits.

(i) If another plan contains a provision whereby such plan considers their plan to be excess of other available benefits or considers their plan to be secondary only in normal coordination of benefits situations, this plan will coordinate to consider benefits payable on a 50%/50% basis, between this plan and the other plan.

(j) If none of the above rules apply, then the expenses must be shared equally between the plans.

The total maximum benefit limits under this Plan will only be reduced by the charges actually paid by this Plan. Any benefits coordinated and paid by other coverage providers will not be charged against the benefit limits of this Plan.

G-2. **Coordination With Medicare**. This Plan is intended to comply with Federal Regulations with respect to Medicare coverage and coordination of benefits. When determining Medicare benefits, the Plan will base its payment upon benefits that have been paid by Medicare under Parts A and B, whether or not the covered Participant and/or Dependent has enrolled for the full coverage. In the case of services and supplies for which Medicare makes direct reimbursement to the health care provider, this Plan will coordinate its benefits based on the amount approved by Medicare and not the amount of the charge.

G-3. **Coordination With Medicaid**. Notwithstanding any other provisions of this Plan to the contrary, this Plan shall not take into account, with respect to Plan enrollment or the payment of benefits to a covered Participant and/or Dependent, that such Participant and/or Dependent qualifies for medical assistance under a state Medicaid plan.

H. MISCELLANEOUS

H-1. **Amendment or Termination of the Plan.** Although the Employer intends to continue the Plan, it reserves the right to amend or terminate the Plan or to modify the Plan to reduce, increase or modify any and all of the benefits provided under the Plan. Any decision to amend, terminate or modify the Plan shall be made by a written instrument by the Board of Commissioners or other governing body of your Employer or by any person or persons authorized by the Board of Commissioners to take such action. This decision shall be communicated to all participants in writing.

When changes are made to Component Benefit Programs, they are made in the form of amendments and/or summaries of material modification. The procedure for amending a plan is as follows:

(a) The proposed amendment request by the Plan Sponsor is sent to the Plan Administrator of the plan.

(b) The Plan Administrator develops an amendment and/or summary of material modification in accordance with the amendment request from the Plan Sponsor. The authorized representative for the County of Jackson will then approve and sign the amendment and/or summary of material modification.

(c) The approved amendment and/or summary of material modification becomes part of the plan document and summary plan description and is available to the Department of Labor upon request. Adoption of an amendment and/or summary of material modification shall be effective as of the date indicated within the document (to the extent permitted by law) upon approval by the Plan Sponsor.

Unless otherwise provided in the Component Benefit Programs, no Employee, Participant, Dependent or any other person shall have any further right, title, interest or claim, legal or equitable, in or to any reimbursement or benefit payable under such Plan beyond the date in which such Plan or benefit is terminated. Assets remaining in the Plan upon termination arising from employer contributions will revert to the Employer. Information concerning asset distribution after termination of the Plan shall be made available by the Plan Administrator at no cost upon written request.

H-2. **No Contract of Employment.** The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time.

H-3. **Subrogation, Reimbursement and Third Party Recovery Provision**. Unless otherwise provided in the Component Benefit Programs, the Plan shall have the following rights:

(a) Benefits under the Plan shall be paid second to other rights of recovery and will be paid only if the Participant fully adheres to the terms and conditions of the Plan. The Plan shall have the right to recover from the Participant or beneficiary any payment for benefits paid by the Plan to which the Participant or beneficiary is entitled to recover from a third person, including but not limited to any liability insurance, uninsured/underinsured motorist proceeds, or other health plan. Specifically, the Plan has a first lien upon any recovery, whether by settlement, judgment or otherwise that the Participant or beneficiary receives from a third person, not to exceed the amounts of benefits paid by the Plan or the amount received by the Participant or beneficiary for such treatment. This lien or right of reimbursement exists regardless of (1) whether the money or other valuable consideration is designated as economic or non-economic damages; (2) whether the recovery is partial or complete; and (3) who holds the money or other valuable consideration or where it is held. Any settlement or recovery shall first be applied to reimbursement of medical expenses paid by the Plan.

(b) If benefits are paid or payable by this Plan as the result of an action of a third party, this Plan shall be subrogated to all rights of recovery of any participant or beneficiary under this Plan in respect to such action. No Plan benefits shall be provided unless the Participant provides all information, documentation, and agreements required by the Plan or its agents to process a claim, including but not limited to, reimbursement and subrogation agreements as the Plan or its agents may request. Failure or refusal to execute such agreements or furnish such information does not preclude the Plan from exercising its rights to subrogation or obtaining full reimbursement. Participants receiving benefits under this Plan are obligated to avoid doing anything that would prejudice the Plan's rights, including but not limited to reimbursement.

(c) If any suit is filed, the Participant shall retain an attorney who will not assert the common fund, make-whole, or other apportionment actions in contravention of the Plan's reimbursement terms and that reimbursement shall be made immediately upon collection of any sum recovered regardless of its legal, financial or other sufficiency. The Plan shall be informed of when an attorney is hired to represent the Participant and the Participant shall inform his/her attorney of the Plan's rights.

(d) If a suit is filed, the Plan may cause to be recorded a notice of payment of benefits, and such will constitute a lien on any judgment recovered less a pro rata share of court costs.

(e) If suit is filed against the Participant to enforce this provision, the Participant agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

(f) If a person to whom benefits are paid or payable under this Plan fails to bring suit promptly against a third party, the Plan may institute suit against such third party in its own name or in the name of such person and the Plan shall be entitled to retain from any judgment the amount of benefits paid or to be paid to such person without reduction for court costs, attorney fees, comparative negligence, limits of collectability or responsibility, or otherwise. The remainder of any recovery shall be paid to such person or as the court directs.

(g) If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of applicable state law and whether the minor's representative has access or control of any recovery funds.

(h) The Plan Administrator has sole discretion to interpret the terms and conditions of this provision in its entirety and reserves the right to make changes as it deems necessary.

H-4. **Applicable Laws.** This Plan shall be construed, administered and enforced according to applicable state laws, to the extent not superseded by the Code, the Public Health Service Act ("PHSA"), or any other applicable federal law, including, but not limited to, COBRA, NMHPA, USERRA, the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, ("PPACA"), the Mental Health Parity Act, as amended ("MHPA"); the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"); the Genetic Information Nondiscrimination Act of 2008 ("GINA"); the Family and Medical Leave Act of 1993, as amended ("FMLA"); the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"); and the Women's Health and Cancer Rights Act of 1998, as amended ("WHCRA") and other group health plan laws to the extent required by such laws.

H-5. **Mastectomy Related Benefits.** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related medical and

surgical benefits under a group health plan and who elect breast reconstruction in connection with such mastectomy, coverage under that same group health plan will be provided in a manner determined in consultation with the attending physician and the patient, for:

(a) all stages of reconstruction of the breast on which the mastectomy was performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) prostheses and treatment of physical complications of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under that group health plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

H-6. **Newborns' and Mothers' Health Protection Act ("NMHPA").** Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

H-7. **ERISA Rights.** This Plan is exempt as a "governmental plan" from the provisions of ERISA. Any reference to ERISA within this document is for informational purposes only and does not cause this Plan to become subject to ERISA.

H-8. **Further Information**. You may obtain additional copies of the individual Plans or insurance contracts from the Employer's Human Resources Department. The Human Resources Department is also responsible for answering your questions relating to the individual Plans and insurance contracts under this document.

Exhibit A

Component Benefit Program Information

Jackson County
ADMINISTRATOR/CONTROLLER

Michael R. Overton, Administrator/Controller **Adam J. Brown, Deputy Administrator**

TO: Personnel and Finance Committee
Board of County Commissioners

FROM: Michael Overton, Administrator/Controller

SUBJECT: Pension Board Services Agreement

DATE: October 10, 2011

Motion Requested
Approve and authorize Administrator/Controller to sign the service contract between the Jackson County Employees' Retirement System Board and Jackson County, Michigan.

I. Background

A. The County has provided administrative services for the retirement system since its inception. While the employees charged with providing the services were paid like other County employees, they took direction from and reported to the Retirement Board. They considered themselves to be employees of the Retirement Board…not the County.

B. The Retirement Board has the legal authority to hire employees, but with that comes the legal responsibility for the employees. The Retirement Board was relying on the County's HR Department to provide all the legally mandated services and postings.

C. Non County employees working in the County building created inequities in the workplace that had an adverse affect on other employees' morale and performance.

D. Only County employees are legally eligible for County benefits such as BC/BS.

II. Current Situation

A. The retirement of the Pension Coordinator provides an opportunity to modify the relationship with the Retirement Board by means of a service contract in which the Retirement Board contracts with the County for administrative services.

III. Analysis

A. **Strategic** - This service agreement provides for an improved work environment and a more efficient use of tax dollars.

B. **Financial** - This service contract requires the retirement system to pay the full cost of administering the program.

C. **Legal** - Current employees and retirees will be better served by co-locating retirement personnel with the County's current HR Department.

D. **Timing** - Given the retirement of the Pension Coordinator, the transition to a contractual relationship is timely and should go smoothly.

IV. Recommendation

The County Administrator/Controller and the Jackson County Retirement System Board recommend approval of the service contract.

Attachments: Service Contract

SERVICE CONTRACT BETWEEN JACKSON COUNTY EMPLOYEES' RETIREMENT SYSTEM AND JACKSON, COUNTY MICHIGAN

THIS CONTRACT is made this 22d day of September, 2011 by and between the Jackson County Employees' Retirement System (hereafter called Client) and the County of Jackson, Michigan (hereafter called Contractor), whose principal office is located at 120 W. Michigan Avenue, Jackson, MI 49201; for the purpose of providing staff/administrative services for the Client.

NOW, THEREFORE, the Client and Contractor, for the considerations stated herein, mutually agree as follows:

Article I: <u>This contract contemplates the following services:</u>

a. The Client (Jackson County Employees' Retirement System Board of Trustees) shall establish policy for the pension system and shall establish, monitor and govern its own investment policies of the pension system.

b. The Contractor shall provide staff charged with the day-to-day administration of the Client's retirement system. These staff shall be employees of the Contractor.

c. The Contractor's staff shall perform the following general duties to include, but not limited to: attend meetings of the Client's Board of Trustees; take minutes of said meetings; provide customer service for members of the Jackson County Employees' Retirement System including pension estimates, calculations, responses to employee/retiree inquiries, handling all related pension benefit correspondence and applications, report generation and other such reasonable duties that the Board requests.

Article II: <u>Cost/Services Reimbursement:</u>

Client shall compensate Contractor for its services, and provide other reasonable cost allocations as follows via Contractor's typical cost allocation/reimbursement process:

1. Staffing up to 1.75 full-time equivalents (FTEs).

2. Allocated Costs (includes building and equipment use, information technology support, and Administrative Services) based upon the most recent Maximus cost allocation study. Upon annual receipt of the Maximus report the Contractor shall provide the Client the Employee Retirement System portion of the Maximus report within 60 days.

The costs for the above may be adjusted annually as market, financial or organizational conditions warrant.

Client and Contractor shall comply with all applicable State of Michigan, federal, and local laws and regulations in the administration of all contractual responsibilities.

SERVICE CONTRACT BETWEEN JACKSON COUNTY EMPLOYEES' RETIREMENT SYSTEM AND JACKSON, COUNTY MICHIGAN

Evaluation: The Contractor will annually seek Client input regarding the performance of the employees assigned to the Employee Retirement System operations.

Termination Clause: Either Party may terminate this contract with ninety (90) days written notice.

Authority: Contractor and Client certify that the below named individuals have the authority to enter into this Contract on behalf of their respective organizations, and voluntarily do so on the date indicated below. Any changes to this contract shall be made pursuant to an addendum, signed by both parties.

CLIENT:

By: _____ 9-22-11
Jackson County Employees' Retirement System Date

CONTRACTOR:

By: _____ _____
Michael Overton, Administrator/Controller Date

Jackson County
ADMINISTRATOR/CONTROLLER

Michael R. Overton, Administrator/Controller **Adam J. Brown, Deputy Administrator**

TO: Personnel & Finance Committee
Board of County Commissioners

FROM: Michael R. Overton
Administrator/Controller

SUBJECT: Hiring of Equalization Director

DATE: October 3, 2011

Motion Requested
Waive Personnel Policy 3100 to allow for the Administrator/Controller to conduct the recruitment and selection of the County Equalization Director with the Board of Commissioners ratifying the selection.

I. Background

A. The County Equalization Director position was vacated in August of 2011.

B. The Board of Commissioners established Policy 3100 in October 2004, which specifies the procedures for hiring Department Heads.

C. The policy specifies that a member of the Board of Commissioners is to be involved in the selection of the Equalization Director among other department heads.

D. The Board has waived the policy for the previous two department heads hired within the last year, which include the Human Resources Director and the Department on Aging Director.

II. Current Situation

A. The Administrator/Controller's Office is requesting that we be authorized to proceed with the recruitment and selection without adherence to Policy 3100 for the involvement of a member of the Board of Commissioners on the hiring panel. The Board of Commissioners will still be required to ratify the selection of the Equalization Director in a public meeting as per policy.

B. The recruitment is still open, but we are prepared to begin the interview process.

C. Upon selection of a candidate by a hiring panel selected by the Administrator/ Controller, the Board of Commissioners will approve the candidate at the next Board Meeting.

III. Analysis

A. **Strategic** – The Equalization Director will be expected to be a part of the leadership of Jackson County. We intend to question the candidates about their ability to participate in the Board's strategic plan and in the improved work environment team. Furthermore, having recently begun to contract assessing in one of the County's townships, we are looking for a candidate who can fulfill the Board's goal of intergovernmental cooperation.

B. **Financial** – Given the state requirements for certification, the candidate pool for Equalization Directors is typically small. As was the case for the previous Equalization Director, we may have to hire outside of the current pay grade to adapt to market conditions.

C. **Legal** – Given the size of Jackson County and the businesses that must be equalized, Jackson County is required to have a Level 4 Assessor certified by the state, or a candidate that can be certified within the next year.

D. **Timing** – The Equalization Director fills critically needed services for the County with regard to completing state mandated equalization functions. We have received great cooperation from the State as we transition without an Equalization Director.

IV. Recommendation

The Administrator/Controller recommends the Board of Commissioners waive the requirement in Personnel Policy 3100 requiring a member of the Board of Commissioners to participate in the selection process and allow for the Administrator/Controller to conduct the recruitment and selection of the County Equalization Director with the Board of Commissioners ratifying the selection.

Attachments:

REGISTER OF DEEDS OFFICE
JACKSON COUNTY, MI

Mindy Reilly
Register of Deeds

Mona Webb
Chief Deputy

TO: County Affairs

FROM: Mona Webb
Chief Deputy, Register of Deeds

SUBJECT: Budget Adjustment

DATE: October 10, 2011

Motion Requested- Move $57,000 from Automation pooled funds to Contractual Services

I. Background

A. This project, to have data and images available on line dating back to 1965, was started in 2009. We had some delays but will now be finished by November 2011.

II. Current Situation

A. We budgeted for this project in 2010

B. Didn't get started until end of 2010 year and had returned monies to Pooled Accounts

III. Analysis

A. Strategic-

B. Financial- Possible increased revenue
Disaster recovery
Has no effect on the County General Fund

C. Customer- 24hour on line access to Register of Deeds records.

Jackson County Department on Aging
October 2011 Budget Adjustment Summary

	Revenue Change	Expense Change	Net Org Key Change
101670 Home Care	-12,777	7,525	20,302
101671 Senior Centers	2,300	275	-2,025
101672 Case Coord., MMAP, Chore, Adm.	9,334	2,764	-6,570
101673 Meals on Wheels	-200	15,507	15,707
101674 Congregate Meals	2,006	-17,299	-19,305
101678 Geriatric Mental Health	8,170	61	-8,109
	8,833	8,833	0

Summary:
The Department on Aging experienced various funding and staff changes throughout 2011.
(Specifics given on respective budget adjustment sheets.)
Net change to department budgets is zero.

M. Wandell

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
REVENUE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	670	676	006	Respite Care Grant	56,000		3,000	53,000
101	670	676	008	Prsnl Care Medicaid Wvr AAA	25,000		14,000	11,000
101	670	676	010	Grant-AAA	29,920		400	29,520
101	670	696	030	Caregiver Services Grant	11,050		890	10,160
101	670	696	045	Grant-Homemaker/Personal Care	120,000		1,500	118,500
101	670	696	047	Homemaker Medic. Waiver-AAA	36,000		6,000	30,000
								0
101	670	685	000	Reimbursement	150	2,490		2,640
101	670	696	006	Donations-Respite	2,920	1,800		4,720
101	670	696	040	Donations-Homemaker/Personal	22,000	6,000		28,000
101	670	695	000	Miscellaneous	10,050	2,723		12,773
								0
								0
								0
								0
								0
								0
								0
								0
								0
						13,013	25,790	-12,777

REASONING:
State grant reductions and lower Medicaid Waiver referrals.
Reimbursement for staff time to conduct Creating Confident Caregiver seminars; short-term funding.
Home Care Services client donations and Respite cost share higher than expected.

DEPT HEAD Marie Wandell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
EXPENSE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
								0
101	670	704	000	Wages-Full Time	143,429		3,300	140,129
101	670	705	000	Wages-Part Time	149,084		2,600	146,484
101	670	705	500	Wages-Casual	171,051	10,710		181,761
101	670	711	000	Wages- In Lieu of Insurance	4,590		540	4,050
101	670	716	000	Health Insurance	18,338	1,500		19,838
101	670	718	000	Retirement	31,835	480		32,315
101	670	718	100	RHS Employer Contribution	0	430		430
101	670	719	000	Worker's Comp	3,513	45		3,558
								0
101	670	728	000	Printing	600	400		1,000
101	670	730	000	Office Supplies	1,750		800	950
101	670	741	000	Food Charges (CG Ed)	100		100	0
101	670	776	000	Cleaning Supplies	2,000	1,000		3,000
101	670	801	000	Professional Services	1,000	800		1,800
101	670	850	000	Telephone	900		500	400
								0
								0
						15,365	7,840	7,525

REASONING:
Adjust for sharing full-time Account Clerk with Health Department.
More Home Care Worker Casual hours.
Former Account Clerk in DROP; New Deputy Director RHS program.
Former Director received In-Lieu; new Deputy Director receives health insurance.
Home Care Worker latex glove cost increase (cleaning supplies).
More Home Care Workers taking Hep B series (Professional Services).
Caregiver Education offering Congregate meal; no need for Food Charges budget.

DEPT HEAD Marie Wandell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
REVENUE
2011

LINE ITEM								
FUND	DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	671	685	000	Reimbursement	0	100		100
101	671	695	000	Miscellaneous	1,500	2,000		3,500
101	671	696	000	Donations-Senior Center	4,000	200		4,200
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
						2,300	0	2,300

REASONING:

More non-grant senior center revenue than expected.

DEPT HEAD Marci Wandell DATE 10/2/11

BUDGET DIR DATE

COMMITTEE DATE

ADMIN DATE

BOARD OF COMM DATE

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
EXPENSE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	671	704	000	Wages-Full Time	22,608		1,985	20,623
101	671	711	000	Wages-In Lieu of Insurance	300		300	0
101	671	715	000	FICA	2,213		220	1,993
101	671	716	000	Health Insurance	5,249	950		6,199
101	671	718	000	Retirement	3,431		900	2,531
101	671	718	100	RHS Employer Contribution	0	200		200
101	671	728	000	Printing	6,594	200		6,794
101	671	729	000	Postage	1,911	550		2,461
101	671	730	000	Office Supplies	2,640	2,000		4,640
101	671	811	000	Dues and Publications	260	200		460
101	671	816	000	Service Contracts	781	415		1,196
101	671	850	000	Telephone Usage	750		135	615
101	671	861	000	Mileage-Sr Health	1,210			1,210
101	671	959	060	Respite-RSVP bus tickets	2,000		700	1,300
								0
								0
								0
						4,515	4,240	275

REASONING:
Adjust for sharing full-time Account Clerk with Health Department.
Former Account Clerk in DROP; New Deputy Director RHS program.
Former Director received In-Lieu; new Deputy Director receives health insurance.
Office supplies to replace large screen TV for Wii games, and wireless cost.

DEPT HEAD Marie Wandell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
REVENUE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	672	686	000	Senior Chore Donation	2,000		1,100	900
101	672	698	020	HCFA-MMAP	13,000	4,498		17,498
101	672	676	011	Purchase of Service	4,300	5,936		10,236
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
						10,434	1,100	9,334

REASONING:
Chore reduced lawn mowing; fewer client donations.
Additional MMAP Senior Medicare Patrol grant funding.
Purchase of Service revenue for MMAP MIPPA: Medicare Low Income Subsidy application program

DEPT HEAD Marie Wandell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
EXPENSE
2011

LINE ITEM FUND	DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	672	704	000	Wages-Full Time	104,409		4,045	100,364
101	672	704	040	Wages-Longevity/Incentive	80	1,000		1,080
101	672	711	000	Wages-In Lieu of Insurance	2,100		1,000	1,100
101	672	716	000	Health Insurance	17,431	3,109		20,540
101	672	718	000	Retirement	18,797	700		19,497
101	672	718	100	RHS Employer Contribution	0	400		400
101	672	728	000	Printing	4,200	1,000		5,200
101	672	729	000	Postage	2,415		600	1,815
101	672	730	000	Office Supplies	4,000	2,000		6,000
101	672	850	000	Telephone Use	2,000	200		2,200
								0
								0
								0
								0
								0
						8,409	5,645	2,764

REASONING:
Adjust for sharing full-time Account Clerk with Health Department.
Former Account Clerk in DROP; New Deputy Director RHS program.
Former Director received In-Lieu; new Deputy Director receives health insurance.
Printing and Office supplies for Senior Medicare Patrol education workshop.
Director Blackberry phone cost.

DEPT HEAD Marce Schmidell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
REVENUE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	673	696	062	USDA-Home delivered meals	110,000	5,000		115,000
101	673	696	063	Grant-Home delivered meals	290,000		10,000	280,000
101	673	696	080	HDM Medicaid Waiver AAA	128,000	15,000		143,000
101	673	696	061	Misc. - HDM	3,000		2,000	1,000
101	673	696	060	Donations-HDM	127,000		8,200	118,800
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
						20,000	20,200	-200

REASONING:
2009 and 2010 received additional USDA in December; expect same in 2011.
State grant funds cut.
Medicaid Waiver for Meals on Wheels higher than expected.
Client donations year to date lower than expected.

DEPT HEAD Marce Wandell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
EXPENSE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	673	704	000	Wages-Full Time	215,010		10,400	204,610
101	673	705	500	Wages-Casual	99,033	10,200		109,233
101	673	711	000	Wages-In lieu of insurance	3,450		600	2,850
101	673	716	000	Health Insurance	68,299		2,000	66,299
101	673	718	000	Retirement	28,620	2,000		30,620
101	673	718	100	RHS Employer Contribution	0	150		150
101	673	728	000	Printing	500	600		1,100
101	673	728	025	Bad Debt Expense	0	100		100
101	673	729	000	Postage	315	100		415
101	673	776	000	Cleaning Supplies (meal pakg)	75,000	2,000		77,000
101	673	816	000	Service Contracts	5,000		500	4,500
101	673	863	000	Vehicle Repair & Maintenan	13,956	2,357		16,313
101	673	864	000	Gasoline Usage	15,450	11,500		26,950
								0
						29,007	13,500	15,507

REASONING:
Adjust for sharing full-time Account Clerk with Health Department.
Nutrition Manager and FT Cook positions vacant several weeks.
Former Account Clerk in DROP; New Deputy Director RHS program.
Former Director and Nutrition Manager received In-Lieu; new Deputy Director receives health insurance.
Meals on Wheels meals provided increase, which increases packaging (Cleaning Supplies) and delivery cost; fuel cost increase.
Bad debt expense for donation check insufficient funds.

DEPT HEAD Marie Wandell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
REVENUE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	674	696	071	USDA-Congregate Meals	22,000	2,000		24,000
101	674	696	072	Grant-Congregate Meals	143,000	1,500		144,500
								0
101	674	696	075	Recovery Act Revenue	0	506		506
101	674	696	079	Max Meals	10,000		2,000	8,000
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
						4,006	2,000	2,006

REASONING:
2009 and 2010 received additional USDA in December; expect same in 2011.
One-time recovery act revenue from Mich. Office of Services to the Aging.
Fewer Max Meals provided.

DEPT HEAD Marce Wandell DATE 10/2/11

BUDGET DIR ____________ DATE ____________

COMMITTEE ____________ DATE

ADMIN ____________ DATE

BOARD OF COMM ____________ DATE

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
EXPENSE
2010

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	674	704	000	Wages-Full Time	92,912		7,800	85,112
101	674	705	000	Wages-Part Time	18,884	700		19,584
101	674	711	000	Wages-In Lieu of Insurance	1,350		450	900
101	674	705	500	Wages-Casual	68,937		13,800	55,137
101	674	715	000	FICA	13,977		1,350	12,627
101	674	716	000	Health Insurance	25,272	2,200		27,472
101	674	718	000	Retirement	9,107		890	8,217
101	674	718	100	RHS Employer Contribution	0	545		545
								0
101	674	728	000	Printing	200	400		600
101	674	776	000	Cleaning Supplies	8,700	4,000		12,700
101	674	801	000	Professional Services	8,854		854	8,000
101	674	811	000	Dues (food licenses)	2,000	200		2,200
101	674	816	000	Service Contracts	1,400		200	1,200
101	674	861	000	Mileage	2,000		400	1,600
101	674	933	000	Maintenance-Office Equip	500	400		900
						8,445	25,744	-17,299

REASONING:
Adjust for sharing full-time Account Clerk with Health Department. Nutrition Manager, FT Cook, and Enrichment Specialist positions vacant eight weeks.
Former Account Clerk in DROP; New Deputy Director RHS program.
Former Director and Nutrition Manager received In-Lieu; new Deputy Director receives health insurance.
Second Congregate Cold Meal packaging cost (Cleaning Supplies).
Kitchen equipment upkeep and repair expenses (Maintenance-Office Equipment).

DEPT HEAD Marie Crandell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
REVENUE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	678	555	700	Lifeways Grant	0	720		720
101	678	676	011	Purchase of Service	9,500	5,500		15,000
101	678	695	000	Misc.-client cost share Cnty respite	6,500		1,500	5,000
101	678	676	020	Cnslg Medicaid Waiver	0	1,400		1,400
101	678	677	040	Reimbursement - MCBR	0	2,000		2,000
101	678	685	000	Reimbursement	75	50		125
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
						9,670	1,500	8,170

REASONING:
Continuation of LifeWays Anti-Stigma funding.
Depression and Memory Screen revenue not reduced as expected.
Respite cost share calculations per family less than last year.
Now billing Medicare and Medicaid Waiver for Counseling.

DEPT HEAD Marcie Wandell DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

COUNTY OF JACKSON
DEPT. ON AGING BUDGET ADJUSTMENT
EXPENSE
2011

FUND	LINE ITEM DEPT.	ACCOUNT		ACCOUNT DESCRIPTION	CURRENT BUDGET	INCREASE	DECREASE	AMENDED BUDGET
101	678	704	000	Wages-Full Time	61,898		1,500	60,398
101	678	711	000	Wages-In lieu of insurance	3,210		210	3,000
101	678	715	000	FICA	7,368		115	7,253
101	678	716	000	Health Insurance	1,491	650		2,141
101	678	718	000	Retirement	11,170	900		12,070
101	678	718	100	RHS Employer Contribution	0	146		146
								0
101	678	730	000	Office Supplies	342	100		442
101	678	850	000	Telephone Usage	390		160	230
101	678	861	000	Mileage	3,500	400		3,900
101	678	957	000	Employee Training	400		150	250
								0
								0
								0
						2,196	2,135	61

REASONING:
Adjust for sharing full-time Account Clerk with Health Department.
Former Account Clerk in DROP; New Deputy Director RHS program.
Former Director received In-Lieu; new Deputy Director receives health insurance.
More home visits (mileage) for caregiver support and counseling.
Staff attending no-cost training when available.

DEPT HEAD Marcie Schmidt DATE 10/2/11

BUDGET DIR _____ DATE _____

COMMITTEE _____ DATE _____

ADMIN _____ DATE _____

BOARD OF COMM _____ DATE _____

Commissioner Board Appointments – October 2011

BOARD	NEW TERM EXPIRES	CURRENT MEMBER	APPLICANTS	COMMITTEE RECOMMENDED APPOINTMENTS
Board of County Canvassers (one from each political party)				
1) One public member (Rep.)	10/2015	Roger Warren	Roger Warren Mark Smith	Roger Warren
1) One public member (Dem.)	10/2015	Kim Justin	Heather Allison Linda Marks Sandra Marsh	Sandra Marsh
Department of Human Services				
1) One public member	10/2014	Brad Williams	Brad Williams	Brad Williams
Land Bank Authority				
1) One Commissioner member	10/2015	Carl Rice, Jr.	Carl Rice, Jr.	Carl Rice, Jr.

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COUNTY OF JACKSON
REQUEST FOR BOARD OR COMMISSION APPOINTMENT

Mail or personally deliver to: *County of Jackson Administrator/Controller's Office- 6th Floor*
120 West Michigan Avenue, Jackson, MI 49201
(517) 788-4335 fax (517) 780-4755

The Jackson County Board of Commissioners appoints individuals to numerous Boards and Commissions. Persons who wish to serve should complete the following information.

NAME: WARREN (Last) ROGER (First) G. (Middle Initial)

HOME ADDRESS: 1646 GARY PAUL LN. (Street) JACKSON (City) 49203 (Zip Code)

TELEPHONE: 517 787 1158 (Home, Work, Cell, or Business (Include Area Code)) RGLENWARREN@ATT.NET (E-mail Address)

JACKSON COUNTY CLERK
2011 OCT 13 PM 3:33
FILED

Name of Board(s) or Commission(s) to which Appointment is requested:

1. CANVASS BOARD 2. 3.

Community Activities/Civic Organization/Boards/Commissions:

Activity/Organization:	Length of Service	Position(s) Held:
REP. PARTY	14 YEARS	FAIR BOOTH CHAIR AND OTHER COMMITTEES

Employment:

Current Employer:	Position:	Dates of Employment:
JACKSON CO.	COUNTY CANVASSER	11-1-07

Education: HIGH SCHOOL GRAD. SOME COLLEGE MILITARY LEADERSHIP COURSES

Please indicate why you are requesting appointment to this Board(s)/Commission(s):

TO CONTINUE SERVING JACKSON CO. AS CANVASSER AS THE MOST EXPERIENCED REPUBLICAN MEMBER.

Additional Information you feel may be helpful in considering your request for Appointment:

THE MOST EXPERIENCED DEM. HAS MISSED SOME ELECTIONS, WE NEED HERS AND MY EXPERIENCE

Roger W Warren
Signature

9-30-11
Date

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COUNTY OF JACKSON
REQUEST FOR BOARD OR COMMISSION APPOINTMENT

Mail or personally deliver to: ***County of Jackson Administrator/Controller's Office- 6th Floor***
120 West Michigan Avenue, Jackson, MI 49201
(517) 788-4335 fax (517) 780-4755

JACKSON COUNTY RECEIVED SEP 30 2011 ADMINISTRATORS OFFICE

The Jackson County Board of Commissioners appoints individuals to numerous Boards and Commissions. Persons who wish to serve should complete the following information.

NAME: ~~MR~~ SMITH / MARK L.
Last First Middle Initial

HOME ADDRESS: 11735 SUTTON RD (LIBERTY TWP) CLARKLAKE 49234
Street City Zip Code

TELEPHONE: 517-740-2135 ARMSMITHART@YAHOO.COM
Home, Work, Cell, or Business (Include Area Code) E-mail Address

Name of Board(s) or Commission(s) to which Appointment is requested:

1. BOARD OF CANVASSERS 2. 3.

Community Activities/Civic Organization/Boards/Commissions:

Activity/Organization:	Length of Service	Position(s) Held:
LIBERTY TWP	1-YEAR (CURRENTLY SERVING)	ALTERNATE
BOARD OF REVIEW		

Employment:

Current Employer:	Position:	Dates of Employment:
W. JOHNSON SERVICE ADRIAN, MI	RETAIL SALES	5/2002 TO PRESENT
RETIRED MICHIGAN DEPARTMENT OF CORRECTIONS		7/72 TO 4/2001

Education:

ASSOCIATES DEGREE - CRIMINAL JUSTICE

Please indicate why you are requesting appointment to this Board(s)/Commission(s):

EVERY CITIZEN SHOULD SERVE, SHOULD TAKE A TURN,

Additional Information you feel may be helpful in considering your request for Appointment:

Mark Smith
Signature

9-30-11
Date

Bdcommapptform 10-13-09

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COUNTY OF JACKSON
REQUEST FOR BOARD OR COMMISSION APPOINTMENT

Mail or personally deliver to: *County of Jackson Administrator/Controller's Office- 6th Floor*
120 West Michigan Avenue, Jackson, MI 49201
(517) 788-4335 fax (517) 780-4755

The Jackson County Board of Commissioners appoints individuals to numerous Boards and Commissions. Persons who wish to serve should complete the following information.

NAME: Allison (Last) Heather (First) A (Middle Initial)

HOME ADDRESS: 1907 Chapin (Street) Jackson (City) 49203 (Zip Code)

TELEPHONE: 517 784 4445 (Home, Work, Cell, or Business (Include Area Code)) — (E-mail Address)

Name of Board(s) or Commission(s) to which Appointment is requested:

1. Canvass 2. 3.

Community Activities/Civic Organization/Boards/Commissions:

Activity/Organization:	Length of Service	Position(s) Held:
U A W Retirees		Trustee
Democratic Party		Volunteer

Employment:

Current Employer:	Position:	Dates of Employment:
retired		

Education:

12 th grade graduate

Please indicate why you are requesting appointment to this Board(s)/Commission(s):

asks to apply
need more representation in the East End

Additional Information you feel may be helpful in considering your request for Appointment:

dependable

FILED
2011 OCT -3 AM 10:46
JACKSON COUNTY CLERK

Heather Allison
Signature

9-30-11
Date

Bdcommapptform 10-13-09

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COUNTY OF JACKSON
REQUEST FOR BOARD OR COMMISSION APPOINTMENT

Mail or personally deliver to: *County of Jackson Administrator/Controller's Office- 6th Floor*
120 West Michigan Avenue, Jackson, MI 49201
(517) 788-4335 *fax (517) 780-4755*

The Jackson County Board of Commissioners appoints individuals to numerous Boards and Commissions. Persons who wish to serve should complete the following information.

NAME: Marks (Last) Linda (First) F (Middle Initial)

HOME ADDRESS: 1126 S. Bowen St (Street), Jackson (City) 49203 (Zip Code)

TELEPHONE: 517-962-4333 (H) (Home, Work, Cell, or Business (Include Area Code))

ccslou@aol.com (E-mail Address)

Name of Board(s) or Commission(s) to which Appointment is requested:

1. Board of Canvassers (alternate)
2.
3.

Community Activities/Civic Organization/Boards/Commissions:

Activity/Organization:	Length of Service	Position(s) Held:
MidSouth Advisory Bd.	1 yr.	board member
Jackson Co. Dem. Comm.	1 yr	member
Cascades Humane Society	2 yrs.	volunteer.

Employment:

Current Employer:	Position:	Dates of Employment:
Retired for 9 yrs.	State of Michigan DHS	1973-2002

Education:
B.A. + M.A. - Central Mich. U.

Please indicate why you are requesting appointment to this Board(s)/Commission(s):
I served as an alternate in the last election & would love to continue to do so.

Additional Information you feel may be helpful in considering your request for Appointment:

Linda F Marks
Signature

9-29-11
Date

Bdcommapptform 10-13-09

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COUNTY OF JACKSON
REQUEST FOR BOARD OR COMMISSION APPOINTMENT

Mail or personally deliver to: ***County of Jackson Administrator/Controller's Office- 6th Floor***
120 West Michigan Avenue, Jackson, MI 49201
(517) 788-4335 fax (517) 780-4755

The Jackson County Board of Commissioners appoints individuals to numerous Boards and Commissions. Persons who wish to serve should complete the following information.

NAME: MARSH (Last) SANDRA (First) J. (Middle Initial)

HOME ADDRESS: 3448 N SANDSTONE (Street) JACKSON (City) 49201 (Zip Code)

TELEPHONE: (517) 750-4023 (Home, Work, Cell, or Business (Include Area Code)) SANDRA.MARSH521@GMAIL.COM (E-mail Address)

Name of Board(s) or Commission(s) to which Appointment is requested:

1. Bd of CANVASSERS 2. 3.

Community Activities/Civic Organization/Boards/Commissions:

Activity/Organization:	Length of Service	Position(s) Held:
Dept of Human Services	6 YRS	VOLUNTEER-VARIOUS
CAA	5 YRS	TAX PREPARER
City of JACKSON	6 YRS	ELECTION INSPECTOR

Employment:

Current Employer:	Position:	Dates of Employment:
NONE		

Education:
BACHELOR'S - BUSINESS ADMIN. (MINOR) FAMILY LIFE EDUCATION

Please indicate why you are requesting appointment to this Board(s)/Commission(s):
I HAVE SERVED AS AN ALTERNATE SINCE 2010 AND ENJOY BEING INVOLVED IN THE ELECTION PROCESS

Additional Information you feel may be helpful in considering your request for Appointment:
I AM FAMILIAR WITH THE CANVASSER PROCESS AS WELL AS THE ELECTION PROCESS. I AM RELIABLE AND HONEST

Signature: Sandra Marsh Date: 9/28/11

Bdcommappform 10-13-09

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COUNTY OF JACKSON
REQUEST FOR BOARD OR COMMISSION APPOINTMENT

Mail or personally deliver to: *County of Jackson -- Administrator/Controller's Office -- 6th Floor*
120 West Michigan Avenue, Jackson, MI 49201
(517) 788-4335 *FAX (517) 780-4755*

The Jackson County Board of Commissioners appoints individuals to numerous Boards and Commissions. Persons who wish to serve should complete the following information.

NAME: Williams (Last) Sterry (BRAD) (First) _____ (Middle Initial)

HOME ADDRESS: 902 Oakridge Drive (Street) Jackson (City) 49203 (Zip Code)

TELEPHONE: 517-782-1010 (Home, Work, Cell, or Business (Include Area Code)) copperorchid@ameritech.net (E-mail Address)

Name of Board(s) or Commission(s) to which Appointment is requested:

1. Re-Appointment to DHS Board 2. _____ 3. _____

Community Activities/Civic Organization/Boards/Commissions:

Activity / Organization:	Length of Service	Position (s) Held:
Current Board Member of DHS	2 Years	Vice Chair
City LDFA/Brownfield Board	10 Years +	Board Member
Diability Connections Board	2 Years -	Board Memebr

Employment:

Current Employer:	Position:	Dates of Employment:
NA	Retired	NA

Education:

35+ Years with the Department of Social Services/FIA/DHS stationed in Jackson. Graduate of Grand Valley State University (College).

Please indicate why you are requesting appointment to this Board (s) /Commission (s):

Re-appointment to the DHS Board to continue to move the MCF in a positive direction, offer transparency, and represent the Co. in State matters RE: DHS.

Additional Information you feel may be helpful in considering your request for appointment:

As one of the two "County Appointed" board members, I would like to continue to serve the interests of our Jackson residents

S. Bradford Williams (Signature:) 7/28/2011 (Date:)

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COUNTY OF JACKSON
REQUEST FOR BOARD OR COMMISSION APPOINTMENT

Mail or personally deliver to: *County of Jackson Administrator/Controller's Office- 6th Floor*
120 West Michigan Avenue, Jackson, MI 49201
(517) 788-4335 fax (517) 780-4755

The Jackson County Board of Commissioners appoints individuals to numerous Boards and Commissions. Persons who wish to serve should complete the following information.

NAME: Jr. Rice (Last) Carl (First) R. (Middle Initial)

HOME ADDRESS: 5562 Dogwood Dr. (Street) Jackson County (City) 49201 (Zip Code)

TELEPHONE: 517-745-2124 (Home, Work, Cell, or Business (Include Area Code)) cricejr@gmail.com (E-mail Address)

Name of Board(s) or Commission(s) to which Appointment is requested:

1. LAND BANK AUTHORITY 2. 3.

Community Activities/Civic Organization/Boards/Commissions:

Activity/Organization:	Length of Service	Position(s) Held:
Board of Commissioners	7 months	Commissioner District-3
Land Bank Authority	7 months	Appointed voting member by BOC
Airport Board	7 months	Appointed voting Board member by BOC

Employment:

Current Employer:	Position:	Dates of Employment:
Self - A Voice from Heaven	Chairman/Founder	Years

Education:

Bachelor's – Human Services...Master's – Counseling...Doctorate - Theology

Please indicate why you are requesting appointment to this Board(s)/Commission(s):

During my time with the Land Bank, I have learned its purpose and reason. The other members and I, have built a working relationship, to address the goals of the Land Bank.

I have spent time asking questions and studying...to understand the numerous functions of the Land Bank. Needed to constructively make decisions...and I like what were doing to help.

Additional Information you feel may be helpful in considering your request for Appointment:

Looking forward to continuing to be part of what we have started !

CR/88
Signature

8-8-11
Date