BENZIE COUNTY
BOARD OF COMMISSIONERS

448 COURT PLACE – BEULAH, MI 49617 – (231) 882-9671
www.benzieco.net

MEETING AGENDA
July 12, 2016
Commissioners Room, Governmental Center, Beulah, Michigan

PLEASE TURN OFF ALL ELECTRONIC DEVICES

9:00 a.m.	CALL TO ORDER
	ROLL CALL
	INVOCATION AND PLEDGE OF ALLEGIANCE
	APPROVAL OF AGENDA
	APPROVAL OF MINUTES – 6/28/2016 (open & closed)
	PUBLIC INPUT
	ELECTED OFFICIALS & DEPT HEAD COMMENTS
	COMMISSIONER REPORTS
	COUNTY ADMINISTRATOR'S REPORT –
	FINANCE – Approval of Bills
	HR and PERSONNEL – Consent Calendar
	COMMITTEE APPOINTMENTS –
	ACTION ITEMS – EMPG Agreement; 44 North Agreements (3); Fisk Housing Request
	PRESENTATION OF CORRESPONDENCE
	NEW BUSINESS –
10:00	Bill Kennis, Benzie Bus
10:15	
10:30	
	PUBLIC COMMENT
	ADJOURNMENT

Times Subject to Change

THE COUNTY OF BENZIE WILL PROVIDE NECESSARY REASONABLE AUXILIARY AIDS AND SERVICES, SUCH AS SIGNERS FOR THE HEARING IMPAIRED AND AUDIO TAPES OF PRINTED MATERIALS BEING CONSIDERED AT THE MEETING, TO INDIVIDUALS WITH DISABILITIES AT THE MEETING OR HEARING UPON THIRTY (30) DAYS NOTICE TO THE COUNTY OF BENZIE. INDIVIDUALS WITH DISABILITIES REQUIRING AUXILIARY AIDS OR SERVICES SHOULD CONTACT THE COUNTY BY WRITING OR CALLING THE FOLLOWING:

BENZIE COUNTY CLERK
448 COURT PLACE
BEULAH MI 49617
(231) 882-9671

This notice was posted by Dawn Olney, Benzie County Clerk, on the bulletin board in the main entrance of the Benzie County Governmental Center, Beulah, Michigan, at least 18 hours prior to the start of the meeting. This notice is to comply with Sections 4 and 5 of the Michigan Open Meetings Act (PA 267 of 1976).

PUBLIC INPUT

Purpose: The Benzie County Board of Commissioners is a public policy setting body and subject to the Open Meetings Act (PA 267 of 1976). The Board also operates under a set of "Benzie County Board Rules (section 7.3)" which provides for public input during their meetings. It continually strives to receive input from the residents of the county and reserves two opportunities during the monthly scheduled meeting for you the public to voice opinions, concerns and sharing of any other items of common interest. There are however, in concert with meeting conduct certain rules to follow.

Speaking Time: Agenda items may be added or removed by the board but initially at least two times are devoted to Public Input. Generally, however, attendees wishing to speak will be informed how long they may speak by the chairman. All speakers are asked to give their name, residence and topic they wish to address. This and the statements/comments will be entered into the public record (minutes of the meeting). Should there be a number of speakers wishing to voice similar opinions, an option for a longer presentation may be more appropriate for the group and one or more speakers may talk within that time frame.

Group Presentations – 15 minutes
Individual Presentations – 3 minutes

Board Response: Generally, as this is an "Input" option, the board will not comment or respond to presenters. Silence or non-response from the board should not be interpreted as disinterest or disagreement by the board. However, should the board individually or collectively wish to address the comments of the speaker(s) at the approval of the Chair and within a time frame previously established, responses may be made by the board. Additionally, the presenter may be in need of a more lengthy understanding of an issue or topic and may be referred to a committee appropriate to address those issues.

Public Input is very important in public policy settings and is only one means for an interchange of information or dialogue. Each commissioner represents a district within the county and he/she may be individually contacted should greater depth or understanding of an issue be sought. Personal contact is encouraged and helpful to both residents and the board.

Commissioner Contacts:

District I -- Lisa Tucker (Almira East of Reynolds Road).....
District II -- Vance Bates (Almira Twp West of Reynolds Road, Platte and Lake Townships).....
District III - Roger Griner (Crystal Lake, Frankfort).....651-0757
District IV - Coury Carland (Benzonia).....231-930-7560
District V - Frank Walterhouse (Homestead).....325-2964
District VI - Evan Warsecke (Colfax, Inland).....640-2319
District VII – Gary Sauer (Blaine, Gilmore, Joyfield, Weldon).....651-0647

THE BENZIE COUNTY BOARD OF COMMISSIONERS
June 28, 2016

The Benzie County Board of Commissioners met in a regular meeting on Tuesday, June 28, 2016, 448 Court Place, Government Center, Beulah, Michigan.

The meeting was called to order by Chairman Roger Griner at 9:00 a.m.

Present were: Commissioners Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke
Excused: Bates

The invocation was given by Commissioner Griner followed by the pledge of allegiance.

Agenda:
Motion by Sauer, seconded by Warsecke, to approve the agenda as amended, correcting Actions Items: 2016-019, removing COA Computer Purchase, add Health Dept 2% Grant Application. Ayes: Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

Minutes:
Motion by Walterhouse, seconded by Warsecke, to approve the regular session minutes of June 14, 2016 as presented. Ayes: Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

9:02 a.m. Public Input
Eric VanDussen spoke regarding the court's determination of the OMA violation by the HR committee.
9:06 a.m. Public Input Closed

ELECTED OFFICIALS & DEPT HEAD COMMENTS:
Tom Longanbach, Chair of the Building Authority, stated that Thursday, June 30 at 9:00 a.m. the local inspections will be done on the Maples; July 7, 2016 at 10:30 a.m. Ed Hale inspection.

Sabra Boyle, Council on Aging, gave the report for Doug Durand; written report has been provided to the board and she spoke regarding the Diamond Tours trip to Mackinac Island with the next one being to Memphis in November; 173 booklets have been handed out for Project Fresh; Received a $1,250 grant from Meals on Wheels of America for the efforts in March; will attend the Benzie Showcase on August 6 in Beulah.

Benzie Home Health Care report for May, 2016 provided.

COMMISSIONER REPORTS
Comm Carland reported that it has been pretty quiet; attended the LPT meeting last month and Frank Post discussed the grants which have been applied for to the Grand Traverse Band; discussed the drowning in Loon Lake; Airport Authority needs a little attention from this board.

Comm Tucker -- no report.

Comm Walterhouse – no report.

Comm Sauer went to the Village of Elberta and their grant request for the restroom facility at the Farmers Marks has been granted; regarding the Road Commission – the Nostwick bridge project is completed; Benzie Home Health Care is really having a hard time getting CENAs.

Comm Warsecke – no report.

Comm Griner spoke regarding the Enbridge Pipeline 5 – he attended a public forum in Traverse City last week, it was a company sponsored event; there are 2 – 20" pipes not 1 – 30"; 1" steel; buried on each end 800 feet; carries liquefied natural gas (25%); all goes to Sarnia Ontario, about 55% comes back to Michigan 23 million gallons per day go through it. Crystal Lake Twp and the City of Frankfort will all hear about the airport soon – they was to have a paid administrator.

COUNTY ADMINISTRATOR'S REPORT – Mitch Deisch

- Wants to set down with Chairman Griner regarding the AES representation.
- Ad will appear in the Record Patriot tomorrow for the ACO director.
- Setting up a meeting with the finance committee regarding the budget.
- July 12 board meeting Peter Cohl will discuss the labor negotiations in closed session.

FINANCE

Bills: Motion by Carland, seconded by Walterhouse, to approve payment of the bills from June 14, 2016 to June 28, 2016 in the amount of $160,323.94 as presented. Roll call. Ayes: Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

Michelle Thompson, County Treasurer, also reported on the Land Bank Authority; tax bills are being printed for mailing on July 1; Benzie Community Chorus will be hosting concerts this week Friday, Saturday and Sunday at The Mills.

Finance Consent Calendar:

Motion by Walterhouse, seconded by Sauer, to approve the June 14, 2016 Finance Committee Consent Calendar items 1 and 2 as presented. Roll call. Ayes: Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

Comm Tucker inquired regarding raises; Mitch stated it will be part of the conversation, the expenses outstrip the revenue.

Michelle Thompson stated regarding the Land Sale proceeds -- $50,000 has been budgeted as a transfer to the General Fund and that leaves $5,800 left that we could budget if we needed to.

HR AND PERSONNEL – None

COMMITTEE APPOINTMENTS

Airport Authority: Motion by Carland, seconded by Walterhouse, to accept the resignation of Ken Laurence from the Frankfort City County Airport Authority and send a letter of thank you. Ayes: Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

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Comm Tucker -- no report.

Comm Walterhouse – no report.

Bestie Valley Trail: Motion by Carland, seconded by Sauer, to affirm the appointments of Paul Bare and Dan Schoonmaker, with John Wheeler and Gregory Nowell, as the alternates, as the Crystal Lake Property Rights Association appointees, and Gary Pallin as the Village of Beulah representative to the Betsie Valley Trail, as requested. Ayes: Carland, Griner, Sauer, Stucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

Committee Appointment Policy: To be handled in HR this afternoon.

ACTION ITEMS

2016-019: Motion by Walterhouse, seconded by Carland, to adopt Resolution 2016-019 Truth & Taxation Resolution to Adopt Millage Rate as presented, authorizing the chairman to sign. Roll call. Ayes: Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

Health Dept 2% Grant: Motion by Sauer, seconded by Carland, to approve the Tribal Council Allocation of 2% Fund Application for the Benzie Leelanau District Health Department in the amount of $4,500.00 as presented, authorizing the chairman to sign. Roll call. Ayes: Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

CORRESPONDENCE

- Road Commission minutes of May 26, 2016 received.
- Eaton County resolution regarding "Dark Stores" received.
- Benzie-Leelanau District Health Dept minutes of June 17, 2016 received.

Jennifer Berkey, MSUE Annual Report

Ms. Berkey presented the 2015-16 Annual Report touching on Developing Youth and Strong Communities; Keeping People Healthy: Disease Prevention and Management; Supporting Food and Agriculture; Fostering Strong Communities and Businesses. She stated they would be holding an open house in August and will notify the board of that date.

Motion by Walterhouse, seconded by Sauer, to accept the Michigan State University Extension Annual Report for 2015-16 and place on file. Ayes: Carland, Griner, Sauer, Tucker, Walterhouse and Warsecke Nays: None Exc: Bates Motion carried.

9:55 a.m. Comm Tucker excused.

Elaine Wood, Networks Northwest Annual Report

Ms. Wood presented the FY 2015 Annual Report and stated that Coury Carland, Roger Griner, Art Jeannot and Bill Kennis are present and members of their board, together with Betty Workman. All are representing Benzie County very well. She talked about Talent Development; Business Development and Community Planning and Development.

Motion by Walterhouse, seconded by Carland, to accept the Networks Northwest Annual Report for FY 2015 and place on file. Ayes: Carland, Griner, Sauer, Walterhouse and Warsecke Nays: None Exc: Bates and Tucker Motion carried.

Bob Schlueter, Area Agency on Aging Annual Report
Mr. Schlueter presented the 2015 Annual Report for Area Agency on Aging of Northwest Michigan and says thank you to Chairman Griner for sitting on their board; last year 4643,915 was spend in Benzie County and $107,452 went through the Commission on Aging; he stated they work very closely with all 10 Council on Aging offices; they are very active with the veterans.
Motion by Walterhouse, seconded by Warsecke, to accept the Area Agency on Aging of Northwest Michigan 2015 Annual Report and place on file. Ayes: Carland, Griner, Sauer, Walterhouse and Warsecke Nays: None Exc: Bates and Tucker Motion carried.

Peg Minster, Planning Commission Annual Report
Ms. Minster gave the annual report stating the Mission statement and purpose of the Planning Commission and that great communities don't happen by accident – they happen by design; the 2015 activities; the Master Plan be complete by July 31, 2016. A draft copy of the Master Plan is also provided to the board.
Motion by Carland, seconded by Sauer, to accept the Planning Commission Annual Report dated June 2016 and place on file. Ayes: Carland, Griner, Sauer, Walterhouse and Warsecke Nays: None Exc: Bates and Tucker Motion carried.

10:45 a.m. PUBLIC INPUT
Jean Vogler stated that the mikes don't work when you are a foot away. We cannot hear the board members when they are speaking.

10:51 a.m. Motion by Sauer, seconded by Carland, to enter into closed session to discuss the County Administrator's Six-Month Evaluation in accordance with MCL 15.268 section 8(a) of the Open Meetings Act. Roll call. Ayes: Carland, Griner, Sauer, Walterhouse and Warsecke Nays: None Exc: Bates and Tucker Motion carried.

11:40 a.m. Re-Enter Open Session

PUBLIC INPUT – None

Motion by Carland, seconded by Sauer, to adjourn until the July 12, 2016 Regular meeting or the call of the chair. Ayes: Carland, Griner, Sauer, Walterhouse and Warsecke Nays: None Exc: Bates and Tucker Nays: None Motion carried

Roger L. Griner – Chair Dawn Olney, Benzie County Clerk

INDEX

1. Approved the agenda as amended.
2. Approved the regular session minutes of June 14, 2016 as presented.
3. Approved payment of the bills.
4. Approved the June 14, 2016 Finance Committee Consent Calendar items 1 and 2 as presented.

5. Accepted the resignation of Ken Laurence from the Airport Authority.
6. Affirmed the appointments of Paul Bare and Dan Schoonmaker, with John Wheeler and Gregory Nowell, as the alternates, as the Crystal Lake Property Rights Association appointees, and Gary Pallin as the Village of Beulah representative to the Betsie Valley Trail.
7. Adopted Resolution 2016-019 Truth & Taxation Resolution to Adopt Millage Rate as presented.
8. Approved the Tribal Council Allocation of 2% Fund Application for the Benzie Leelanau District Health Department in the amount of $4,500.00 as presented.
9. Accepted the MSU Extension Annual Report for 2015-16.
10. Accepted the Networks Northwest Annual Report for FY 2015.
11. Accepted the Area Agency on Aging of Northwest Michigan 2015 Annual Report.
12. Accepted the Planning Commission Annual Report dated June 2016.
13. Entered closed session for the County Administrator's Six-Month Evaluation in accordance with MCL 15.268 section 8(a) of the Open Meetings Act.

Motion by Walterhouse, seconded by Sauer, to approve the Finance Consent Calendar items as follows:

1. To approve the purchase of a new Pick Up for the Solid Waste Recycling Department and use Solid Waste fund balance to purchase it.

2. To approve the purchase of services and equipment from TKS Security for a price "not to exceed" $9,383.50 and that reimbursement from the MMRMA for half of the amount specified based on the approved grant.

DAWN OLNEY
BENZIE COUNTY CLERK
448 COURT PLACE
BEULAH, MICHIGAN 49617

DESTROY DATE: _____

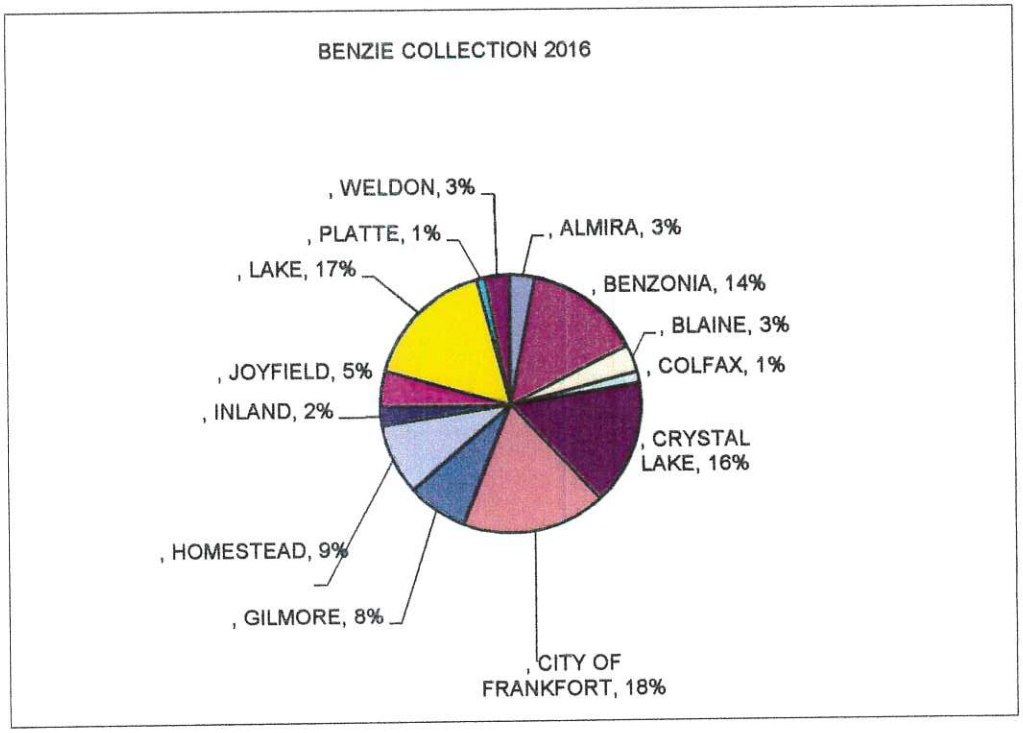
June 28, 2016

County Administrator 6-Month Evaluation

Elected Officials and Department Head Comments

2016 BENZIE COUNTY COLLECTION - TOTAL SERVED June 25th 2016 Frankfort

ALMIRA	9
BENZONIA	42
BLAINE	10
COLFAX	4
CRYSTAL LAKE	46
CITY OF FRANKFORT	52
GILMORE	22
HOMESTEAD	26
INLAND	7
JOYFIELD	13
LAKE	48
PLATTE	3
WELDON	9
PEOPLE TOTAL SERVED	291



Frankfort Tire Collection

1594 PTE Collected (2 Trailers)

Spent $3,344.56 from the DEQ Grant

Upcoming tire collections on July 16th and August 20th (1 trailer at each event)

HHW Collection Summary

ERG ENVIRONMENTAL SERVICES

13039 MERRIMAN ROAD, SUITE 200
LIVONIA, MICHIGAN 48150-1816
734.437.9650 (P) • 734.437.9651 (F)

BENZIE COUNTY

COLLECTION DATE	June 25, 2016
# OF VEHICLES	?
EVENT LOCATION	Frankfort Industrial Park

TYPE OF MATERIAL	# OF CONTAINERS	CONTAINER SIZE & TYPE	TOTAL WEIGHT	UNIT
Flammable Liquid	1	55 Gal Drum	256	lbs
Oil Based Paint/Solvents	6	Cubic Yard	3,288	lbs
Latex Paint	0	Cubic Yard	0	lbs
Aerosol Cans	1	Cubic Yard	469	lbs
Aerosol Cans	1	55 Gal Drum	119	lbs
Acidic Products	1	55 Gal Drum	79	lbs
Caustic/Basic Products	1	55 Gal Drum	153	lbs
Toxic Products	4	Cubic Yard	2,887	lbs
Herbicides & Pesticides	2	Cubic Yard	836	lbs
Oil/Antifreeze	2	Cubic Yard	1,192	lbs
Propane	1	55 Gal Drum	26	lbs
Fire Extinguishers	1	55 Gal Drum	19	lbs
Other Cylinders	0	Each	0	lbs
Smoke Detectors	1	Pail	16	lbs
Expired Medicines	1	55 Gal Drum	87	lbs
Medical Waste Sharps	1	55 Gal Drum	52	lbs
Reactives	2	Pail	11	lbs
Mercury Devices	1	Pail	4	lbs
Fluorescent Lamps	4	Pallet	1,109	lbs
PCB Ballasts	0	55 Gal Drum	0	lbs
Lithium Battery	1	Pail	22	lbs
Household Battery	3	55 Gal Drum	1,026	lbs
TOTAL WEIGHT FOR THIS COLLECTION			11,651	LBS

Benzie County Solid Waste Department
Coordinator's Report
JULY 2016

General Administration:	Status:	ACTION
Mobile Home Parks	Recycling Fees are charged to Park Owners / Past Delinquent Taxes are forgiven for Inland and Benzonia Townships	COMPLETED
HHW and Electronics Collections	June 25th completed /	REPORT
DNR Illegal Dumpsites Project	Filled a 30 yard dumpster 30 yard DNR dumpster at 669 property	ONGOING
Recycling Brochures & HHW Brochures	Keeping the Website updated and handing out brochures at clean up events	
Current Financial Report	Report provided to SWAC today	Revenue and Expenditures
New Coordinator Toured the American Waste Facility		
New Fiscal Year Budget Preparation Process	Set @ $22 per household to create budget	Currently in review process
Lease Agreements with Site Hosts are updated and in place until December 31, 2017		ON FILE
Certificate of Coverage through MMRMA are updated according to Lease Agreements and in place		ON FILE

Recycle Site Updates:	Status:	
Signage	Surveillance / Violations signs for all sites	Signs are up at all recycling sites
Lighting / Cameras at Frankfort, Thompsonville & Almira	In place and operational	Completed
School Cardboard Trailers	Coordinator is delegating responsibilities over summer months	ONGOING
Expanded Recycling Sites in Frankfort and Thompsonville	4 bins in Frankfort / 2 bins in Thompsonville	
Betsie Valley School Cardboard Trailer	Benzie County is responsible for that trailer along with 3 other sch	
Thompsonville Requesting Snow Fence Installation	Coordinator has installed it @ Village request	COMPLETED
Glass Only Bins Removed - All Single Stream Recyclables in One Bin		NEW DECALS IN PLACE ON BINS

Public Relations / Education:	Status:	
Educational Article and Advertising in Record Patriot	Public Education being Addressed	ONGOING

COMMUNITY INVOLVEMENT	Coordinator involved in B-PAC, Benzie Composts, Upcoming Township Clean Up Events		
FESTIVALS AND COMMUNITY	Coordinator involved in Business Expo, Showcase, Rotary Presentation, Library Events		Early Childhood event
COLLECTIONS CONDUCTED	Coordinator conducted Paper Shredding event, Latex Paint event, HHW / Electronics event,		
Compost Drop Off Site at Grow Benzie	Cooperative	ONGOING	Will Expand in 2016
TIRE CLEAN UP Events in 2016 - DEQ Grant Award of $15,000.00		Benzie County was awarded the funding on 4/29	3 Tire Collections in 2016

Regional Initiatives :	Status:	
Regional SWAC Meeting	10 Counties in N. MI	Meets in T.C. Regularly
Emmet County Recycling Program Research		Coordinator will tour and report back
Exploring a tri-county Recycling Initiative/Transfer station opportunities		Benzie, Leelanau, Manistee

Miscellaneous:		
Summer Site Attendants in place		
Battery Solutions continues to pick up batteries 'on call' basis		$.45 per pound / $100 transportation charge
ReConnect continues to accept UPS shipped rechargeable batteries		NO CHARGE ONGOING

Local/State/National Legislation:	Status:	
State Level Proposals to amend Part 115, Solid Waste Management, of the Natural Resources and Environmental Protection		Act, 1994 PA 451,
Governor Snyder's Recycling Council	ONGOING PROGRESS	Data Measurement
ReTrac Data Tracking System	All Counties will be required to use this data tracking system	Benzie County Data is being entered

Animal Control Report				
6/1/2016 - 6/30/2016				
	Dogs	Cats	Cal YTD Dogs	Cal YTD Cats
Admitted	22	18	111	87
Released	12	2	52	4
Euthanized	0	1	1	4
Adopted	8	20	64	48
Rescue/Foster	0	1	2	6
Animal in shelter	7	15		
Other animals admitted	0			
Calls for Service			29	
Total Number of After Hours Calls			6	
Total Number of Miles Driven			400	617
Total Gallons of Gas			27.05	44.98
Current Truck Mileage			33,520	3,592
Phone Calls			95	
Visitors			240	
Cleaning Time			157 hrs	

Report Written by: Jaime Croel
Please call (231) 882-9505 or stop by if you have any questions

Benzie County Office of Emergency Management

Emergency Management Activities

June 2016

Below are outlined many of the activities I have been involved in for the month of June 2016.

1.	**Meeting with the American Red Cross** On Wednesday June 1st I had a meeting with the new area representative of the American Red Cross. Megan Powers was just recently assigned to Traverse City and was meeting all of the area Emergency Managers.
2.	**Region 7 Homeland Security Planning Board** On Thursday June 2nd, 2016 I attended the R7HSPB meeting in Grayling.
3.	**Benzie County CERT Meeting** On Wednesday June 8th, 2016 we had a monthly meeting/training of the CERT Program. We began training on "Search and Rescue Management" and also discussed the upcoming Frankfort Independence Day Activities.
4.	**Meeting Regarding the Upcoming Independence Day Actives in the City of Frankfort** On Monday June 13th, 2016 we held a meeting of all the emergency first responders, city officials and activity organizers for the upcoming Frankfort Independence Day activities. This meeting was review changes to the plans for the events on July 4th.
5.	**Meeting regarding Consolidation of National Park Volunteer Search and Rescue and CERT Program** On Thursday June 16th, David Hanchett and I met with Ranger Joe Lachowski to discuss the possibility of consolidation of the VSAR from Sleeping Bear Dunes and CERT. Because of the National Lakeshores limited resources, they are interested in our volunteer program to provide support to their SAR efforts in events that may cover extended periods of time. They are especially interested in the "Volunteer Reception Center" and "Search and Rescue Management" training that CERT has completed.
6.	**Webinar on Smart 911 and RAVE** On Friday June 17th, 2016 we held a webinar to look at the Smart 911 and RAVE notification systems. The Smart 911 caller's Safety Profile contains family member information, photos, medical conditions, disabilities, exact addresses, even pet information, which lets 911 and first responders quickly send the right help to the right location. Another component is the RAVE Alert Emergency Notification lets you communicate with and alert your entire facility in minutes. RAVE Alert uses all communication modes to send emergency alerts including; mobile phones, landlines, email, text, social media, IPAWS-OPEN, etc.
7.	**Attendance at the Frankfort City Commission Meeting** On Tuesday June 21st, 2016 I attended the Frankfort City Commission Meeting to discuss the upcoming Frankfort Independence Day Activities and it "Incident Action Plan" or IAP; I developed for emergency first responders assigned to the events. After going over the details of the IAP the Frankfort City Commission adopted the IAP in concept for use during the activities.
8.	**Attendance at the Benzie County Fire/EMS Association Meeting** On Tuesday June 21st, 2016 I attended the Benzie County Fire/EMS Association Meeting at the

Benzie County Government Center. I reported to the association the applications for 2% Revenue Sharing Grants that were submitted that were relevant to both fire and EMS. There was also some discussion regarding the status of obtaining non-profit status for the association.

9. Fire Chiefs Meeting to Go over Personnel Accountability for Personnel

On Monday June 27th, 2016 I met with all of the Benzie County Fire Chiefs to go over the Personnel Accountability System and how it will be integrated into the computer tablets we received from 2% Revenue Sharing from the Grand Traverse Band of Ottawa and Chippewa Indians.

10. Final Meeting Regarding the Upcoming Independence Day Actives in the City of Frankfort

On Monday June 27th, 2016 we held our final meeting of all the emergency first responders, city officials and activity organizers for the upcoming Frankfort Independence Day activities. This meeting was to hammer out any final changes to the plans for the events on July 4th.

11. Meeting of the Local Emergency Planning Committee Local Planning Team (LPT)

On Thursday June 23rd, 2016 we held our LPT meeting in the EOC. The main topic of discussion was possible grant recommendations for Region 7 Consideration. They include;

- Request from Platte Township for a Fixed Site Generator for their Township Hall
- Request from Inland Township for a Fixed Site Generator for their Township Hall and Fire Station.
- Training Funded By Region 7 that would include
  - ICS-300 and ICS-400 Classes
  - Anhydrous Ammonia Training
  - Laser PER-275 (Law Enforcement Active Shooter Emergency Response)

12. After Action Review of the Response to the Drowning on Loon Lake

On Thursday June 30th, 2016 the participants in the response to the drowning on Loon Lake. A man drowned Wednesday June 22nd while snorkeling in Loon Lake at Sleeping Bear Dunes National Lakeshore. A dive team recovered the man's body in Loon Lake about 6:30 p.m. after he was reported missing a little over two hours earlier from the lake near Platte River.

The purpose of an AAR is to evaluate what strategies and tactics went well and what needed improvement.

13. Upcoming Events

I have scheduled the following for the next two months;

July 4th – City of Frankfort Independence Day Activities
July 7th – R7HSPB Meeting-Grayling
July 13th – CERT Monthly Meeting and Training
July 18th – LEPC Meeting in the EOC
July 28th –LPT Meeting in the EOC
August 4th – R7HSPB Meeting-Grayling
August 10th – CERT Monthly Meeting and Training
August 15th – LEPC Meeting in the EOC
August 16th – Benzie County Fire/EMS Association
August 25th –LPT Meeting in the EOC

Benzie County
Office Of Emergency Management
Region 7 Homeland Security

Memorandum

To: Roger Griner, Chair
From: Frank Post, Emergency Management Coordinator
Date: July 6th, 2016
Subject: Acceptance to the National Emergency Management Advanced Academy.

Just to let you and the Board of Commissioners know, I was accepted to the National Emergency Management Advanced Academy that is held at the Emergency Management Institute in Emmitsburg MD. They have assigned class dates of

- E0451-Advanced I-November 14th through 18th, 2016
- E0452-Advanced II-January 30th through February 3rd, 2017
- E0453-Advanced III-May 8th through 12th, 2017
- E0454-Advanced IV-August 21st through 25th, 2017

As a reminder, all travel and lodging are paid for. Our only cost is a meal ticket for each of the sessions.

Emergency Management Institute
U.S. Department of Homeland Security
16825 South Seton Avenue
Emmitsburg, Maryland 21727

FEMA

Dear National Emergency Management Advanced Academy Student:

Congratulations on your acceptance into the National Emergency Management Advanced Academy (NEMAA), the Federal Emergency Management Agency's flagship program for emergency management advanced skills using a whole community approach. We received a tremendous number of highly qualified applicants and have placed several applicants on a wait list. Therefore, your selection is most noteworthy and in order to foster classroom cohesion, you will progress through the Academy as Cohort FY17-1.

Throughout the NEMAA program, you will gain a deeper understanding of contemporary/emerging issues and changes in the Emergency Management community of practice. The Advanced Academy is designed to enhance your skills to successfully impact important emergency management public policies by working collaboratively with other emergency management personnel from the whole community. Additionally, this Academy allows you to share best practices and participate in case studies/exercises with other Emergency Management Professionals facing similar challenges.

I am delighted to welcome you to the Advanced Academy and look forward to working with you. As a student of **Cohort FY17-1,** you must complete all four courses listed below in sequential order and a research paper to graduate. Your course dates are as follows:

Cohort FY17-1 Schedule:

- **E0451 Advanced I: November 14-18, 2016**
- **E0452 Advance II: January 30 – February 3, 2017**
- **E0453 Advance III: May 8-12, 2017**
- **E0454 Advance IV: August 21-25, 2017**

You will be receiving information from our Admissions Department over the next couple of weeks that will provide details on attending training at the National Emergency Training Center in Emmitsburg, Maryland.

If you have admissions questions, please contact Tina Hahn at TINA.HAHN@FEMA.DHS.GOV immediately, but no later than **Monday, August 1st, 2016**. For program questions, please contact the EMPP helpdesk at FEMA-EMPP-ADVANCED-ACADEMY@FEMA.DHS.GOV.

Best Regards,

Kelly Garrett

Mr. Kelly Garrett
Director
Emergency Management Professional Program
Emergency Management Institute

Commissioner Report

County Administrator's Report

FINANCE REPORT

Human Resources (HR) Report

HR Committee
Meeting Notes
June 28, 2016

The meeting was called to order by Commissioner Evan Warsecke at 1:00 pm

Present:	Evan Warsecke, Coury Carland and Gary Sauer
Others Present:	Dawn Olney, Mitch Deisch, Maridee Cutler, Ted Schendel, Dan Smith, Michelle Thompson
Public:	Susan Zenker

The pledge of allegiance was given.

Agenda: Motion by Carland, seconded by Sauer, to approve the agenda as presented. Ayes: All Nays: None Motion carried.

Minutes: Motion by Carland, seconded by Sauer, to approve the May 24, 2016 minutes as presented. Ayes: All Nays: None Motion carried.

Public Input - None

Committee Appointment Policy: Discussions held; the policy should remain as is.

Chris Woods – Step 3 Grievance, Mitch: The committee has agreed that this matter shall be handled by the County Administrator on behalf of the HR Committee. All grievances will be decided on a case-by-case basis.

Clerical Position, Child Care Position, Jail Secretary: Mitch stated that these three positions are in flux; Sheriff is setting up interviews at this time; there remains the option that the Sheriff and Prosecutor may share the position.

Wages: Mitch stated that this remains a growing concern for Benzie County; we are getting farther and farther behind; we hire people to perform a service; further discussions were held regarding health insurance, millage rate, budget, fund balance – all of those items play a role in wages. He stated that it is the non-union wages that are falling behind. Mitch and Maridee will work up a spreadsheet showing 1%, 2% and 3% wage increases, as well at health insurance options of 80/20, or a 5% or 10% contribution by the employees and bring back to this committee.

Other: None

2:10 p.m. Public Input:
Susan Zenker stated that any employee that is having nothing taken out of their paycheck for health insurance is lucky; she is employed by the private sector and her employer has the 80/20 plan so she has health insurance taken out every week.
Ted Schendel told her that we are reaching the point that employees will have to pay toward their health insurance.

Public Input Closed.

Motion by Sauer, seconded by Carland, to adjourn at 2:13 p.m. Ayes: Carland, Sauer and Warsecke Nays: None Motion carried.

Dawn Olney
Benzie County Clerk

Committee Appointments

ACTION ITEMS

Benzie County
Office Of Emergency Management
7th Region 7 Homeland Security

Memorandum

Agenda

To: Roger Griner, Chair
Benzie County Board of Commissioners
From: Frank Post, Emergency Management Coordinator
Date: June 27th, 2016
Subject: 2015 Emergency Management Grant Program (EMPG)Approval

Attached is a copy of the 2016 EMPG grant for the fiscal year 2015/16. If you will recall, this grant program pays approximately 36% to 45% of the wages and benefits of the Emergency Management Coordinator position in Benzie County. The differences in the percentages is typically based on the number of Emergency Management programs that receive funding and how much money the state receives from FEMA. This award is for $19,194.00 and is for 35.6931% of wages and benefits. The last few years there has been a supplemental award that has will move the percentage up to 41% to 43% and we received additional dollars at the end of the year because the state had excess FEMA funds to distribute.

The program is limited to 50% of wages and benefits.

GRANT PROCESS
The EMPG program starts with the approval of a Work Agreement. This puts MSP EMHSD on notice that we will be applying for funding for our Emergency Management Position as well as putting the County on notice as to the performance requirements for funding. The Board of Commissioners approved that Work Agreement in early September 2015. Every quarter thereafter and throughout the fiscal year I submitted reports to the District Emergency Management Coordinator for the Michigan State Police. They review the progress of compliance and approve the document going forward.

Toward the end of the performance period we receive a Grant Agreement (the document under consideration) which outlines specifically what the funding is expected to be a formal agreement that the county will substantially achieve the goals outlined in the Work Agreement. This is the document that specifically requests reimbursement for the wages and benefits of the Emergency Management Coordinator Position paid during the performance period.

RECOMMENDATION
It is my recommendation that Benzie County Board of Commissioners approve the 2016 EMPG application and authorize the Chair and Emergency Management Coordinator sign on behalf of the county.

STATE OF MICHIGAN

DEPARTMENT OF STATE POLICE

LANSING

RICK SNYDER
GOVERNOR

COL. KRISTE KIBBEY ETUE
DIRECTOR

June 20, 2016

Dear Local Emergency Management Coordinator:

Enclosed is the Fiscal Year 2016 Emergency Management Performance Grants (EMPG) Grant Agreement package. Please return the required grant documentation listed on the enclosed ***Subrecipient Checklist*** to our office at the following address:

Attn: Ms. Mary K. Mankowski
Emergency Management and Homeland Security Division
Michigan Department of State Police
PO Box 30634
Lansing, Michigan 48909

Reimbursement for the EMPG program is contingent upon completion of the activities in the signed *Emergency Management Annual Work Agreement*. In order to remain eligible for EMPG funding, current and adequate plans must be maintained and exercise requirements must be met. If a work activity is not completed in the designated quarter, reimbursement may not be made until the work is completed. The Emergency Management and Homeland Security Division District Coordinators may make recommendations on reimbursement, but final approval remains with the Deputy State Director of Emergency Management and Homeland Security, who may or may not approve a delay in the completion of the activity. If work activities (for which funds have been withheld) have not been completed by the end of the fiscal year, forfeiture of those funds may be required. As a recipient of funding from the U.S. Department of Homeland Security, you are responsible for the management and fiscal control of all funds. These responsibilities include accounting for receipts and expenditures, maintaining adequate financial records, and refunding expenditures disallowed by federal or state audit. For specific responsibilities and requirements, please refer to Section II (Statutory Authority) and Section IV (Responsibilities of the Subrecipient) in the Fiscal Year 2016 EMPG Grant Agreement.

This grant agreement and all required attachments must be completed, signed, and returned **no later than August 22, 2016.** If this requirement is not met, this grant agreement will be invalid after August 22, 2016, unless a prior written exception is provided by the Michigan State Police, Emergency Management and Homeland Security Division.

Sincerely,

Chris A. Kelenske

Capt. Chris A. Kelenske, Commander
Deputy State Director of Emergency Management
and Homeland Security

Enclosures (8)

RECEIVED

JUN 28 2016

DAWN OLNEY
BENZIE COUNTY CLERK
BEULAH, MI 49617

Michigan State Police

Emergency Management and Homeland Security Division

Grant Agreement

FEDERAL AWARD IDENTIFICATION

SUBRECIPIENT NAME	GRANT NAME	CFDA NUMBER
County of Benzie	Emergency Management Performance Grant	97.042
SUBRECIPIENT IRS/VENDOR NUMBER	**FEDERAL AWARD IDENTIFICATION NUMBER (FAIN)**	**FEDERAL AWARD DATE**
38-6004838	EMC-2016-EP-00001-S01	5/31/2016
SUBRECIPIENT DUNS NUMBER	**SUBAWARD PERFORMANCE PERIOD** FROM	TO
151930112	10/1/2015	9/30/2016

RESEARCH & DEVELOPMENT	Funding	Total
N/A	Federal Funds Obligated by this Action	$19,194.00
INDIRECT COST RATE	Total Federal Funds Obligated to Subrecipient	$19,194.00
None on file	Total Amount of Federal Award	$9,031,286.00

FEDERAL AWARD PROJECT DESCRIPTION

2016 Emergency Management Performance Grant

DETAILS

The 2016 EMPG allocation is 35.6931% of the Subrecipient's emergency program manager's salary and fringe benefits. The FY 2016 EMPG program has a 50% cost match (cash or in-kind) requirement.

FEDERAL AWARDING AGENCY	PASS-THROUGH ENTITY (RECIPIENT) NAME
Federal Emergency Management Agency Grant Operations 245 Murray Lane – Building 410, SW Washington DC 20528-7000	Michigan State Police Emergency Management and Homeland Security Division PO Box 30634 Lansing, MI 48909

State of Michigan
FY 2016 Emergency Management Performance Grant
Grant Agreement

October 1, 2015 to September 30, 2016

CFDA Number: 97.042
Grant Number: EMC-2016-EP-00001

This Fiscal Year (FY) 2016 Emergency Management Performance Grants (EMPG) grant agreement is hereby entered into between the Michigan Department of State Police, Emergency Management and Homeland Security Division (hereinafter called the Recipient), and the

COUNTY OF BENZIE
(hereinafter called the Subrecipient)

I. Purpose

The purpose of this grant agreement is to provide federal pass-through funds to the Subrecipient for the development and maintenance of an emergency management program capable of protecting life, property, and vital infrastructure in times of disaster or emergency.

The FY 2016 EMPG program plays an important role in the implementation of the National Preparedness System (NPS) by supporting the building, sustainment, and delivery of core capabilities essential to achieving the National Preparedness Goal of a secure and resilient Nation. The objective of the NPS is to facilitate an integrated, all-of-nation/whole community, risk driven, capabilities-based approach to preparedness.

In support of the National Preparedness Goal, the FY 2016 EMPG program supports a comprehensive, all-hazard emergency preparedness system to build and sustain core capabilities across the Prevention, Protection, Mitigation, Response, and Recovery mission areas.

For more information on NPS, federally designated priorities, and the FY 2016 EMPG objectives, as well as guidance on allowable costs and program activities, please refer to the FY 2016 EMPG Notice of Funding Opportunity (NOFO) located at http://www.fema.gov/grants.

II. Statutory Authority

Funding for the FY 2016 EMPG is authorized by Section 662 of the *Post-Katrina Emergency Management Reform Act of 2006* (PKEMRA), as amended, (Pub. L. No. 109-295) (6 U.S.C. § 762); the *Robert T. Stafford Disaster Relief and Emergency Assistance Act*, as amended (Pub. L. No. 93-288) (42 U.S.C. §§ 5121 et seq.); the *Earthquake Hazards Reduction Act of 1977, as amended* (Pub. L. No. 95-124) (42 U.S.C. §§ 7701 et seq.); and the *National Flood Insurance Act of 1968*, as amended (Pub. L. No. 90-448) (42 U.S.C. §§ 4001 et seq.).

Appropriation authority is provided by the *Department of Homeland Security Appropriations Act, 2016*, (Pub. L. No. 114-113).

The Subrecipient agrees to comply with all EMPG program requirements in accordance with the federal FY 2016 EMPG NOFO; the *Michigan Emergency Management Act*, Act 390, P.A. of 1976, as amended at http://www.legislature.mi.gov/doc.aspx?mcl-Act-390-of-1976; and the *Robert T. Stafford Disaster Relief and Emergency Assistance Act,* as amended (Pub. L. No. 93-288) (42 U.S.C. §§ 5121 et seq.) located at http://www.fema.gov/robert-t-stafford-disaster-relief-and-emergency-assistance-act-public-law-93-288-amended.

The Subrecipient shall also comply with the most recent version of:

A. 2 CFR, Part 200 of the Code of Federal Regulations (CFR), *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* located at http://www.ecfr.gov.

B. 44 CFR, Part 10, *Environmental Considerations.*

III. Award Amount and Restrictions

A. The **County of Benzie** is awarded **$19,194.00** under the **FY 2016 EMPG**. The Recipient determined the Subrecipient's EMPG allocation as 35.6931% of the Subrecipient's emergency program manager's salary and fringe benefits. The Subrecipient may receive less than the allocated amount if the Subrecipient's cost share of wages and fringe benefits paid to the program manager are less than the total allocation. The Subrecipient's EMPG program budget must be documented on the Local Budget for Emergency Management Performance Grant form (EMD-17).

B. The FY 2016 EMPG covers eligible costs from October 1, 2015 to September 30, 2016. The funds awarded in the grant agreement shall only be used to cover allowable costs that are incurred during the agreement period. Grant agreement funds shall not be used for other purposes. For guidance on allowable costs, please refer to the FY 2016 EMPG NOFO, specifically Appendix B.

C. This grant agreement designates EMPG funds for the administration and oversight of an approved emergency management program. **The Subrecipient may utilize grant funds for the reimbursement of salary, overtime, compensatory time off, and associated fringe benefits for the program manager, and up to 5% of the total allocation may be utilized for M&A costs.** No other expenditures are allowed. **If M&A costs are claimed, a narrative must be submitted detailing the expenses that are included in these costs**.

D. The FY 2016 EMPG program has a 50% cost match (cash or in-kind) requirement, as authorized by the *Robert T. Stafford Disaster Relief and Emergency Assistance Act,* as amended, (Pub. L. No. 93-288) (42 U.S.C. §§ 5121 et seq.), specifically, Title VI, sections 611(j) and 613. Federal funds cannot exceed 50% of eligible costs. Unless otherwise authorized by law, federal funds cannot be matched with other federal funds.

   The Federal Emergency Management Agency (FEMA) administers cost matching requirements in accordance with 2 CFR § 200.306. To meet matching requirements, the Subrecipient contributions must be reasonable, allowable, allocable, and necessary under the grant program and must comply with all federal requirements and regulations.

   See the FY 2016 EMPG NOFO for additional match guidance, to include match definitions, basic guidelines, and governing provisions.

E. All EMPG funded personnel must complete training requirements for the National Incident Management System (NIMS) and the FEMA Professional Development Series (PDS) and record proof of completion. All EMPG funded personnel must also participate in no less than three exercises in a 12 month period.

   EMPG programs are required to fill out a quarterly training and exercise report (Quarterly Training and Exercise Reporting Worksheet) identifying training and exercises completed during the quarter. Guidance for accomplishing these requirements will be provided by the Recipient.

F. Upon request, the Subrecipient must provide to the Recipient information necessary to meet any state or federal subaward reporting requirements.

IV. Responsibilities of the Subrecipient

A. **Grant funds must supplement, not supplant, state or local funds**. Federal funds must be used to supplement existing funds, not replace (supplant) funds that have been appropriated for the same purpose. Potential supplanting will be carefully reviewed in subsequent monitoring reviews and audits. Subrecipients may be required to supply documentation certifying that a reduction in non-federal resources occurred for reasons other than the receipt or expected receipt of federal funds.

B. The Subrecipient agrees to comply with all applicable federal and state regulations; the FY 2016 EMPG NOFO, the *Agreement Articles Applicable to Subrecipients: Fiscal Year 2016 Emergency Management Performance Grants*, and the EMPG Guidebook (EMD-PUB 208) located at http://www.michigan.gov/emhsd. Each of these documents is incorporated by reference into this grant agreement. The *Agreement Articles Applicable to Subrecipients: Fiscal Year 2016 Emergency Management Performance Grants* document is included in the grant agreement packet.

C. In addition to this grant agreement, the Subrecipient shall complete, sign, and submit to the Recipient the following documents, which are incorporated by reference into this grant agreement:
   1. Standard Assurances
   2. Certifications Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements
   3. Audit Certification (EMD-053)
   4. Request for Taxpayer Identification Number and Certification (W-9)
   5. Other documents that may be required by federal or state officials

D. Complete and submit quarterly work reports, the Quarterly Training and Exercise Worksheet, and the Annual Training and Exercise Plan Worksheet in accordance with the schedule outlined in the FY 2016 EMPG Work Agreement/Quarterly Report (EMD-31).

E. Enact enabling legislation establishing the local emergency management program and ensure a copy of the local resolution or ordinance is on file with the Recipient.

F. Appoint an emergency management program manager who is able to assume responsibility for the following functions:
   1. Development and maintenance of programs and systems for effective coordination of community resources in each of the five mission areas: prevention, protection, mitigation, response, and recovery.
   2. Planning and preparation for population protection, including evacuation, shelter/reception, logistics and resource management. Ensure that Executive Order #13347 entitled Individuals with Disabilities in Emergency Preparedness and the *Rehabilitation Act of 1973* are being addressed. Further information on disability emergency preparedness programs can be found at http://www.disability.gov.
   3. Planning and preparation for its appropriate role in response to natural and man-made emergencies and disasters.
   4. Exercising the emergency operations plan of the jurisdiction.
   5. Emergency management training.
   6. Response and recovery from natural and man-made hazards, homeland security related incidents, and other emergencies that may threaten the safety and well-being of citizens and communities.
   7. Promoting public awareness of hazards and encouraging family and individual preparedness.
   8. Identifying and implementing measures to mitigate the negative impact of disasters and emergencies.
   9. Comply with National Incident Management System (NIMS) requirements to be eligible to receive federal preparedness funds. NIMS information is available at http://www.fema.gov/national-incident-management-system. More information on complying with NIMS is available from the State NIMS Coordinator.
   10. Identify and prioritize needs while simultaneously addressing issues of state and national concern through implementation of the National Preparedness System and the integration of preparedness efforts that build, sustain, and deliver the core capabilities necessary to achieve the desired outcomes identified in the National Preparedness Goal.

G. Provide the Recipient with complete job description for the federally funded EMPG program manager, including non-EMPG duties.

H. Notify the Recipient immediately of any changes in the EMPG funded program manager's position.

I. The Subrecipient will contribute to the development and maintenance of the state's multi-year Training and Exercise Plan (TEP) and conduct exercises that comply with local, state, and federal requirements, including the Homeland Security Exercise and Evaluation Program (HSEEP) to accomplish this goal. Specific requirements are as follows:
   1. Exercises must be conducted by the Subrecipient at least annually.
   2. Exercises must comply with the Subrecipient's annual EMPG Work Agreement.
   3. The Subrecipient must also submit a three-year exercise plan worksheet reflecting upcoming training events and exercises which are to be included in the annual state multi-year Training and Exercise Plan.
   4. An After Action Report/Improvement Plan (AAR/IP) shall be completed for each exercise and submitted to the Michigan State Police (MSP), Emergency Management and Homeland Security Division (EMHSD) State Exercise Officer.

J. Ensure the EMPG funded program manager completes specific training classes as required by the annual EMPG Work Agreement.

K. Have an approved and current emergency operations plan on file with the MSP/EMHSD District Coordinator.

L. The Subrecipient agrees to prepare the form EMD-007 EMPG Expenses Claimed for Local Program Contributions. This form is also referred to as the EMPG Quarterly Billing. The Subrecipient agrees to submit this form with supporting documentation, including all required authorized signatures and required reimbursement documentation, to the appropriate District Coordinator by the due date following the end of **each** quarter. The most current EMD-007 form must be used and can be obtained from the District Coordinator.

M. Comply with applicable financial and administrative requirements set forth in the current edition of 2 CFR, Part 200, including, but not limited to, the following provisions:
   1. Account for receipts and expenditures, maintain adequate financial records, and refund expenditures disallowed by federal or state audit.
   2. Retain all financial records, statistical records, supporting documents, and other pertinent materials for at least three years after the grant is closed by the awarding federal agency for purposes of federal and/or state examination and audit.
   3. Non-federal organizations which expend $750,000 or more in federal funds during their current fiscal year are required to have an audit performed in accordance with the Single Audit Act of 1984, as amended, and 2 CFR, Part 200.

N. Complete federally-mandated reporting requirements, including, but not limited to, requirements related to the *Federal Funding Accountability and Transparency Act of 2006* (FFATA) (Public Law 109-282), as amended by Section 6202(a) of the *Government Funding Transparency Act of 2008* (Public Law 110-252) and Department of Homeland Security (DHS) program specific reporting requirements.

O. The Subrecipient must acknowledge and agree to comply with applicable provisions governing DHS access to records, accounts, documents, information, facilities, and staff. The Subrecipient also agrees to require any subrecipients, contractors, successors, transferees, and assignees to acknowledge and agree to comply with these same provisions. Detailed information on record access provisions can be found in the *DHS Standard Administrative Terms and Conditions* located at https://www.dhs.gov/publication/fy15-dhs-standard-terms-and-conditions, specifically in the DHS Specific Acknowledgements and Assurances on pages 1.

V. Responsibilities of the Recipient

The Recipient, in accordance with the general purposes and objectives of this grant agreement, will:

A. Administer the grant in accordance with all applicable federal and state regulations and guidelines and submit required reports to the awarding federal agency.

B. Provide direction and technical assistance to the Subrecipient.

C. Provide to the Subrecipient any special report forms and reporting formats (templates) required for administration of the program.

D. Reimburse the Subrecipient, in accordance with this grant agreement, based on appropriate documentation submitted by the Subrecipient.

E. At its discretion, independently, or in conjunction with the federal awarding agency, conduct random on-site reviews of the Subrecipient(s).

VI. Reporting Procedures

A. The Subrecipient agrees to prepare quarterly work reports using the FY 2016 EMPG Work Agreement/Quarterly Report (EMD-31) and submit them through EMHSD's online reporting tool by the due date following the end of **each** quarter. Reimbursement of expenditures by the Recipient is contingent upon the Subrecipient's completion of scheduled work activities.

B. If the Subrecipient fails to complete the scheduled work activities during a quarter, the Recipient will withhold reimbursement until either the work is completed or the Deputy State Director of Emergency Management and Homeland Security approves a delay in the completion of the activity. If scheduled work activities are not completed by the end of the fiscal year, September 30, 2016, any balance of the EMPG award may be forfeited.

C. A Subrecipient that fails to complete the annual exercise requirement, as scheduled within the FY 2016 EMPG Work Agreement/Quarterly Report may be ineligible for EMPG funding for that quarter and all subsequent quarters until the qualifying exercise is completed.

D. The Subrecipient's failure to fulfill the quarterly reporting requirements, as required by the grant, may result in the suspension of grant activities until reports are received.

E. Reporting periods and due dates are listed in the FY 2016 EMPG Work Agreement/Quarterly Report (EMD-31) located at http://www.michigan.gov/emhsd.

VII. Payment Procedures

A. The Subrecipient agrees to prepare the form EMD-007 EMPG Expenses Claimed for Local Program Contributions. This form is also referred to as the EMPG Quarterly Billing. The Subrecipient agrees to submit this form with supporting documentation, including all required authorized signatures and required reimbursement documentation, to the appropriate District Coordinator by the due date following the end of **each** quarter. The most current EMD-007 form must be used and can be obtained from the District Coordinator.

B. If the Subrecipient submits required quarterly reports that are late or incomplete, the reimbursement may not be processed until the following quarter.

C. The Subrecipient agrees to return to the Recipient any unobligated balance of funds held by the Subrecipient at the end of the agreement period or handle them in accordance with the instructions provided by the Recipient.

VIII. Employment Matters

The Subrecipient shall comply with Title VI of the *Civil Rights Act of 1964*, as amended; Title VIII of the *Civil Rights Act of 1968*; Title IX of the *Education Amendments of 1972 (Equal Opportunity in Education Act)*; the *Age Discrimination Act of 1975*; Titles I, II and III of the *Americans with Disabilities Act of 1990*; the *Elliott-Larsen Civil Rights Act*, 1976 PA 453, as amended, MCL 37.2101 *et seq.*; the *Persons with Disabilities Civil Rights Act*, 1976 PA 220, as amended, MCL 37.1101 *et seq.*, and all other federal, state and local fair employment practices and equal opportunity laws and covenants. The Subrecipient shall not discriminate against any employee or applicant for employment, to be employed in the performance of this grant agreement, with respect to his or her hire, tenure, terms, conditions, or privileges of employment; or any matter directly or indirectly related to employment because of his or her race, religion, color, national origin, age, sex, height, weight, marital status, limited English proficiency, or handicap that is unrelated to the individual's ability to perform the duties of a particular job or position. The Subrecipient agrees to include in every subcontract entered into for the performance of this grant agreement this covenant not to discriminate in employment. A breach of this covenant is a material breach of the grant agreement.

The Subrecipient shall ensure that no subcontractor, manufacturer, or supplier of the Subrecipient for projects related to this grant agreement appears on the Federal Excluded Parties List System located at https://www.sam.gov.

IX. Limitation of Liability

The Recipient and the Subrecipient to this grant agreement agree that each must seek its own legal representative and bear its own costs, including judgments, in any litigation that may arise from performance of this contract. It is specifically understood and agreed that neither party will indemnify the other party in such litigation.

This is not to be construed as a waiver of governmental immunity for either party.

X. Third Parties

This grant agreement is not intended to make any person or entity, not a party to this grant agreement, a third party beneficiary hereof or to confer on a third party any rights or obligations enforceable in their favor.

XI. Grant Agreement Period

This grant agreement is in full force and effect from October 1, 2015 to September 30, 2016. No costs eligible under this grant agreement shall be incurred before the starting date of this grant agreement, except with prior written approval. This grant agreement package consists of two identical grant agreements, simultaneously executed; each is considered an original having identical legal effect. This grant agreement may be terminated by either party by giving thirty (30) days written notice to the other party stating reasons for termination and the effective date, or upon the failure of either party to carry out the terms of the grant agreement. Upon any such termination, the Subrecipient agrees to return to the Recipient any funds not authorized for use, and the Recipient shall have no further obligation to reimburse the Subrecipient.

XII. Entire Grant Agreement

This grant agreement is governed by the laws of the State of Michigan and supersedes all prior agreements, documents, and representations between the Recipient and the Subrecipient, whether expressed, implied, or oral. This grant agreement constitutes the entire agreement between the parties and may not be amended except by written instrument executed by both parties prior to the grant end date. No party to this grant agreement may assign this grant agreement or any of his/her/its rights, interest, or obligations hereunder without the prior consent of the other party. The Subrecipient agrees to inform the Recipient in writing immediately of any proposed changes of dates, budget, or services indicated in this grant agreement, as well as changes of address or personnel affecting this grant agreement. Changes in dates, budget, or services are subject to prior written approval of the Recipient. If any provision of this grant agreement shall be deemed void or unenforceable, the remainder of the grant agreement shall remain valid.

The Recipient may suspend or terminate grant funding to the Subrecipient, in whole or in part, or other measures may be imposed for any of the following reasons:

A. Failure to expend funds in a timely manner consistent with the grant milestones, guidance, and assurances.
B. Failure to comply with the requirements or statutory objectives of federal or state law.
C. Failure to make satisfactory progress toward the goals or objectives set forth in the annual EMPG Work Agreement.
D. Failure to follow grant agreement requirements or special conditions.
E. Failure to submit required reports.
F. Filing of a false certification in the application or other report or document.

Before taking action, the Recipient will provide the Subrecipient reasonable notice of intent to impose corrective measures and will make every effort to resolve the problem informally.

XIII. Business Integrity Clause

The Recipient may immediately cancel the grant without further liability to the Recipient or its employees if the Subrecipient, an officer of the Subrecipient, or an owner of a 25% or greater share of the Subrecipient is convicted of a criminal offense incident to the application for or performance of a state, public, or private grant or subcontract; or convicted of a criminal offense, including, but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under state or federal antitrust statutes; or convicted of any other criminal offense which, in the sole discretion of the Recipient, reflects on the Subrecipient's business integrity.

XIV. Freedom of Information Act (FOIA)

Much of the information submitted in the course of applying for funding under this program, or provided in the course of grant management activities, may be considered law enforcement-sensitive or otherwise critical to national security interests. This may include threat, risk, and needs assessment information; and discussions of demographics, transportation, public works, and industrial and public health infrastructures. Therefore, each Subrecipient agency Freedom of Information Officer will need to determine what information is to be withheld on a case-by-case basis. The Subrecipient should be familiar with the regulations governing Protected Critical Infrastructure Information (6 CFR, Part 29) and Sensitive Security Information (49 CFR, Part 1520), as these designations may provide additional protection to certain classes of homeland security information.

XV. Official Certification

For the Subrecipient
The individual or officer signing this grant agreement certifies by his or her signature that he or she is authorized to sign this grant agreement on behalf of the organization he or she represents. The Subrecipient agrees to complete all requirements specified in this grant agreement.

Benzie County	15-193-0012
Subrecipient Name	Subrecipient's DUNS Number

For the Chief Elected Official

Roger Griner	Chair, Benzie County
Printed Name	Title
Signature	Date

For the Local Emergency Program Manager

Frank Post	Emergency Management Coordinator
Printed Name	Title
Frank Post	6/23/2016
Signature	Date

For the Recipient (Michigan State Police, Emergency Management and Homeland Security Division)

Chris A. Kelenske, Captain	Deputy State Director of Emergency Management and Homeland Security
Printed Name	Title
Chris A. Kelenske	June 20, 2016
Signature	Date

U.S. DEPARTMENT OF JUSTICE
OFFICE OF JUSTICE PROGRAMS
OFFICE OF THE COMPTROLLER

CERTIFICATIONS REGARDING LOBBYING; DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS; AND DRUG-FREE WORKPLACE REQUIREMENTS

Applicants should refer to the regulations cited below to determine the certification to which they are required to attest. Applicants should also review the instructions for certification included in the regulations before completing this form. Signature of this form provides for compliance with certification requirements under 28 CFR Part 69, "New Restrictions on Lobbying" and 28 CFR Part 67, "Government-wide Debarment and Suspension (Nonpro-curement) and Government-wide Requirements for Drug-Free Workplace (Grants)." The certifications shall be treated as a material representation of fact upon which reliance will be placed when the Department of Justice determines to award the covered transaction, grant, or cooperative agreement.

1. LOBBYING

As required by Section 1352, Title 31 of the U.S. Code, and implemented at 28 CFR Part 69, for persons entering into a grant or cooperative agreement over $100,000, as defined at 28 CFR Part 69, the applicant certifies that:

(a) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making of any Federal grant, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal grant or cooperative agreement;

(b) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal grant or cooperative agreement, the undersigned shall complete and submit Standard Form - LLL, "Disclosure of Lobbying Activities," in accordance with its instructions;

(c) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subgrants, contracts under grants and cooperative agreements, and subcontracts) and that all subrecipients shall certify and disclose accordingly.

---

2. DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS (DIRECT RECIPIENT)

As required by Executive Order 12549, Debarment and Suspension, and implemented at 28 CFR Part 67, for prospective participants in primary covered transactions, as defined at 28 CFR Part 67, Section 67.510—

A. The applicant certifies that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, sentenced to a denial of Federal benefits by a State or Federal court, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) Have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

(d) Have not within a three-year period preceding this application had one or more public transactions (Federal, State, or local) terminated for cause or default; and

B. Where the applicant is unable to certify to any of the statements in this certification, he or she shall attach an explanation to this application.

---

3. DRUG-FREE WORKPLACE (GRANTEES OTHER THAN INDIVIDUALS)

As required by the Drug-Free Workplace Act of 1988, and implemented at 28 CFR Part 67, Subpart F, for grantees, as defined at 28 CFR Part 67 Sections 67.615 and 67.620—

A. The applicant certifies that it will or will continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an on-going drug-free awareness program to inform employees about—

(1) The dangers of drug abuse in the workplace;

(2) The grantee's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will—

1406 N Mitchell Street
Cadillac, MI 49601
855-306-1099 Phone
855-306-1098 Fax
www.44n.com

ACTION 7

May 10, 2016

Maridee Cutler
Benzie County
448 Court Place
Beulah, MI 49617

Re: Enclosed Plan Amendment

Dear Ms. Cutler:

Your plan document has been amended in order to best comply with Medicare Secondary Payer regulations and recent Affordable Care Act guidance that relates to out-out payment programs/cash-in-lieu payment programs.

Opt-Out payments/Cash-In-Lieu payments to Medicare eligible employees are prohibited for employers of 20 or more because they are considered prohibited incentives under Medicare Secondary Payer (MSP) rules. The general rule is that an employer (with 20 or more employees) cannot offer, subsidize, or incent any active Medicare eligible employee to not enroll in the employer's group health plan. We recommend adopting the revised language to clarify that the opt-out program offered through the cafeteria plan will operate in accordance with all applicable laws and regulations, include those required by the Medicare Secondary Payer rules.

IRS Notice 2015-17 states that a general pay increase that is conditioned upon the purchase of health insurance constitutes an "employer payment plan" prohibited by the Affordable Care Act. It is possible that an employer's opt-out program may be deemed a general pay increase that is conditional upon the purchase of other health coverage, especially if the opt-out program requires proof of other coverage in order to receive the opt-out payment. To avoid this situation, we recommend adopting the revised language which expressly disclaims that the opt-out payment program is not an employer payment plan.

The enclosed plan amendment and summary of material modifications (SMM) modify your cafeteria plan document to a) state that the opt-out payment program will operate pursuant to all applicable laws, including Medicare Secondary Payer rules and b) expressly disclaim that the opt-out program is not an employer payment plan. If you would like to adopt this amendment, please complete the Amendment and the Adoption Agreement, then return a copy of both in the enclosed envelope. Please distribute the SMM to all employees eligible to participate in the cafeteria plan, including those who are not enrolled.

As always, if you have any questions, please do not hesitate to contact your Account Coordinator or a member of your service team.

Sincerely,

Your 44N Service Team

KH:kh

RECEIVED
JUL 01 2016
DAWN OLNEY
BENZIE COUNTY CLERK
BEULAH, MI 49617

Benzie County
Section 125 Cafeteria Plan Amendment
Employer "Opt-Out" or "Cash in Lieu of" Payments

Section III of the Plan Document is hereby amended as follows:

Opt-Out Option. An Eligible Employee may opt out of Benzie County group benefit plan and receive additional cash payment in lieu of benefits only to the extent permitted by applicable law (which include Medicare Secondary Payer rules). Employees enrolled in the employer's group benefit Plan as a dependent of another employee (i.e. spouse or parent) are not eligible for cash in lieu of. The amount of payment in lieu of benefits will be communicated to participants at the time of the enrollment period.

The opt-out option is not intended to be a reimbursement benefit of any kind. The cash benefit is taxable and is considered unrestricted cash compensation, and is not intended for the direct or indirect purchase/reimbursement of any other medical insurance premium (whether individual or group coverage).

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing amendment to the Benzie County Section 125 Cafeteria Plan, Benzie County has caused this Amendment to be executed in its name and on its behalf, on this ____ day of _____, 2016, to be effective as of 11/1/2015.

Benzie County

By: _____
Printed Name and Title

Signature: _____

Date: _____

Benzie County
Section 125 Cafeteria Plan Amendment
Employer "Opt-Out" or "Cash in Lieu of" Payments

Section III of the Plan Document is hereby amended as follows:

Opt-Out Option. An Eligible Employee may opt out of Benzie County group benefit plan and receive additional cash payment in lieu of benefits only to the extent permitted by applicable law (which include Medicare Secondary Payer rules). Employees enrolled in the employer's group benefit Plan as a dependent of another employee (i.e. spouse or parent) are not eligible for cash in lieu of. The amount of payment in lieu of benefits will be communicated to participants at the time of the enrollment period.

The opt-out option is not intended to be a reimbursement benefit of any kind. The cash benefit is taxable and is considered unrestricted cash compensation, and is not intended for the direct or indirect purchase/reimbursement of any other medical insurance premium (whether individual or group coverage).

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing amendment to the Benzie County Section 125 Cafeteria Plan, Benzie County has caused this Amendment to be executed in its name and on its behalf, on this ____ day of _____, 2016, to be effective as of 11/1/2015.

Benzie County

By: _____
Printed Name and Title

Signature: _____

Date: _____

Benzie County
Section 125 Cafeteria Plan
Summary of Material Modifications (SMM)
Describing Amendment
Employer "Opt-Out" or "Cash in Lieu of" Payments
Pursuant to IRS Notice 2015-87

What follows is a Summary of Material Modifications to the Benzie County Amendment Employer "Opt-Out" or "Cash in Lieu of" Payments Section 125 Cafeteria Plan (the "Plan"). It is intended to notify you of important changes made to the Plan effective 11/1/2015. You should take the time to read this Summary carefully and keep it with the copy of the Summary Plan Description that was previously provided to you. If you need another copy of the Summary Plan Description or if you have any questions regarding these changes to the Plan, please contact the Benzie County office during normal business hours at 448 Court Place, Beulah, MI 49617, telephone number 231-882-0035.

Section III of the Plan Document is hereby amended as follows:

Opt-Out Option. An Eligible Employee may opt out of Benzie County group benefit plan and receive additional cash payment in lieu of benefits only to the extent permitted by applicable law (which include Medicare Secondary Payer rules). Employees enrolled in the employer's group benefit Plan as a dependent of another employee (i.e. spouse or parent) are not eligible for cash in lieu of. The amount of payment in lieu of benefits will be communicated to participants at the time of the enrollment period.

The opt-out option is not intended to be a reimbursement benefit of any kind. The cash benefit is taxable and is considered unrestricted cash compensation, and is not intended for the direct or indirect purchase/reimbursement of any other medical insurance premium (whether individual or group coverage).

This Summary is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this Summary, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this Summary and the Plan, or if any point is not discussed in this Summary or is only partially discussed, the terms of the Plan will govern in all cases. The Employer or its authorized representative, reserves the right, to amend, modify or terminate the Plan, or any benefits provided under the Plan.

CERTIFICATE OF ADOPTING RESOLUTION

The Employer hereby certifies that the following resolutions were duly adopted by the Employer on _____, 2016, and that such resolutions have not been modified or rescinded as of the date hereof;

Amendment
Employer "Opt-Out" or "Cash in Lieu of" Payments

RESOLVED, that the **Amendment Employer "Opt-Out" or "Cash in Lieu of" Payments** to the Benzie County Section 125 Cafeteria Plan effective 11/1/2015 is hereby approved and adopted and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Amendment.

RESOLVED, that the proper officers of the Employer shall act as soon as possible to notify employees of the Employer of the adoption of this Amendment to the Plan by delivering to each employee a copy of the summary description of the changes to the Plan in the form of the Summary of Material Modifications, which form is hereby approved.

The undersigned further certifies that attached hereto, are true copies of this Amendment to the Plan and Summary of Material Modifications approved and adopted in the foregoing resolutions.

Benzie County

By: _____
Printed Name and Title

Signature: _____

Date: _____

CERTIFICATE OF ADOPTING RESOLUTION

The Employer hereby certifies that the following resolutions were duly adopted by the Employer on _____, 2016, and that such resolutions have not been modified or rescinded as of the date hereof;

Amendment
Employer "Opt-Out" or "Cash in Lieu of" Payments

RESOLVED, that the **Amendment Employer "Opt-Out" or "Cash in Lieu of" Payments** to the Benzie County Section 125 Cafeteria Plan effective 11/1/2015 is hereby approved and adopted and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Amendment.

RESOLVED, that the proper officers of the Employer shall act as soon as possible to notify employees of the Employer of the adoption of this Amendment to the Plan by delivering to each employee a copy of the summary description of the changes to the Plan in the form of the Summary of Material Modifications, which form is hereby approved.

The undersigned further certifies that attached hereto, are true copies of this Amendment to the Plan and Summary of Material Modifications approved and adopted in the foregoing resolutions.

Benzie County

By: _____
Printed Name and Title

Signature: _____

Date: _____

44 NORTH
FOLLOW US . WE KNOW THE WAY

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Cadillac, MI 49601
855-306-1099 Phone
855-306-1098 Fax
www.44n.com

ACTN 3

June 10, 2015

Maridee Cutler
Benzie County
448 Court Place
Beulah, MI 49617

Dear Ms. Cutler:

Re: Enclosed Plan Amendment

In IRS Notice 2014-55, the IRS expanded the permitted election change rules for cafeteria plans to allow midyear election changes in two additional situations in which employees may want to drop their employer-sponsored health coverage. Beginning September 18, 2014, cafeteria plans may allow employees in the following situations to prospectively revoke an election for coverage under a group health plan that is not a health FSA and that provides minimum essential coverage:

- *Reduction of Hours.* An employee who was expected to average at least 30 hours of service per week may drop group health plan coverage midyear if the employee's status changes so that the employee is expected to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan (e.g., because the plan's eligibility provisions have been drafted to avoid penalties under health care reform's employer shared responsibility provisions). However, the change must correspond to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped.

- *Exchange Enrollment.* An employee who is eligible to enroll in Exchange coverage (during an Exchange special or open enrollment period) may drop group health plan coverage midyear, but only if the change corresponds to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Exchange coverage that is effective no later than the day after the last day of the original coverage.

Allowing the additional election change events is optional and requires a plan amendment. The amendment generally must be adopted on or before the last day of the plan year in which the additional changes are allowed and can be effective retroactively to the first day of that plan year, provided that the plan operates in accordance with the guidance and that participants are informed of the amendment. Under a special rule, employers that begin allowing the changes during the 2014 plan year have until the last day of the 2015 plan year to adopt an amendment.

The enclosed plan amendment and summary of material modifications (SMM) modify your cafeteria plan document to allow these election changes beginning with the 2015 plan year. If you would like to adopt this amendment, please complete the Amendment and the Adoption Agreement, then return a copy of both in the enclosed envelope. If you would like them retroactive to your 2014 plan year, please notify us and we will send you a new set of documents. Please distribute the SMM to the employees enrolled in your group medical plan with pre-tax cost share deductions.

As always, if you have any questions, please do not hesitate to contact your customer service representative.

Sincerely,

Kristine M. Hurd

Kristine M. Hurd
Administrative Assistant

RECEIVED
JUL 01 2016
DAWN OLNEY
BENZIE COUNTY CLERK
BEULAH, MI 49617

Benzie County
Section 125 Cafeteria Plan
Summary of Material Modifications (SMM)
Describing Amendment Allowing Additional Election Changes
Pursuant to IRS Notice 2014-55

What follows is a Summary of Material Modifications to the Benzie County 2015 Amendment Elections Section 125 Cafeteria Plan (the "Plan"). It is intended to notify you of important changes made to the Plan effective November 01, 2014. You should take the time to read this Summary carefully and keep it with the copy of the Summary Plan Description that was previously provided to you. If you need another copy of the Summary Plan Description or if you have any questions regarding these changes to the Plan, please contact the Benzie County office during normal business hours at 448 Court Place, Beulah, MI 49617, telephone number 231-882-0035.

Additional Election Changes Permitted Beginning November 01, 2014 *(Applies Only to Premium Payment Benefits for Medical Plan Coverage)*. The Plan's provisions regarding election changes during the Plan Year have been amended to allow the following additional election changes beginning November 01, 2014:

- If you were reasonably expected to average 30 hours of service or more per week and experience an employment status change such that you are reasonably expected to average less than 30 hours of service or more per week, you may prospectively revoke your election for Medical Plan coverage, provided that you (i) request the election change within the Plan's election change period and (ii) certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the Medical Plan coverage is revoked.

- If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Medical Plan coverage, provided that you (i) request the election change within the Plan's election change period and (ii) certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Medical Plan coverage.

These additional election changes will become effective no earlier than the first day of the next calendar month following the date that the election change request is filed (as determined by the Plan Administrator, election changes may become effective later to the extent that the other coverage commences later), and will remain in effect for the rest of the Plan Year unless a subsequent event recognized under IRS regulations or other guidance allows for a further election change. Election changes under this provision are subject to the terms and conditions of the Medical Plan and will not be permitted unless a corresponding change is allowed under that plan (i.e., to drop Medical Plan coverage for you or related individuals during the Plan Year).

This Summary is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this Summary, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this Summary and the Plan, or if any point is not discussed in this Summary or is only partially discussed, the terms of the Plan will govern in all cases. The Employer or its authorized representative, reserves the right, to amend, modify or terminate the Plan, or any benefits provided under the Plan.

Benzie County
Section 125 Cafeteria Plan Amendment
Allowing Additional Election Changes Pursuant to IRS Notice 2014-55

Additional Election Changes Pursuant to IRS Notice 2014-55 *(Applies Only to Premium Payment Benefits for Medical Plan Coverage).* Notwithstanding any other provision of the Plan to the contrary, the following additional election changes shall be permitted beginning November 01, 2014:

- An employee who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Medical Plan coverage, provided that the employee (i) requests the election change within the Plan's election period and (ii) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Medical Plan coverage is revoked.

- An employee who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Medical Plan coverage, provided that the employee (i) requests the election change within the Plan's election period and (ii) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Plan coverage.

Election changes made pursuant to this provision will become effective no earlier than the first day of the next calendar month following the date that the election change request is filed (as determined by the Plan Administrator, election changes may become effective later to the extent that the other coverage commences later), and shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event recognized under IRS regulations or other guidance allows for a further election change. Election changes under this provision shall be further subject to the terms and conditions of the Medical Plan and shall not be permitted unless a corresponding change is allowed under that plan (i.e., to drop Medical Plan coverage for the employee or related individuals during the Plan Year).

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing amendment to the Benzie County Section 125 Cafeteria Plan, Benzie County has caused this Amendment to be executed in its name and on its behalf, on this ____ day of _____, 2015, to be effective as of November 01, 2014.

Benzie County

By: _____
Printed Name and Title

Signature: _____

Date: _____

Benzie County
Section 125 Cafeteria Plan Amendment
Allowing Additional Election Changes Pursuant to IRS Notice 2014-55

Additional Election Changes Pursuant to IRS Notice 2014-55 *(Applies Only to Premium Payment Benefits for Medical Plan Coverage).* Notwithstanding any other provision of the Plan to the contrary, the following additional election changes shall be permitted beginning November 01, 2014:

- An employee who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Medical Plan coverage, provided that the employee (i) requests the election change within the Plan's election period and (ii) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Medical Plan coverage is revoked.

- An employee who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Medical Plan coverage, provided that the employee (i) requests the election change within the Plan's election period and (ii) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Plan coverage.

Election changes made pursuant to this provision will become effective no earlier than the first day of the next calendar month following the date that the election change request is filed (as determined by the Plan Administrator, election changes may become effective later to the extent that the other coverage commences later), and shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event recognized under IRS regulations or other guidance allows for a further election change. Election changes under this provision shall be further subject to the terms and conditions of the Medical Plan and shall not be permitted unless a corresponding change is allowed under that plan (i.e., to drop Medical Plan coverage for the employee or related individuals during the Plan Year).

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing amendment to the Benzie County Section 125 Cafeteria Plan, Benzie County has caused this Amendment to be executed in its name and on its behalf, on this ____ day of _____, 2015, to be effective as of November 01, 2014.

Benzie County

By: _____
Printed Name and Title

Signature: _____

Date: _____

CERTIFICATE OF ADOPTING RESOLUTION

The Employer hereby certifies that the following resolutions were duly adopted by the Employer on _____, 2015, and that such resolutions have not been modified or rescinded as of the date hereof;

Amendment
Allowing Additional Election Changes Pursuant to IRS Notice 2014-55

RESOLVED, that the **Amendment Allowing Additional Election Changes Pursuant to IRS Notice 2014-55** to the Benzie County Section 125 Cafeteria Plan effective November 01, 2014 is hereby approved and adopted and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Amendment.

RESOLVED, that the proper officers of the Employer shall act as soon as possible to notify employees of the Employer of the adoption of this Amendment to the Plan by delivering to each employee a copy of the summary description of the changes to the Plan in the form of the Summary of Material Modifications, which form is hereby approved.

The undersigned further certifies that attached hereto, are true copies of this Amendment to the Plan and Summary of Material Modifications approved and adopted in the foregoing resolutions.

Benzie County

By: _____
Printed Name and Title

Signature: _____

Date: _____

CERTIFICATE OF ADOPTING RESOLUTION

The Employer hereby certifies that the following resolutions were duly adopted by the Employer on _____, 2015, and that such resolutions have not been modified or rescinded as of the date hereof;

Amendment
Allowing Additional Election Changes Pursuant to IRS Notice 2014-55

RESOLVED, that the **Amendment Allowing Additional Election Changes Pursuant to IRS Notice 2014-55** to the Benzie County Section 125 Cafeteria Plan effective November 01, 2014 is hereby approved and adopted and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Amendment.

RESOLVED, that the proper officers of the Employer shall act as soon as possible to notify employees of the Employer of the adoption of this Amendment to the Plan by delivering to each employee a copy of the summary description of the changes to the Plan in the form of the Summary of Material Modifications, which form is hereby approved.

The undersigned further certifies that attached hereto, are true copies of this Amendment to the Plan and Summary of Material Modifications approved and adopted in the foregoing resolutions.

Benzie County

By: _____
Printed Name and Title

Signature: _____

Date: _____

Actm 4

44 NORTH
FOLLOW US . WE KNOW THE WAY

1406 N Mitchell Street
Cadillac, MI 49601
855-306-1099 Phone
855-306-1098 Fax
www.44n.com

October 21, 2015

Maridee Cutler
Benzie County
448 Court Place
Beulah, MI 49617

Dear Ms. Cutler:

Thank you for choosing Advanced Benefit Solutions, parent company to 44North, to administer your Health Reimbursement Arrangement (HRA) Plan and Section 125 Cafeteria – Flexible Spending Account (FSA) Plan. We greatly appreciate the trust you have placed in us.

Please **keep** the enclosed documents and process them as follows:

- ☐ FSA Plan Document – please date and sign where indicated and return one of the signature pages
- ☐ FSA SPD – please copy and distribute to *new* plan participants ✓
- ☐ FSA SMM – please copy and distribute to *current* plan participants ✓

We look forward to working with you in the ever-evolving world of employee benefits. If you have any questions, please do not hesitate to contact your Account Coordinator or a member of your service team.

Sincerely,

Your 44N Service Team

KH

Benzie County

Section 125 Cafeteria Plan

Plan Document

Amended October 01, 2015

Benzie County
Section 125 Cafeteria Plan
Plan Document
Amended October 01, 2015

Table of Contents

Purpose

The Name of this Plan is Section 125 Cafeteria Plan, established by the Employer, Benzie County, whose address is 448 Court Place, Beulah MI 49617. For more information on the Plan Sponsor, see Administrative Facts section. The effective date of this Plan is Saturday, November 01, 2003.

The purpose of the Plan is to allow Employees of the Employer to choose certain Benefits provided by the Employer or additional cash compensation so that Employees may receive Benefits that best meet their individual needs. The Employer intends that the Plan qualify as a "cafeteria plan" within the meaning of section 125(a) of the Internal Revenue Code of 1986, as amended, and that the Qualified Benefits that an Employee elects to receive under the Plan be eligible for exclusion from the Employee's income for Federal Income Tax purposes. The Employer may offer a choice among additional benefits that may not constitute Qualified Benefits, but nothing in this Plan shall be construed as offering any taxable benefits except to the extent that the Employer may otherwise specifically provide.

Section I

Definitions

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

"Affiliated Company" means:

A. any corporation which is a member of a controlled group of corporations including those within the meaning of section 1563(a) and 414(b) of the Code, determined without regard to sections 1563(a)(4) and (e)(3)(C), including the Employer;
B. any organization under common control with the Employer within the meaning of section 414(c) of the Code;
C. any organization which is included with the Employer in an affiliated service group within the meaning of section 414(m) of the Code; or
D. any other entity required to be aggregated with the Employer pursuant to regulations under section 414(o) of the Code.

"Benefit Credits" means the amount set aside for Benefits under Section 3 and credited to the Participant's Reimbursement Account(s).

"Benefits" means the Qualified Benefits of Benzie County Section 125 Cafeteria Plan available from time to time as described herein, and as set forth in the Benefit Schedules attached hereto.

"Board" means the Board of Directors of Benzie County.

"**Carry Over**" means up to $500 of unused amounts remaining at the end of a plan year in a health FSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year, provided that the plan does not incorporate the Grace Period.

"**Change in Status**" means:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, divorce, legal separation, annulment, or death of the Participant's spouse.

(b) *Number of Dependents.* An event affecting the Participant's number of Dependents, including birth, death, adoption, and placement for adoption.

(c) *Employment Status.* A change in employment status of the Participant, his spouse or Dependents, including (1) termination or commencement of employment (as determined under the Code Section 125 regulations); (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; or (5) a change in the employment status of the Participant, his spouse or dependent (e.g., hourly to salary, union to non-union, or full-time to part-time), that affects that person's rights under this Plan or an underlying benefit program (e.g., changing from salaried to hourly-paid, union to non-union or part-time from full-time).

(d) *Dependent Eligibility Requirements.* An event that causes a Participant's Dependent to satisfy or cease to satisfy the eligibility requirements for a particular benefit, such as attaining a specified age or the Dependent's status as a student.

(e) *Change in Residence.* A change in the place residence of the Participant, his spouse or Dependent.

(f) Any other events included under Code Section 125, or regulations or other guidance promulgated there under relating to changes in family status. The determination of whether there is a Change in Status shall be determined by the Plan Administrator in its sole discretion, consistent with the regulations under Code Section 125.

"**Code**" means the Internal Revenue Code of 1986, and the same as may be amended from time to time.

"**Committee**" means the individuals who may be appointed by the Plan Administrator to administer the process of claims review for the Plan in accordance with Section 5.

"**Compensation**" means earnings from this Employer.

"**Compensation Reduction Agreement**" means a voluntary agreement whereby an Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if the agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year), for purposes of obtaining the Qualified Benefits offered by the Plan.

"**Dependent**" means: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent as defined in Code §105(b), (2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Component, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

"**Effective Date**" means Saturday, November 01, 2003.

"**Eligible Benefit**" This Plan considers any expenses incurred by a participant for any product or service that is necessary for the good health of the covered individual and which is not reimbursed or reimbursable by any medical or health plan available to the individual.

"**Eligible Employee**" means any Employee who meets the specific eligibility requirements for the Plan. Part-Time employees who work less than 30 hrs/week are ineligible for this Plan.

"**Eligible Benefit Expenses**" means those eligible expenses as shown on Schedule A of this document, incurred by the Participant, or the Participant's Spouse or Dependents, after the effective date of the Participant's participation herein and during the Plan Year otherwise allowable as deductions under Code section 213 (without regard to the limitations contained in section 213(a)), but shall not include an expense incurred:

(A) for the payment of premiums under a health insurance plan not sponsored by the Employer, or

(B) for the purpose of cosmetic surgery as defined by Code section 213(d)(9).

Restriction on Reimbursement of Medicines and Drugs. Notwithstanding any other provision of the Plan to the contrary, effective January 1, 2011, Medical Care Expenses eligible for reimbursement under the Medical FSA component shall include expenses for medicines or drugs incurred after December 31, 2010

only if the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin. The Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied.

For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense that is covered by the benefits provided by this cafeteria plan and not when the participant is formally billed for, is charged for, or pays for the medical care.

"Employee" means any person employed by the Employer in a permanent full-time or part-time capacity, but not including temporary or seasonal employees, leased employees, independent contractors and employees who work outside the United States.

"Employer" means Benzie County and any other business organization which succeeds to its business and elects to continue this Plan and which adopts this Plan with the consent of the Board.

"Enrollment Period" means the period upon becoming an eligible employee. In addition, the Plan Administrator has specified another acceptable enrollment periods, which is open enrollment during the month prior to Plan Anniversary and upon becoming an eligible employee.

"Entry Date" means the date upon which your participation begins after you have enrolled in the Plan.

"Expense" means any amount paid or incurred by the Employee for Eligible Benefit Expense not otherwise reimbursed under any group plan, the reimbursement of which by the Employer is intended to be excludable from the income of such Participant under various provisions of the Code.

"Grace Period" means the period of up to two-and-one-half months following each Plan Year. The reimbursement expenses incurred during the Grace Period shall be made in accordance with IRS Notice 2005-42 (or any subsequent guidance). The Grace Period for the Medical Reimbursement plan is 0 days. The Grace Period for the Dependent Care Plan is 0 days.

"Highly Compensated Employee" means any Employee defined as such in section 414(q) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, which may be modified or amended at any time

"Key Employee" means any Employee defined as such in section 416(i)(1) of the Code.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 2, below.

"Participating Employer" means the Employer and any affiliated company, which adopts this Plan with the consent of the Board.

"Plan" means the Benzie County Flexible Benefits Plan described herein

"Plan Year" means Saturday, November 01, 2003 through Sunday, October 31, 2004. After the first Plan Year, the second Plan Year begins Monday, November 01, 2004. The Plan Year beginning, Sunday November 1, 2014 will end Wednesday, September 30, 2015. The subsequent Plan Year will begin Thursday, October 1, 2015.

"Premium Expense" means the expense or premium paid for the cost of Benefits elected by the Participant

"Qualified Benefits," means each benefit described in section 125(f) of the Code and the regulations promulgated there under.

"Reimbursement Accounts" means the accounts established as provided under Section 3, in the Participant's name and which are used to record the allocation of Benefit Credits and their expenditure (reimbursement) for Qualified Benefits.

"Retirement" means the voluntary withdrawal of active employment with the Employer after attaining the minimum retirement age and years of service.

"Spouse" (as used in this Plan) means: an individual who is treated as a spouse for federal tax purposes. Notwithstanding the above, for purposes of the DCAP Component, the term Spouse shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who is married to the Participant and files a separate federal income tax return, where (i) the

Participant maintains a household that constitutes a Qualifying Individual's principal place of abode for more than one-half of the taxable year, (ii) the Participant furnishes more than half of the cost of maintaining such household, and (iii) during the last 6 months of such taxable year, the individual is not a member of such household..

Section II

Participation in the Plan

Commencement of Participation. Each Eligible Employee shall be eligible to become a Participant on his Entry Date. The Entry Date(s) for this Plan is/are the

Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing Enrollment Forms and Compensation Reduction Agreements, and by providing such data as are reasonably required by the Employer as a condition of such participation. The Compensation Reduction Agreement shall be governed by Section 4 of this document. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

Cessation of Participation. A Participant will cease to be a Participant as of the earlier of:

A. the date on which the Plan terminates;
B. the date on which he ceases to be an Eligible Employee; or
C. the date on which he fails to make a contribution required under the terms of the Plan.
D. the date on which a Participating Employer terminates its participation in the Plan.

Nothing in this section shall prohibit the payment of Benefits with respect to claims arising prior to the Participant's termination of participation.

Notwithstanding the foregoing, a former Participant who continues to receive Compensation from the Employer shall remain a Participant for all purposes until such Compensation ceases.

Notwithstanding the above provisions, a Participant will cease to be a Participant on the last day of the plan year in which a qualifying event occurs.

However, if the Participant has any unused benefits remaining at the termination of participation, the Participant will be allowed to claim those benefits in accordance with Forfeiture of Section III, Benefits, below.

Recommencement of Participation. A former active Participant will recommence participation as of his date of reemployment. A reemployed former active Participant may not make a new election, which is effective during the Plan Year in which he separated from service with the Employer.

FMLA Leave. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA Leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Plan Participants.

Section III

Benefits and Benefit Rules

Benefit Plans

This Plan contains the Qualified Benefits of:

Medical Reimbursement Account Plan
Dependent Care Reimbursement Account Plan
Premium Conversion Plan

Medical Reimbursement Account Plan

There are some expenses you know you will have to pay for in the coming year; for instance, new eyeglasses, medical and dental expenses not reimbursed by the health plan. Normally you would pay for expenses like these with after-tax income. And because taxes reduce the value of your dollars, you would have to earn considerably more than $100 to pay $100 of these expenses.

If you are eligible to participate, the Benzie County Flexible Benefit Plan allows you to contribute pretax income to create a special reimbursement account in order to reimburse yourself on a pretax basis for payment of certain medical and other outlined expenses (See Schedule A). It's like getting a discount on these bills since you don't have to earn as much money to pay for them. The money you contribute to the reimbursement account by automatic payroll deduction is not subject to federal or Social Security taxes, but depending on your residence, may be subject to state and local income taxes.

How the Medical Reimbursement Account Works

You may establish a reimbursement account for predictable medical expenses, including dental and vision care expenses. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be paid for with pretax pay, deposited on a per pay period basis to the medical reimbursement account. The minimum and maximum pretax deferral allowed for the Medical Reimbursement Account during a Plan Year is shown on Schedule A. Once you have completed the Compensation Reduction Agreement for the Medical Reimbursement Account, you may file a claim for the afore mentioned medical expenses incurred on or after your entry date, and during the current Plan Year, that have not been reimbursed under any other Employer's accident or health plan. Generally, the qualified expenses are costs you have paid or incurred that exceed any plan deductibles and co-payments, as determined as allowable medical expenses under IRS Code Section 213, and to the limit of your Benefit Credits. The Plan Administrator will inform you of the rules that apply to filing claims.

Under this category are expenses such as non-reimbursable medical expenses covered by any other Employer's accident and health plan. Generally, the expenses covered must be "medically necessary," or prescribed by a licensed practitioner to qualify. Covered expenses *do not include* premiums paid for other health plan coverage, including plans maintained by the employer of a family member, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage.

One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs because the tax laws only allow up to $500 of unused amounts in your medical reimbursement account to be to be carried over at the end of each Plan Year or a Grace Period of up to 2 ½ months. Please see the Reimbursements section under benefit rules whether or not your plan has a Carry Over or a Grace Period.

When you are reimbursed for these qualified expenses, your Medical Reimbursement Account will be debited in the amount of reimbursement, provided there are sufficient Benefit Credits available. Once you have elected the amount of your compensation reduction, you may not add to or change the amount except as explained above as a result of a Change of Status. You may make a new election to change or eliminate the compensation reduction amounts at the beginning of each Plan Year. The Internal Revenue Code Section 125 states that these balances cannot be combined with any other reimbursement accounts in this or any other Plan, or used for purposes other than for which they are originally intended.

If your plan does not have a Carry Over or a Grace Period, compensation reduction amounts in the form of Benefit Credits remaining in your Reimbursement Account after all qualified claims have been filed and paid during a Plan, cannot be carried forward in any following year, and will be forfeited. It is therefore important that you carefully estimate your potential needs for the entire length of the Plan Year to assure that you have enough credits for your needs, but so as to have no un-used, remaining credits that you will lose.

Notwithstanding the foregoing, the maximum amount of reimbursement under the Medical Reimbursement Account which is part of this Plan will be available at all times throughout the coverage period in accordance with proposed Treasury regulations section 1.125-2(A-7)(b)(2).

Opt-Out for Health Savings Account (HSA) Coverage

During open enrollment or if a HIPAA Special Enrollment event occurs, a Participant may elect to opt-out a spouse and/or child(ren) from coverage under this Plan if the spouse and/or child(ren) are enrolled in a Qualifying High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). The Participant must complete a "Waiver of Coverage" form to opt-out a spouse and/or child(ren) from coverage under the Plan.

The spouse and/or child(ren) and Participant understand that by electing to opt-out of coverage under the Plan, the spouse and/or child(ren) will:

A. Not be entitled to any benefits or other payments from the Plan.

B. Have no right or claim to any contributions made to the Plan for the purposes of funding the spouse's and/or child(ren)'s eligibility for coverage.

C. Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by the spouse's and/or child(ren)'s HDHP.

D. Have no right to return to coverage under the Plan until such time as the HDHP coverage is lost as allowed in section titled Events Permitting Exception to Irrevocability Rule, the Dependent otherwise meets the eligibility requirements of the Plan and provides written notice to the Plan Administrator of the desire to once again become covered by the Plan.

The "Waiver of Coverage" form can be obtained from the Plan Administrator. The participant must indicate the date upon which the waiver of coverage will be effective.

Dependent Care Reimbursement Account Plan

Provision of Benefits. Benefits under this Plan shall take the form of reimbursement for Dependent Care, as determined by Code Sec.129, by the Employer for Eligible Expenses incurred by a Participant during the Plan Year. A Participant shall be entitled to benefits under this Plan only for Eligible Expenses incurred after becoming a Participant.

Funding. All Benefits of this Plan will be paid by the Employer, based on the Contributions from the Compensation Reduction Agreements provided by the Participants. Contributions to this Plan for the Plan Year will be limited to the amounts determined by the Compensation Reduction Agreements entered into by the Plan Participants for a Plan Year. All contributions by the Participants will be held by the Employer in whatever manner the Employer deems necessary, as credits in the Participant's Account. Contributions may not exceed the maximum contribution shown on Schedule B of this document. Employer contributions to Dependent Care, if available, will be made on a prospective basis, and will be available for the entire Plan Year.

Claims. The Plan Administrator will inform you as to the frequency of claim submission(s). The Plan Administrator will pay the claims as expeditiously as possible, at times determined by the Plan Administrator.

Amount of Reimbursement. A Participant shall be entitled to benefits under this Plan in an amount that does not exceed his Benefit Credits. No Eligible Expense shall be reimbursed to the extent that the expense exceeds such amount. Each payment hereunder shall be a charge to the Participant's Benefit Credits.

Limitations on Reimbursement. The Employer's payment of benefits under this Plan for any Plan Year will be limited to the lesser of (i) the Participant's Eligible Expenses for the year, or (ii) the Participant's Benefit Credits.

Covered Expenses. Reimbursement shall be provided to any individual only for Eligible Expenses incurred while that individual is a Participant. Reimbursement for Eligible Expenses incurred during a period of participation may be made after such participation ceases, as provided for in the Claims section. An Eligible Expense shall be considered incurred when the goods or services giving rise to such Eligible Expense are provided, irrespective of when such Eligible Expenses are billed to the Participant. Reimbursement shall not be made for any amount that does not qualify as an Eligible Expense, and no Participant or former Participant shall receive any amount by which his Benefit Credits allocated under the Cafeteria Plan for Eligible Expense reimbursement exceed the amount actually paid as reimbursement for Eligible Expenses.

Eligible Expenses or Reimbursable Expenses are expenses payable by the Plan Administrator according to the definitions below. The term "Eligible" Expense means any reasonable expense incurred by the Participant or his Spouse for Qualifying Services for the cost of sending a child of the Participant to a Qualifying Day Care Center. The Employer shall determine in its sole discretion whether any expense is reasonable. An expense shall be an Eligible Expense only if it is payable to a person who is not either the dependent of the Participant, or the Participant's Spouse, or a child of the Participant under the age of 19 as of the close of the Plan Year in which the Qualified Services are rendered.

"Qualifying Day Care Center" means a day care center that provides full-time or part-time care for more than six individuals (other than individuals who reside at the day care center) on a regular basis during the Eligible Employee's taxable year, and which:

A. complies with all applicable laws and regulations of the state and town, city or village in which it is located; and

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

"Qualifying Individual" means:

A. a tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1);

B. a tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

C. a Spouse of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principle residence of the participant for more than one-half of the Plan Year.

D. In the case of divorced or separated parents, a Qualifying Individual who is a small child shall, as provided in Code § 21 (e)(5), shall be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

E. *Exclusion.* Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;
- a Participant's child (as defined in Code §152(f)(1)) who is under l9 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant's under age 13 qualifying child (as defined in Code §152(a)(1)).

"Qualifying Services," means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

"Services" means the duties performed to enable a Participant and his Spouse to remain gainfully employed and which are related to the care of a Qualifying Individual.

"Spouse" means the person to whom the Participant is legally married but shall not include an individual legally separated from a Participant under a decree of legal separation.

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

If dependent care is required to enable you and a spouse (or single person) to work, these expenses may be eligible for reimbursement. Included are payments to child care centers, nursery schools, kindergarten and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after-school and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), or a non-relative, as long as such person is reporting payments as income, is also eligible. However you must have accumulated a sufficient credit balance in your Dependent Care Reimbursement account in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent weeks as more dollars are contributed from your pay to your Dependent Care Reimbursement account.

Maximum Annual Benefits. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

A. either $5,000 or $2,500 for the calendar year, as applicable:

(1) $5,000 for the calendar year if one of the following applies:
— the Participant is married and files a joint federal income tax return;

— the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or

— the Participant is single or is the head of the household for federal income tax purposes; or

(2) $2,500 for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

B. the Participant's Earned Income for the calendar year;

C. the Earned Income of the Participant's Spouse for the calendar year (note: a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or

D. the Benefit Credits allocated to a Participant's account for the Plan Year.

A Participant who is not married at the close of a Plan Year may not receive reimbursement for Eligible Expenses incurred by him for the Plan Year in excess of the lesser of $5,000 or his Compensation for the Plan Year. Not with-standing the above, the maximum reimbursement paid under this Plan must also be reduced by the amount of any tax-exempt dependent care assistance benefits received by the Participant or his Spouse from any other employer during the Plan Year.

Cash Alternative. Any Participant who has not elected to participate in the Plan under the procedures described in Section 2 to receive Benefit Credits will be assumed to have elected cash Compensation, and his Compensation will not be reduced to cover the payment of non-cash Benefit Credits under this Plan.

Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Employees as to eligibility to participate, contributions and/or Benefits, and to comply in this respect with the requirements of the Code. If in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from coverage under the Plan such Participants and/or reduce such Plan Contributions and/or Benefits under the Plan, all as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

Maximum Overall Contributions. No Participant shall be entitled to reduce Compensation by more than the aggregate **maximum annual benefit** specified in this section 3.

Forfeiture of Unused Benefits. A Participant shall receive no reimbursement for Benefit Credits which are elected but unused during a Plan Year, for any reason.

Premium Conversion Plan

The Premium Conversion Plan included in this Flexible Benefit Plan provides tax-free reimbursement from the Benefit Credits established by the Employer from the Participant's Compensation Reduction account for the costs or premiums charged under the various insurance plan(s) sponsored by Benzie County, the Employer.

Benefit Credits. There shall be credited to each Participant's Reimbursement Account those Benefit Credits that correspond to the Participant's Compensation reduction amounts under Section 4. Such contributions shall not exceed the amounts set forth on Schedule C attached hereto, as revised by the Employer from time to time. The Participant's Benefit Credits shall be credited when the Participant's Compensation is reduced, pursuant to the Compensation Reduction Agreement then in effect. The Benefit Credits shall be allocated in accordance with the Benefits the Participant has designated pursuant to this section. The amount of Benefits actually provided to or for the benefit of any Participant shall be a charge to the balance of his Reimbursement Account.

Election of Benefits. Each Eligible Employee shall submit to the Employer before the close of the Enrollment Period for each Plan Year, or at other designated times, a written statement identifying the Benefits to be provided by the Employer to the Eligible Employee, and the portion of the Eligible Employee's anticipated Benefit Credits for the Plan Year which may be applied to provide each Benefit. If the Participant's Benefit Credits actually exceed the sum of amounts allocated to provide Qualified Benefits available under the Plan, the Participant shall be deemed to have allocated such excess to the provision of additional cash Compensation. Each election under this Section 3 may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of section 125 of the Code.

Any employee who fails to execute an Enrollment Form or Salary Reduction Agreement during the Enrollment Period shall be deemed to have elected to maintain his/her prior Plan Year's election then in effect in respect to pre-tax premiums, but will not be eligible for Medical or Dependent Care Reimbursement Accounts.

Benefit Rules

Nature of Participant Reimbursement Account. No money shall actually be allocated to any Reimbursement Account, any such Reimbursement Account shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be representative of any identifiable Trust assets. No interest will be credited to or paid on amounts credited to a Reimbursement Account.

Provision of Benefits. The Employer shall provide such Benefits as the Participant has elected under the Plan, in such amounts as do not exceed the amount allocated to the provision of each such Benefit and subject to Employee Contributions. Such Benefits shall be subject to the provisions of any plan, Summary Plan Description, contract, or other arrangement setting forth the further terms and conditions pursuant to which such Benefits are provided, and any condition or restriction imposed by an insurance company providing any Benefit. To the extent the Participant has elected to receive additional cash Compensation (or is deemed to have made such an election), such Compensation shall be paid pursuant to this Section.

No amount shall be applied to provide Benefits under this Plan if such amount would exceed the balance of the Participant's Benefit Credits. However, the Employer, at its sole discretion, may defer and provide such Benefits with Employer contributions, which cause the Participant's Benefit Credits to equal or exceed the amount required to provide such Benefits.

Events Permitting Exception to Irrevocability Rule. Once an Eligible Employee has elected Benefits under the Plan and the Plan Year has begun, he may not amend or revoke his election of Benefits, unless there is a Change in Status or as may otherwise be permitted under this Section 3. The revocation of a designation of Benefits and election of new Benefits may be made by an Eligible Employee only if both the revocation of existing designation of Benefits and election of new Benefits are made on account of and consistent with the Change in Status. A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

(a) *Open Enrollment Period (Applies to Premium Payment, Health FSA, and DCAP Benefits).* A Participant may change an election during the Open Enrollment Period.

(b) *Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections II as applicable.

(c) *Leaves of Absence (Applies to Premium Payment, Health FSA, and DCAP Benefits).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section III and upon non-FMLA leave in accordance with Section III.

(d) *Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits as Limited Below, and DCAP Benefits as Limited Below).* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the

occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(3) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.

(e) HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but Not to Health FSA or DCAP Benefits). If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code §9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

(2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

(3) a Participant's or Dependent's coverage under a Medicaid plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage.

(4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not

later than 60 days after the date the Participant or Dependent is determined to be eligible for such assistance.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

An election change under this provision must be requested within 60 days after the termination of Medicaid or state child health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. All other election changes under this provision must be requested within 30 days.

For purposes of this Section, the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits). If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.*

(g) *Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(h) *Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan

Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§152(d)(2)(A) through (G), incorporating the rules of Code §§152(f)(1) and 152(f)(4).

(i) *Change in Coverage (Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits).*

The definition of "similar coverage" under this Section (h) applies also to this Section (i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverage.* If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or

drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(5) *DCAP Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(j) Reduction of Hours (Applies to Premium Payment, but Not to Health FSA Benefits or DCAP Benefits).

(1) Participant who was expected to average at least 30 hours of service per week may drop group health plan coverage midyear if the Participant's status changes so that the Participant is expected

to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan (e.g., because the plan's eligibility provisions have been drafted to avoid penalties under health care reform's employer shared responsibility provisions). However, the change must correspond to the Participant's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped.

(k) Exchange Enrollment (Applies to Premium Payment, but Not to Health FSA Benefits or DCAP Benefits).

(1) A Participant who is eligible to enroll in Exchange coverage (during an Exchange special or open enrollment period) may drop group health plan coverage midyear, but only if the change corresponds to the Participant's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Exchange coverage that is effective no later than the day after the last day of the original coverage.

Procedure for Making New Election If Exception to Irrevocability Applies.

(a) *Timeframe for Making New Election.* Unless specified otherwise (see HIPAA Special Enrollment Rights), a Participant (or an Eligible Employee who, when first eligible or during the Open Enrollment Period declined to be a Participant) must make a new election within **30** days of the occurrence of an event described in the Section titled Events Permitting Exception to Irrevocability Rule, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections (d) through (i), within 30 days after the events described in such Sections). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section (e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

Cash Payments. Any cash to be paid to a Participant with respect to any portion of the Benefit Credits (other than as Qualified Benefits) shall be added to his taxable Compensation and shall be paid to him during the Plan Year subject to any applicable wage withholding or similar taxes. Such payments shall not include interest from the date as of which the Benefit Credits were credited on the Participant's behalf to the date of payment. No Benefit under the Plan shall be paid in any manner that defers the receipt of Compensation beyond the last day of the Plan Year.

Reimbursements. Except as otherwise provided in any plan, contract or arrangement established to provide Benefits, reimbursement of Expenses shall be made at such time and in such amounts as shall be determined by the Employer in accordance with Treasury Regulations 1.125-2 Q&A 7(b)(2). The amount credited to the Participant's Reimbursement Account(s), including Carry Over, if applicable, for any Plan Year shall be used only to reimburse the Participant for Qualified Benefits incurred for such Plan year, and only if the Participant applies for reimbursement on or before the 90th day following the close of the Plan year.

The plan does not allow a grace period and allows a carryover for the Medical Reimbursement Account Plan. The plan does not allow a grace period for the Dependent Care Reimbursement Account Plan.

A Participant may carry over up to $500 of Qualifed Medical Reimbursement Benefits to be used for qualifed medical expenses incurred during the following plan year.

A Participant may elect prior to the beginning of the next Plan Year to waive the carryover for that Plan Year in accordance with procedures established by the Plan Administrator.

Medical Care Expenses incurred in the current Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses during the run-out period, cannot exceed $500, and will

count against the $500 maximum carryover amount.

Forfeitures. If the total Qualified Benefits paid or reimbursed to a Participant with respect to any Plan Year and subseqent Grace Period, if applicable, are less than the Benefit Credits allocated to the provision of such Qualified Benefits, the unused portion shall be forfeited at of the end of the period for filing claims for the Plan Year and subsequent Grace Period, if applicable, whichever is earlier. No Participant shall be entitled to carry over any unused Qualified Benefits to the succeeding Plan Year, or to reallocate the unused portion to any other Benefit, nor shall any Participant be entitled to receive any unused Qualified Benefits in the form of additional cash. Any remaining unused benefit or contribution at the end of the plan year or grace period, if applicable, will be forfeited.

If the total Dependent Care Qualified Benefits paid or reimbursed to a Participant with respect to any Plan Year and subseqent Grace Period, if applicable, are less than the Benefit Credits allocated to the provision of such Qualified Benefits, the unused portion shall be forfeited at of the end of the period for filing claims for the Plan Year and subsequent Grace Period, if applicable, whichever is earlier. No Participant shall be entitled to carry over any unused Dependent Care Qualified Benefits to the succeeding Plan Year, or to reallocate the unused portion to any other Benefit, nor shall any Participant be entitled to receive any unused Dependnet Care Qualified Benefits in the form of additional cash. Any remaining unused benefit or contribution at the end of the plan year or grace period, if applicable, will be forfeited.

A Participant may carry over up to $500 of Qualifed Medical Reimbursement Benefits to be used for qualifed medical expenses incurred during the following plan year. No Participant shall be entitled to carry over any other unused Qualified Benefits to the succeeding Plan Year, or to reallocate the unused portion to any other Benefit, nor shall any Participant be entitled to receive any unused Qualified Benefits in the form of additional cash. Any unused portion of Qualified Benefits in excess of $500 shall be forfeited at the end of the period for filing claims for the Plan Year.

Carryovers may not be cashed or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit on annual salary reductions under the Health FSA.

Terminated employee's unused portions where the Qualifed Benefits paid or reimbursed to a Participant with respect to any plan year are less than the Benefits Credits allocated to the provision of such Qualifed Benefits are forfeited three months following the date of termination or three months after the end of the plan year whichever is earlier unless subject to COBRA and COBRA is elected.

Nondiscrimination. Contributions and Benefits under the Plan shall not discriminate in favor of Highly Compensated Employees nor shall the aggregate cost of the Benefits provided to Key Employees exceed 25% of the aggregate of such cost for the Benefits provided to all Employees under the Plan. The Employer may limit or deny any Employee's Compensation Reduction Agreement to the extent necessary to avoid any such discrimination.

Insurance Contracts. Some or all of the Benefits provided under the Plan may, at the discretion of the Employer, be provided by the purchase of insurance contracts issued by one or more insurance companies, or health care service contracts issued by or provided through a health care service provider, qualified health maintenance organization, or preferred provider organization. Any dividends, retroactive rates, or other refunds, which may become payable under any insurance or health care service contracts or benefit programs due to actuarial error in rate calculation shall be the property of and retained by the appropriate Participating Employer.

Benefit Costs

The cost of each Benefit shall be determined in a uniform manner according to the benefit option cost described on Schedule A, B and C attached hereto. Such costs are subject to change, at the discretion of the Employer, for any future Plan Year for current Participants and at any time prior to the commencement of participation for new Participants.

Termination of Employment. If an Eligible Employee separates from service with the Employer during a period in which he is covered under the Plan, the Employer may terminate the remaining portion of Benefits provided by the Plan. If a terminated Employee who has revoked coverage under the Plan is reemployed by the Employer that said Employee shall be prohibited from making a new benefit election in the Plan Year for which the revocation was effective. However, the reemployed Employee may receive Benefits under the Plan in accordance with the election, which was in effect prior to his termination of employment with the Employer. A terminated Employee shall be entitled to reimbursement for claims for Qualified Benefits incurred prior to his termination of employment, only if the Employee (or his estate) applies for such reimbursement on or before the 90th day following date of termination, but not later than the 90th day following the end of the Plan Year.

Employee Contributions. To the extent a Participant does not have sufficient Benefit Credits to pay for the Benefits selected, the Employer is authorized to withhold the additional amounts from a Participant's Compensation from the Employer to the extent required to pay for said Benefits. Further, the Employer may require that such withholdings be made on a post-tax basis.

Payment of Contributions While on FMLA Leave. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") and who elects to continue participation under this Plan shall be responsible for making the required contributions under the group health insurance plan offered under this Plan during the period of the FMLA Leave. The manner in which such payments are made shall be determined by the Plan Administrator in its sole discretion, as previously stated in Section 2 above. If there is more than one choice below, the Participant may make a selection that best fits his needs.

Prepayment: The Participant may prepay the contributions due during the FMLA Leave period. Prepayments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law.

Pay-As-You-Go: The contributions due during the FMLA Leave period may be paid based on the same schedule as payments would have been due if the Participant had not been on FMLA Leave, on the same schedule as COBRA payments are made, under the Employer's existing rules for payment by employees on leave without pay, or on any other schedule voluntarily agreed upon by the Plan Administrator and the Participant.

Catch-Up Option: The Employer may advance the contributions on behalf of the Participant, and may recoup such contributions upon the Participant's return to employment. The Catch-Up Option shall be applied in a manner consistent with Prop. Treas. Reg. Sec. 1.125-3.

Non-FMLA Leaves of Absence If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 12.4(d) will apply.

Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service", as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions under the Plan, during the period during which he or she is in "uniformed service". The manner in which such payments are made shall be determined by the Plan Administrator. A Participant whose coverage under the group health insurance plan and/or the medical savings account portion of the Plan is terminated on account of his or her being in "uniformed service", and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical savings account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service".

Section IV

Contributions

Funding. The Benefits provided shall be paid by the Employee; provided, however, that the Employer's payments under the Plan shall be limited to such amounts of Compensation as a Participant elects to forego pursuant to a Compensation Reduction Agreement.

If any benefits of this Plan are insured by a third party insurer, those benefits will be paid by the insurer or its nominee, such as a third party administrator.

Execution of Agreements. Approximately 30 days prior to the beginning of the Plan Year, the Administrator shall provide a written election form, which shall include a Compensation Reduction Agreement to each Participant and to each other Employee who is expected to become an Eligible Employee by the first day of the first Plan Year, and all subsequent Plan Years. All Compensation Reduction Agreements entered into by Participants in the Plan shall be executed before the close of the Enrollment Period for the Plan Year for which such agreements will be effective or, in the case of Participants who were not eligible to participate in the Plan at the beginning of the Plan Year, before the first day of the pay period after the Entry Date on which they become eligible to participate in the Plan. Each Compensation Reduction Agreement shall remain effective throughout the Plan Year unless revoked or suspended by reason of any Participant's ceasing to be an Eligible Employee.

No Compensation Reduction Agreement may be revoked by any Participant during the Plan Year for which it is effective, except by reason of a family status change described herein. Any Participant who fails to execute appropriate agreements during the Enrollment Period shall be deemed to have elected to maintain his prior Plan Year's election for health options but will not be eligible for any other Reimbursement Account. Any newly Eligible Employee who fails to execute appropriate agreements during the Enrollment Period to become a Participant shall be deemed to have elected cash Compensation to the extent permissible.

Amount of Compensation Reduction. The Compensation reduction amount shall be specified by the Eligible Employee in the Compensation Reduction Agreement. Such Compensation reduction shall not exceed the amount set forth on Schedule A, B and C attached hereto. The Compensation reduction amount shall be designated on a per pay basis, as indicated.

Crediting of Compensation Reduction Amounts. All Compensation reduction amounts shall be applied to reduce the Participant's Compensation for each pay period in as nearly equal amounts as the Employer deems practicable, except as the Employer shall otherwise determine. Compensation reduction amounts shall be credited to the Participant's Benefit Credits as of the end of the pay period to which such amount is attributable, provided, however, that no person's Compensation for any pay period shall be reduced by reason of a Compensation Reduction Agreement, nor shall any Benefit Credits be credited by reason of such agreement, if such person is not an Eligible Employee on the date as of which such Compensation is otherwise payable.

Section V

Administration

Administrator. The Employer shall serve as the Plan Administrator of this Plan.

The Employer has appointed Benzie County whose address is 448 Court Place, Beulah MI 49617 and whose telephone number is (231)882-0035 as claims manager/administrator.

Plan Year. The First Plan Year will begin Saturday, November 01, 2003 and ends Sunday, October 31, 2004. The current Plan Year will be a short Plan Year and begin Monday, November 01, 2014 and end September 30, 2015. The subsequent year will begin October 01, 2015 and end September 30, 2016.

Name of Plan and Employer Plan Identification Numbers. The Employer Identification Number (EIN) assigned to Benzie County by the Internal Revenue Service (IRS) is 38-6004838. The Plan Number (PN) assigned to this Section 125 by the Employer is 501.

The Name of this Plan is Section 125 Cafeteria Plan, established by the Employer, Benzie County, whose address is 448 Court Place, Beulah MI 49617. For more information on the Plan Sponsor, see Administrative Facts section. The effective date of this Plan is Saturday, November 01, 2003.

Service of Legal Process. Benzie County the Employer has designated the Plan Administrator as its agent for service of legal process in connection with claims under the Plan. Such process may be served on the Employer by directing the process to the Plan Administrator indicated above.

Classification and Funding. The Plan is classified as a Code Section 125 cafeteria plan by the Internal Revenue Service. It includes a Health Flexible Reimbursement account, (herein called "Medical Reimbursement Account") classified by the Department of Labor as a "welfare plan", and includes a Dependent Care Flexible Reimbursement account (herein called "Dependent Care Reimbursement account). The Plan also includes a Premium Conversion Plan. The Plans are funded by employer and employee contributions.

Named Fiduciary. The Employer shall be the named fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration, which has been delegated by the Employer, and any references to the Employer shall instead apply to the delegate. However, if the employer assigns any of the Employer's responsibility to an Employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

Rules of Administration. The Plan Administrator is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual

determinations as to whether any individual is entitled to receive any benefits under the Plan. The Plan Administrator shall adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and Participants and their beneficiaries may examine records pertaining directly to themselves.

Services to the Plan. The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical and other services to carry out the provisions of the Plan. The costs of services and other administrative expenses shall be paid by the Employer.

Funding Policy. Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but shall instead be considered general assets of the Employer. 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. The Employer shall periodically at its discretion review and determine the funding policy of the Plan, with the advice of such experts as the Employer deems appropriate.

Claims Procedure.

A. To receive benefits under the Plan, a Participant must submit written claims for benefits to the Plan Administrator. For purposes of the claims procedure, the Employer will assign a person or a committee, to be the Claims Administrator. The Claims Administrator will review the claim and will advise the Participant of any Benefit to which he is entitled. If a Participant believes he has not been reimbursed in accordance with the Plan or has not been advised of his Benefits, he may submit a written request to the Plan Administrator to provide either an explanation of how Benefits are reimbursed or further information of his Benefits. The Plan Administrator must respond to such a request within a reasonable time. Additionally, the Plan Administrator will provide to every claimant, who is denied a claim for Benefits, a written notice stating, in a format determined to be understood by the claimant,

(i) the specific reason or reasons for the denial;
(ii) specific reference to pertinent plan provisions on which the denial is based;
(iii) 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; and
(iv) an explanation of the claim review procedure set forth in Paragraph B. below.

Such notice will be given within 30 days after the claim is received by the Claim Administrator (or within 45 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 30 day period). If such notification is not given within such period, the claims will be considered denied as of the last day of such period, and such person may then request a review of his claim, as set forth in subsection B., below.

B. Within 180 days of receipt by a claimant of a notice denying a claim under Paragraph A, the claimant or his duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator, or by the Committee which may be appointed by the Employer for that purpose. The Claim Administrator or Committee may extend the 180-day period where the nature of the Benefit involved or other attendant circumstances make such extension appropriate. In connection with such review, the claimant or his duly authorized representative may review pertinent documents and may submit issues and comments in writing. The Claim Administrator or committee shall make a decision promptly, and not later than 60 days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, and specific references to the pertinent Plan provisions on which the decision is based. If the decision on review is not made within such period, the claim will be considered denied.

Claims Appeals. Participants have a right to appeal claim payment determinations. If Participants disagree with any claim payment determination, then said Participant must submit proof that a claim for benefits is covered and payable under the Plan's provisions; including (a) all facts and theories supporting the claim, (b) a statement within the referenced Plan provision. If Participant does so, it may be that some or the entire claim will be payable under the Plan. This Plan allows for two appeals of an adverse benefit determination. Each appeal provides full and fair review of an adverse determination in compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") and the regulations issued there under. Participant will be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, claimant may file an appeal within 180 days

following receipt of this notice, which must be in writing and addressed as follows: 44North 1406 N. Mitchell St, Cadillac, MI 49601, Attn: Claims Appeals. If participant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 60 days after receipt of the appeal. Participant is entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for benefits. If Participant receives an adverse benefit determination following the final appeal, Participant has the right to bring a civil action under section 502(a) of ERISA.

Overpayments or Errors. If it is later determined that the Participant and/or the Participant's Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If the overpayment or erroneous payment is not refunded, the Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from the Participant's compensation.

Nondiscriminatory Operation. All rules, decisions and designations by the Employer, Claim Administrator, and each Committee under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

Liability of Administrative Personnel. Neither the Employer nor any of its Employees shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT PLAN PARTICIPANTS MAY BE USED AND DISCLOSED AND HOW PLAN PARTICIPANTS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a Health Plan subject to HIPAA, the plan shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

The Protected Health Information (PHI) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations ("Rules") and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH") include privacy protections impacting handling of the group health plan medical or financial information that could identify an individual.

Protected Health Information (PHI) is information created or received by Plans subject to HIPAA Plans that relates to the past, present or, future individual's physical or mental health condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Protected Health Information (PHI) provisions of HIPAA and its rules include privacy protections impacting group handling health plan medical or financial information that could identify an individual. Individually identifiable information is protected whether it is in electronic, paper or oral format. The HIPAA rules give individuals control over health and financial information related to their health care. PHI may be used only for limited purposes without consent, and in many situations only upon individual authorization. Regarding their own PHI, they have the right to:

A. Object to using information;
B. Gain access to information;
C. Change information; and
D. Obtain an accounting of any information disclosures.

An underlying principle of the rules is that the "minimum necessary" disclosure should be the standard when using or disclosing information in the normal course of treatment, payment or health plan operations.

Participants in this plan are guaranteed access to their PHI and have the right to: (1) copy and amend health information; (2) receive an accounting of PHI uses; and (3) receive notices of health plans' privacy practices. Individuals have the right to request that PHI use and disclosure be restricted even for treatment and payment purpose.

Certification Requirement

The plan shall disclose PHI, including Electronic PHI, to Authorized Employees of the Employer only upon receipt of a certification by the Employer that the Employer agrees:

A. not to use or further disclose PHI other than as permitted or required by the Privacy Policy or as required by law;
B. to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;
C. not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;
D. to report to the Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures, or any Security Incident, of which the Employer becomes aware;
E. to make available PHI for inspection and copying in accordance with 45 CFR §164.524;
F. to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;
G. to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
H. to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule, the Breach Notification Rule, or the Security Rule;
I. if feasible, to return or destroy all PHI and Electronic PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI 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 PHI infeasible and Electronic PHI;
J. to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and
K. to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

Electronic Data Security Obligations

To the extent the Plan maintains electronic PHI, the Plan will:

A. Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan as required by the HIPAA Security Rules;
B. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;
C. Ensure that the separation is supported by reasonable and appropriate security measures;
D. Ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and
E. Report to the Plan any security incident involving PHI including any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations of which it becomes aware.

Permitted Uses and Disclosures

The Plan places restrictions on the Employer's use or disclosure of PHI received from the plan or an insurer. Insurers may determine what information will be available to the Plan.

Only Authorized employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Authorized employees shall be restricted to the Plan administration functions that the Employer performs on behalf of the Plan.

The HIPAA Plan may disclose PHI to the Authorized employees of the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Authorized employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the plan and agree to use and disclose PHI only as permitted or required by HIPAA. This includes:

A. Plan's own Payment and Health Care Operations functions including;
    a. Enrollment of eligible individuals;
    b. Eligibility determinations;

c. Payment for coverage;
d. Claim payment activities;
e. Coordination of benefits; and
f. Claims appeals.

B. Another HIPAA Health Plan's Payment and Health Care Operations functions;
C. Disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;
D. Disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;
E. Disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g)
F. Disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;
G. Uses and disclosures to comply with workers' compensation laws;
H. Uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;
I. Disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;
J. Uses and disclosures for other governmental purposes, such as for national security purposes;
K. Uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
L. Uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes
M. Uses and disclosures required by other applicable laws
N. Uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508
O. Enrollment of eligible individuals;
P. Eligibility determinations; and
Q. Payment for coverage;

The Plan will meet the minimum necessary uses and disclosures provisions of HIPAA for PHI. However, the minimum necessary provisions *do not apply* to the following:

A. Disclosures to or request by a health care provider for treatment purposes;
B. Disclosures to the individual who is the subject of the information;
C. Uses or disclosures made based on an authorization requested by the individual;
D. Uses or disclosures required for compliance with HIPAA's transaction standards (see 813);
E. Disclosures to HHS when the rule requires the disclosure of information for enforcement purpose; or
F. Uses or disclosures that are required by other laws.

Any uses or disclosures for which the covered entity has a valid authorization are exempt.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Marketing

The group health plan(s) and other covered entities, as defined by HIPAA, will not use or disclose PHI for marketing purposes without your authorization, except for face-to-face communications with the individual or promotional gifts of nominal value.

Communications that are part of treatment or are about a plan's benefits, services or operations are excluded from the definition of marketing, even if they promote the use or sale of a service or product. Specifically excluded from the definition of marketing communications about:

A. Participating providers and health plans in a network, the services offered by a provider or the benefits covered by a health plan;
B. Treatment of the individual; and
C. Case management or care coordination for the individual, or directions or recommendations for alternative treatments, therapies, health care providers or settings of care to that individual.

This health plan is not engaging in marketing when it advises enrollees about other available health coverage that could enhance or substitute for existing health coverage. For example, if a child is about to age out of coverage under a family policy, the plan may send the family information about continuation

coverage for the child. This exception does not extend to excepted benefits under HIPAA, such as accident-only policies or auto medical liability, nor to other lines of insurance. For example, a multi-line insurer may not use PHI to promote its life insurance policies.

It is not marketing for a health plan to communicate about health-related products and services available only to plan enrollees or members that add value to but are not part of a plan of benefits. To qualify for this exclusion, the communication must meet two conditions:

A. It must be health-related. For example, offers of discounts for eyeglasses may be considered part of plan benefits. This exclusion appears to include wellness programs that offer incentives to adopt healthy lifestyle behaviors.
B. It must offer an added value of plan membership and not merely be a pass-through of a discount or item available to the public at large. Thus, a plan could offer its members a special discount for a health/fitness club, but not pass along to its members discounts that the members could obtain directly from the club.

For marketing activities permitted by an authorization, if there is remuneration, the marketing material must state that the entity making the communication is being paid by another entity.

Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health information is prohibited in the following situations:

A. *Genetic Information.* Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility for benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.
B. *Employment-Related Actions.* Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.
C. *Other Benefits.* Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted above, shall not be a permitted use or disclosure.

Plan administration functions do not include functions performed by the Employer for employment-related functions.

The Authorized employees will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of the Plan.

Underwriting

An insurer that receives protected group health plan information for underwriting, premium rating and other similar purpose – and that coverage is not placed with the insurer- cannot use or disclose the information for any purpose other than as required by law.

Verification

In any disclosure other than those allowing the individual to agree or object, verifying the identity of anyone requesting PHI who is not known to the health plan or other covered entity must first occur.

If disclosure is conditional on documentation or statements from the person-seeking PHI, that documentation or statement must be obtained before the PHI can be disclosed.

Breach Notification

Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

Section VI

Continuation Of Coverage

In General. The following provisions shall apply to Benefits provided to Eligible Employees and their dependents under the Plan, but only to the extent that the Benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA) unless the employer is exempt.

Continuation of Coverage. To the extent required by COBRA, a 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 qualified beneficiary who is a covered employee or spouse of the covered employee 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 (i.e. single, family, etc.).

Participant in this Plan has all the benefits and requirements of COBRA previously stated except for: Participant in this Plan may receive all the benefits and requirements of COBRA previously stated except for Cessation of Participation in this Flexible Benefit Plan with regards to benefits remaining at time of Qualifying Event. The Participant's participation will cease at the end of the Plan Year during which the Qualifying Event occurs.

Notwithstanding the above provisions, a Participant will cease to be a Participant on the last day of the plan year in which a qualifying event occurs.

However, if the Participant has any unused benefits remaining at the termination of participation, the participant will be allowed to claim those benefits for in accordance with Forfeiture of Section III, Benefits, above.

Type of Coverage. Continuation coverage under this provision is coverage, which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this 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 this Plan in connection with such group.

COBRA coverage under the Medical Reimbursement Account will be offered only to qualified beneficiaries losing coverage who have under spent accounts. A qualified beneficiary has an under spent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Medical Reimbursement Account coverage that will be charged for the remainder of the Plan Year.

COBRA coverage will consist of the Medical Reimbursement Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year.

Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

A. in the case of a terminated Employee (except for gross misconduct) or a covered Employee whose hours have been reduced, except as provided in B. and C. below, and his covered dependents, the date which is 18 months after the qualifying event;

B. in the case of a qualified beneficiary disabled during the first 60 days following the covered Employee's termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the Plan Administrator with notice of Social Security disability determination within 60 days of the disability determination and within 18 months of the qualifying event; Note: The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The qualified beneficiary receiving the disability extension is required to notify the Plan Administrator if the SSA makes such a determination, and you must provide this notice within the 30-day period after the SSA makes such a determination. Such a notice is to be in writing and delivered in person or mailed to the Plan Administrator.

C. in the case of a terminated Employee (except for gross misconduct) or covered Employee whose hours have been reduced, and the employee became entitled to Medicare less than 18 months before

the qualifying event, for the covered dependents, the date which is 36 months after the date of Medicare entitlement.

D. in the case of a second qualifying event, which includes the death of a covered employee, the divorce of a covered employee and spouse, or a loss of dependent status under the plan, which occurs during the 18-months after the date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee's hours are reduced, you may become entitled to an 18 month extension (giving you a total maximum period of 36 months of continuation coverage). You are entitled to this continuation coverage period only if it would have caused you to lose coverage under the plan, in the absence of the first qualifying event. You are required to notify the Plan Administrator in the same manner as Section B Above.

E. in the case of any qualifying event except as described in A., B., and C. above, the date which is 36 months after the date of the qualifying event;

F. the date on which the Employer or a Participating Employer, if any, ceases to provide any group health plan to any Employee;

G. the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision;

H. the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or otherwise 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 (taking into account, for plan years commencing after June 30, 1997, prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996). In no event will coverage continue longer than the coverage period as set forth in this Section.

I. Your right of continuation coverage under the Plan may be terminated prior to the end of your continuation coverage period if you engage in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary.

J. Your Plan Administrator is required to give you notice of Unavailability of Continuation Coverage should your rights of continuation coverage be denied or terminated. This Notice of Unavailability of Continuation Coverage will state the specific reason for denying your claim for continuation coverage. You will be notified of the date the coverage will terminate, and the reason for termination and the rights the qualified beneficiary may have under the plan or applicable law.

Contribution.

A. A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by the Employer or a participating 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 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.

D. Certain individuals may be eligible for a Federal Income tax credit as a result of the Trade Adjustment Assistance Reform Act of 2002 (HCTC). This tax credit helps pay for the premium of continuation coverage. You may be entitled to this tax credit (payable in some cases directly to the employer to offset the cost of the premium) if you lose your job due to the effect of international trade, and qualify for trade adjustment assistance. Those receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) may become entitled to the tax credit as well. If you become entitled to this tax credit contact HCTC Customer Contact Center at 1-866-628-4282.

Notification by Qualified Beneficiary. Each covered Employee or qualified beneficiary must notify the Employer or a participating Employer in writing of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's spouse, and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within **60** days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph, which occurs after the date of the enactment of the Tax Reform Act of 1986.

Keep Your Plan Informed of Address Changes. In order to protect you and your family's rights, you must keep the Plan Administrator informed of any changes in the addresses of yourself and/or family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Notification Procedure. Any notice that you provide must be in writing addressed to the employer. Oral notice, including notice by telephone, is not acceptable. Electronic notices (email or fax) are not acceptable. Your notice must be complete and must be postmarked no later than the last day of the required notice period. Your notice must state the name and address of the Employer, the name of the group health plan, the name

and address of the employee covered under the plan, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened.

Your notice of a second qualifying event must also name the event and the date it happened.

Your notice of a child's loss of dependent status must include documentation of the date of the qualifying event (i.e., a birth certificate, marriage certificate, or transcript showing the last date of the enrollment in an education institution). This will allow the Plan Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA.

If the qualifying event or the second qualifying is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability or cessation of disability must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled or ceased to be disabled and the date the Social Security Administration made its determination. Your notice of disability or cessation of disability must include a copy of the Social Security Administration's determination.

Notification to Qualified Beneficiary. The Employer or a participating Employer shall provide written notice to each covered Employee and spouse of such covered employee of his/her right to continuation coverage under this provision as required by federal law.

The Employer or a Participating Employer 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 or legal separation of the covered Employee from the covered Employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, Benzie County shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered Employee or the qualified beneficiary notifies Benzie County of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60 days after the date of such qualifying event.

Notification of the requirements of this provision to the spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

Definitions. The italicized terms used in the text of this Section 6 are defined as follows:

"Dependents" means an individual who meets the definition of dependent under the Participating Employer provided health plan covering the Eligible Employee. For the purposes of the Medical Reimbursement Plan, if any, dependents will also include individuals who are dependents within the meaning of section 152(a) of the Code, and as defined in section 1 hereof.

No person shall be considered a dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by the Employer or a participating Employer, then their dependent children may be covered by either spouse, but not by both.

"Election Period" means the 60-day period during which a qualified beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60-day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

"Full-Time Student" means a dependent child who is enrolled in, regularly attends and is recognized by the Registrar of an accredited secondary school, college or university, institution for the training of registered nurses (R.N.), or any other accredited or licensed school for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

"Medicare" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

"Qualified Beneficiary" means an individual who, on the day before the qualifying event for a covered Employee, is a beneficiary under this Plan as the dependent (as defined in Section 1 hereof) of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee's gross misconduct) or the reduction in hours of the covered Employee's employment, the term "qualified beneficiary" includes the covered Employee. Effective January 1, 1997, a child who is born to (or placed for adoption with) a Qualified Beneficiary who is a covered Employee during the Coverage Period shall also be a Qualified Beneficiary.

Exception - the term qualified beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received

no earned income from the employer which constituted income from sources within the United States (within the meaning of Code section 911(d)(2) and section 861(a)(3)). If an individual is not a qualified beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship to such individual.

"Qualifying Event" means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a qualified beneficiary:

(i) the death of the covered Employee;
(ii) the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered employee's employment;
(iii) divorce or legal separation of the covered Employee from such covered Employee's spouse, as herein defined.
(iv) the covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);
(v) a dependent child who ceases to be a dependent child under the terms of this Plan.
(vi) the Company's filing for Chapter 11 reorganization, as it would affect retiree coverage.

"University/College" means an accredited institution listed in the current publication of accredited institutions of higher education.

Section VII

Miscellaneous

Amendment and Termination. The Employer or its authorized representative may amend or terminate this Plan at any time by action of the Board. The Employer may amend this Plan retroactively to enable the Plan to qualify as a cafeteria plan under section 125 of the Code. No amendment shall deprive any Participant or beneficiary of any Benefit to which he or she is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

It is the intention of the Employer that should a termination of the Plan or the amendment of this Plan deprive any Participant of a Benefit Credit in a reimbursement account that exists upon such termination or amendment, that the value of the accounts of the Participant's existing upon that date would be paid to the Participant in full.

Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

Alienation of Benefits. No Account Balances payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for alimony or other payments for the support of a spouse or former spouse or for any other relative of a Participant, prior to actually being received by the person entitled to the Medical or Dependent Care Reimbursement Benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any Account Balance or any right to Medical or Dependent Care Reimbursement Benefits payable hereunder shall be void; provided, however, that nothing herein shall prevent the payment of a Participant's Medical Reimbursement Benefits directly to a service provider if the Participant so requests. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to Medical or Dependent Care Reimbursement Benefits hereunder

Facility of Payment. If the Employer deems any person incapable of receiving Benefit to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete release of the Employer and shall be deemed full payment of the Benefit. Such payments shall, to the extent thereof, discharge all liability of the Employer.

Proof of Claim. As a condition of receiving Benefits under the Plan, any person may be required to submit whatever proof the Employer may require either directly to the Employer or to any person delegated by it.

Status of Benefits. The Employer believes that this Plan is in compliance with section 125 of the Code and that it provides certain Benefits to Employees, which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval, and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting Benefits under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

Agent for Service of Legal Process: The Employer named on Page 1 is the Agent for Service of Legal Process. The Plan Administrator Benzie County may also be an agent for service of legal process.

Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Michigan to the extent not pre-empted by any federal law.

Lost Distributees. Any Benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however that such Benefit shall be reinstated if a claim is made by the Participant for the forfeited Benefit.

Source of Payments. The Employer and any insurance company contracts purchased or held by the Employer shall be the sole sources of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary.

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

Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

Tax Effects. Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether or not payments received by a Participant under the Plan will be treated as includible in gross income for federal or state income tax purposes.

Multiple Functions. Any person or a group of persons may serve in more than one fiduciary capacity with respect to the Plan.

Gender and Form. Unless the context clearly indicates otherwise, pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall include the plural.

No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to purposes other than for the exclusive benefit of Plan participants or their beneficiaries, or for defraying reasonable expenses of administering the Plan.

Prior Year Claims. Claims can be submitted up to 90 days past the end of the plan year including the Grace Period, if applicable.

Benzie County
Section 125 Cafeteria Plan
Plan Document
Amended October 01, 2015

Attest: Benzie County

Executed this Date: 09 / 30 / 2015

By: _____(Authorized Officer)

_____(Printed)

_____(Title)

Status of Benefits. The Employer believes that this Plan is in compliance with section 125 of the Code and that it provides certain Benefits to Employees, which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval, and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting Benefits under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

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Benzie County
Section 125 Cafeteria Plan
Plan Document
Amended October 01, 2015

Attest: Benzie County

Executed this Date: 09 / 30 / 2015

By: _____(Authorized Officer)

_____(Printed)

_____(Title)

Benzie County
Section 125 Cafeteria Plan
Plan Document
Amended October 01, 2015

Schedule A

Schedule of Benefits

Medical Reimbursement Account

Eligible Medical Expenses:

Medical Expenses, Dental Expenses, Vision Expenses

Restriction on Reimbursement of Medicines and Drugs. Notwithstanding any other provision of the Plan to the contrary, effective January 1, 2011, Medical Care Expenses eligible for reimbursement under the Medical FSA component shall include expenses for medicines or drugs incurred after December 31, 2010 only if the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin. The Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied.

Employee Annual Contribution Limitations*

Pay Period for Payroll Contributions: bi-weekly

	Minimum	Maximum
Section 125 Cafeteria Plan (12 months)	$ 0.00*	$2,550.00**

* Employee designated salary reduction and allocation subject to the limitations set forth.

** Employer contributions may be used as indicated in the Funding paragraph of Section 4. In no event may the Employer Contribution and the Employee Contribution together exceed the Employee Contribution Limitation above.

** The Employee contributions necessary to obtain the coverage's set forth in this Schedule A above will be communicated by the Plan Administrator to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period, as included in the Summary Plan Description of the Benefit. The Employee contribution required to obtain coverage under any of the above will be the maximum elected contributions required for coverage under such options.

** Minimum to be determined by Plan Administrator and maximums by allowed maximums which may be, at the Plan Administrator's discretion, indexed for cost-of-living adjustments in accordance with Code Section 125(i)(2). Plan Administrator will communicate the allowed maximum to eligible employees upon commencement of participation and to Participants at the time of the Enrollment Period. Minimum & Maximum Amounts calculated based on Proper Pay. As of the first day of the plan year, the election is irrevocable during the plan year unless there is a change in family status as defined in this document.

Claims can be submitted to the Third Party Administrator:

44North – Cadillac Office
1406 N. Mitchell Street
PO Box 700
Cadillac, MI 49601

Or Faxed to: (855) 306-1098

List, if desirable, names and addresses and phone numbers of provider of insured benefits.

Benzie County
Section 125 Cafeteria Plan
Plan Document
Amended October 01, 2015

Schedule B

Schedule of Benefits

Dependent Care Reimbursement Account

Employee Annual Contribution Limitations*

Pay Period for Payroll Contributions: bi-weekly

	Minimum	Maximum
Section 125 Cafeteria Plan	$ 0.00*	$5,000.00**

* Minimum Contribution as determined by the Employer.

** Maximum Contribution according to Internal Revenue Code Section 129 is $5,000 for a married couple filing a joint federal income tax report, or $ 2,500 for a married employee filing separately, or the lesser of the participant's earned income or the spouse's earned income.

** Employer contributions may be used as indicated in the Funding paragraph of Section IV. In no event may the Employer Contribution and the Employee Contribution together exceed the Employee Contribution Limitation above.

** The Employee contributions necessary to obtain the coverage set forth in this Schedule B will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period, as included in the Summary Plan Description of the Benefit. The Employee contribution required to obtain coverage under any of the above will be the maximum elected contributions required for coverage under such options.

** Minimum to be determined by Plan Administrator and maximums by allowed maximums which may be, at the Plan Administrators discretion, indexed for cost of living adjustments in accordance with Code Section 125(i)(2). Plan Administrator will communicate the allowed maximum to eligible employees upon commencement of participation and to Participants at the time of the Enrollment Period. Minimum & Maximum Amounts calculated based on Proper Pay Period. As of the first day of the plan year, the election is irrevocable during the plan year unless there is a change in family status as defined in this document.

Claims can be submitted to the Third Party Administrator:

44North – Cadillac Office
1406 N. Mitchell Street
PO Box 700
Cadillac, MI 49601

Or Faxed to: (855) 306-1098

Benzie County
Section 125 Cafeteria Plan
Plan Document
Amended October 01, 2015

Schedule C

Schedule of Benefits

Premium Conversion Plan

Pay Period for Payroll Contributions: bi-weekly

Benefit Programs	Coverage Tiers	Employee Contributions
Health Insurance Plan		
	Employee Only	$**
	Employee & Spouse	$**
	Employee & Child	$**
	Employee & Family	$**
Dental Plan		
	Employee Only	$**
	Employee & Spouse	$**
	Employee & Child	$**
	Employee & Family	$**
Vision Plan		
	Employee Only	$**
	Employee & Spouse	$**
	Employee & Child	$**
	Employee & Family	$**

** The Employee contributions necessary to obtain the coverage options set forth in this Schedule C will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period.

Required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option provided above.

The Employee share of the cost of these benefits may be adjusted from time to time to reflect the change in rates charged by the carriers or to comply with Michigan Public Act 152 of 2011 requirements (If Applicable).

Participation in this Plan is conditioned upon the participant completing the **Enrollment Form** provided to each Participant at the time of your enrollment. As of the first day of the plan year, the election is irrevocable during the plan year unless there is a change in family status as defined in this document.

List any Affiliated Employer who has adopted this Plan with name, address and phone numbers.

There are no other Employers affiliated with this plan.

Action 5

Carol Fisk
25235 Farmbrook Rd.
Southfield, MI 48034-1113

Benzie County Board of Commissioners
448 Court Place
Beulah, MI 49617

Dear Benzie Board of Commissioners,

On June 21, I received a letter from Dawn Olney, Benzie County Clerk, regarding Benzie County Housing Project 08-05, for the property at 1651 Beuna Rd. Frankfort, MI 49635. The letter was a notice to pay Benzie County the full amount of $23,634.71 within 45 days of the receipt of the letter. With this response, I am petitioning the board of commissioners to amend the payment plan to a monthly plan over 5 years.

The Benzie County Program was designed to help low income families with much needed repairs, and it did help us, a great deal in 2008 and 2009. We are truly grateful for it. The property has been in our family since 1973 and is currently owned by me, and my daughter Lindsay Fisk. We are current with our taxes.

I moved from Benzie County in 2014 due to a lack of work. It was never my intention to breach the contract, and was an oversight on my part for not reading the agreement more closely. As of June 1st, I began renting the property on some weekends and intended to begin paying back the loan. When I received the letter from Ms. Olney I realized I had made a mistake in both renting the property and no longer having resident status.

As I am not currently employed, and do not have the full amount of the loan to be able to pay in full, I ask that the board consider my request and allow me to make payments immediately from the proceeds of the rental I have accepted. The property is also for sale and at the time of sale Benzie County would be paid the full amount .

Until such time I propose a payment plan as follows: 400.00 per month for 5 years or until the property sells, at which time the balance would be paid.

Enclosed is a copy of the certified letter I received on June 21, 2016.

Thank you for your consideration,

Sincerely,

Carol Fisk

LAW OFFICES
OF
RICHARD J. FIGURA, P.C.
EMPIRE COMMERCE CENTER
11470 S. LEELANAU HWY., STE. 105
PO BOX 447
EMPIRE, MICHIGAN 49630

TELEPHONE: (231) 326-2072 FACSIMILE: (231) 326-2074
Email: rfigura@figuralaw.com

RICHARD J. FIGURA
Attorney, Mediator & Arbitrator

Of Counsel to:
SIMEN, FIGURA & PARKER, P.L.C.
FLINT, MICHIGAN

June 30, 2016

Benzie County - Clerk
Government Center
448 Court Place
Beulah, MI 49617

RE: Request from Carol Fisk for extension of time to repay loan

Dear Ms. Olney:

On March 16, 2009, the County, acting under the authority of a housing program funded by the Michigan State Housing Development Authority (MSHDA) loaned money to Carol Fisk for rehab work in her home on Buena Road in Benzie County. The loan is secured by a mortgage which has been duly recorded with the register of Deeds.

A condition of the loan was that Carol Fisk had to reside in the home as her principal residence. You recently learned that she has not resided in the home for several years. Under the terms of the loan and the mortgage, that meant she had to pay back the amount owed ($23,634.71) within 45 days.

I understand that you advised Ms. Fisk of that requirement, and that she has asked for an extension of the time to pay the amount owed. She says the home is for sale and she will pay off the loan when it sells. That, of course, is something that would happen anyway because to give clear title to any buyer the mortgage will have to be paid and discharged.

We have no idea of when the house will sell, but as things stand now the amount owed is due. While she has requested an extension of time, you do not have the authority to grant her that extension. Such an extension can only be granted by the Board of Commissioners (BOC), and may also require an approval from MSHDA.

If the BOC decides to grant Ms. Fisk a time extension, there should be documentation created to evidence that, and such documentation may require MSHDA's approval. In such case, Ms. Fisk should be required to pay the costs and attorney fees incurred by the County in permitting such extension.

The easiest remedy, of course, is for Ms. Fisk to pay of the loan now, even if she has to borrow funds to do so. Granting her request is, nevertheless, up to the discretion of the BOC .

Please advise if you need anything further from me.

Sincerely,

RICHARD J. FIGURA, PC

Richard J. Figura
rfigura@figuralaw.com

RJF/tjc
cc: Mitch Deisch

DAWN OLNEY
BENZIE COUNTY CLERK

448 COURT PLACE – BEULAH, MI 49617 – (231) 882-9671

June 8, 2016

Carol Susan Fisk
25235 Farmbrook Road
Southfield, MI 48034-1113

Carol Susan Fisk
1651 Buena Road
Frankfort, MI 49635

Dear Ms. Fisk:

Re: Benzie County Housing Project 08-05

I have been notified by State Farm Insurance of your Cancellation Request of your homeowner's policy at 1651 Buena Road, Frankfort, Michigan. When I called them on June 1, I learned that you had called and cancelled the policy on May 24 and before that, on May 13, they issued a business policy on that piece of property. They have also indicated that you did not list Benzie County a lien holder on the policy of which we are to be listed.

I also notice that your policy of insurance has been going to a Southfield address. Your mortgage with Benzie County states that within 45 days following your use of the home as your primary residence, you are to pay the County off in full for the amount of the lien. That amount is $23,634.71.

It is my understanding that back in 2014 the Department of Treasury made the decision that this was not your primary residence and required that back taxes be paid by you back to 2011.

Therefore, please consider this notice to pay Benzie County the amount loaned to you of $23,634.71 within 45 days of receipt of this letter.

Sincerely,

Dawn Olney
Benzie County Clerk

CORRESPONDENCE

No. 2016-161

BAY COUNTY BOARD OF COMMISSIONERS

(1)

JUNE 14, 2016

RESOLUTION

BY: BAY COUNTY BOARD OF COMMISSIONERS (6/14/16)

WHEREAS The Michigan Legislature has a bill pending before it, known as Senate Bill No. 39 introduced in 2015 to amend the "Natural Resources and Environmental Protection Act," that proposes to prohibit the Department of Natural Resources (department) from acquiring surface rights to (additional) land if the department owns the surface rights to more than 4,626,000 acres of land, without an approved (legislative) Strategic Plan which contains a land inventory describing intended and authorized use(s) of existing lands, and if any established payment in lieu of taxes on department land due to a local unit of government is delinquent; and

WHEREAS The proposed amendments require maximizing access to department lands and bodies of water adjacent to the lands by removing, gates, berms, and other human made barriers; and further requires the department to promote public enjoyment of the state's wildlife and other natural resources by providing public access to all lands under control of the department for all natural resource dependent outdoor recreation activities including motorized and non-motorized activities; and

WHEREAS The proposed amendments further provide minor housekeeping edits and procedural updates that enhance transparency and support the intent of the amendments, clarifies authority of the department to sell or lease land and establishes scheduled procedures for processing applications to purchase surplus lands, the allowance of fees, prohibition of preference to a qualified conservation organization over another private party or individual, and limits further purchases of land by the department in a county or township without prior written agreement and authorization by that jurisdiction if more than 33% of the jurisdictions property is owned by the state, federal government, qualified conservation organization and commercial forest-land; and Therefore, Be It:

RESOLVED The Bay County Board of Commissioners supports reducing barriers to the public use of public lands for recreation and access and encourages the department to develop the Strategic Plan in consultation with local jurisdictions where department lands are located to ensure accuracy and local preference in proposed land uses; Be It Further

RESOLVED That Bay County Board of Commissioners supports the passage of Senate Bill No. 39 of 2015; Be It Further

RESOLVED That a copy of this resolution be forwarded to our area Legislators, the Michigan Association of Counties, and the other 82 Michigan Counties.

ERNIE KRYGIER, CHAIR
AND BOARD

Env Affairs - SB 39 of 2015

MOVED BY COMM. Tilley

SUPPORTED BY COMM. Lutz

COMMISSIONER	Y	N	E	COMMISSIONER	Y	N	E	COMMISSIONER	Y	N	E
MICHAEL J. DURANCZYK	X			KIM J. COONAN	X			MICHAEL E. LUTZ	X		
ERNIE KRYGIER	X			THOMAS M. HEREK	X						
VAUGHN J. BEGICK	X			DONALD J. TILLEY	X						

VOTE TOTALS:
ROLL CALL: YEAS____ NAYS____ EXCUSED____
VOICE: XX YEAS 7 NAYS 0 EXCUSED 0

DISPOSITION: ADOPTED X DEFEATED____ WITHDRAWN____
AMENDED____ CORRECTED____ REFERRED____

RECEIVED
JUN 23 2016
DAWN OLNEY
BENZIE COUNTY CLERK
BEULAH, MI 49617

-57-

The regular meeting of the Board of County Road Commissioners of Benzie County was called to order by Chairman Rosa at their offices in Honor, Michigan on Thursday, June 9, 2016 at 9:30 AM.

Present: Chairman Rosa
Vice Chairman Nuske
Comm Mick
Manager Skeels
Superintendent Schaub
Clerk Jordan

Motion by Comm Nuske and supported by Comm Mick to accept the agenda as amended adding the contract from Lake Twp regarding Highland Dr and Spring Valley Rd paving. Ayes: Rosa, Nuske and Mick. Motion carried.

The minutes of 5/26/16 were accepted as presented.

Motion by Comm Mick and supported by Comm Nuske to pay bills # 43023 to # 43069 for the amount of $ 118,582.55 and Payroll # 11-16 for $ 41,434.17. Ayes: Rosa, Nuske and Mick. Motion carried.

Motion by Comm Nuske and supported by Comm Mick to approve the EFT payment to MERS for $32,820.24. Ayes: Rosa, Nuske and Mick. Motion carried.

Superintendent's report: We have paved Thomas, Didrickson, N. Reynolds from US 31-Cinder and are wedging Sutter Rd today. Valley Rd took about 300 tons which leaves about 150 tons for the patching on Marshall. We'll have to add to it. Bridge work has started on Nostwick Rd bridge. He, Matt and Brad Link (bridge engineer) looked at the structure on the Woirol Bridge on Reynolds Rd where Link had some concerns.

Public Input: Ron Evitts-Residents on Nostwick north of the bridge would like a general cost of replacing the bridge.

Standing Guest: Gary Sauer - County Commissioner Liaison-Brought the Commissioners up to date on the county business.

New Business:

Petition for improvements to Lincoln Rd and Harris Rd - We will provide the petitioner with a very general cost of the upgrade requested.

MCRCSIP Board of Directors election - The Board selected Dorothy Pohl for the At-large position.

Correspondence/Information/Discussion

Bellows Lake Rd - Brad met with Almira Twp, a resident and Ann Beaujean regarding the limited sight distance on Bellows Lk Rd.

Rural Task Force - The engineer's estimate came back low for Lindy Rd. The task force decided to give the overage to Grand Traverse County for Cedar Run Rd project overruns.

Fewins Rd draft plans - We are waiting for Elmers to give us a general cost to move the dirt on Fewins. Once we receive it, it will be up to Inland Twp as to whether they can fund it.

Employee resignation - Chuck Nostrandt has turned in his resignation effective 6/09/16.

Radio tower - We will investigate other tower sites.

Benzie County Showcase - August 6, 2016 from 10 AM - 2 PM.

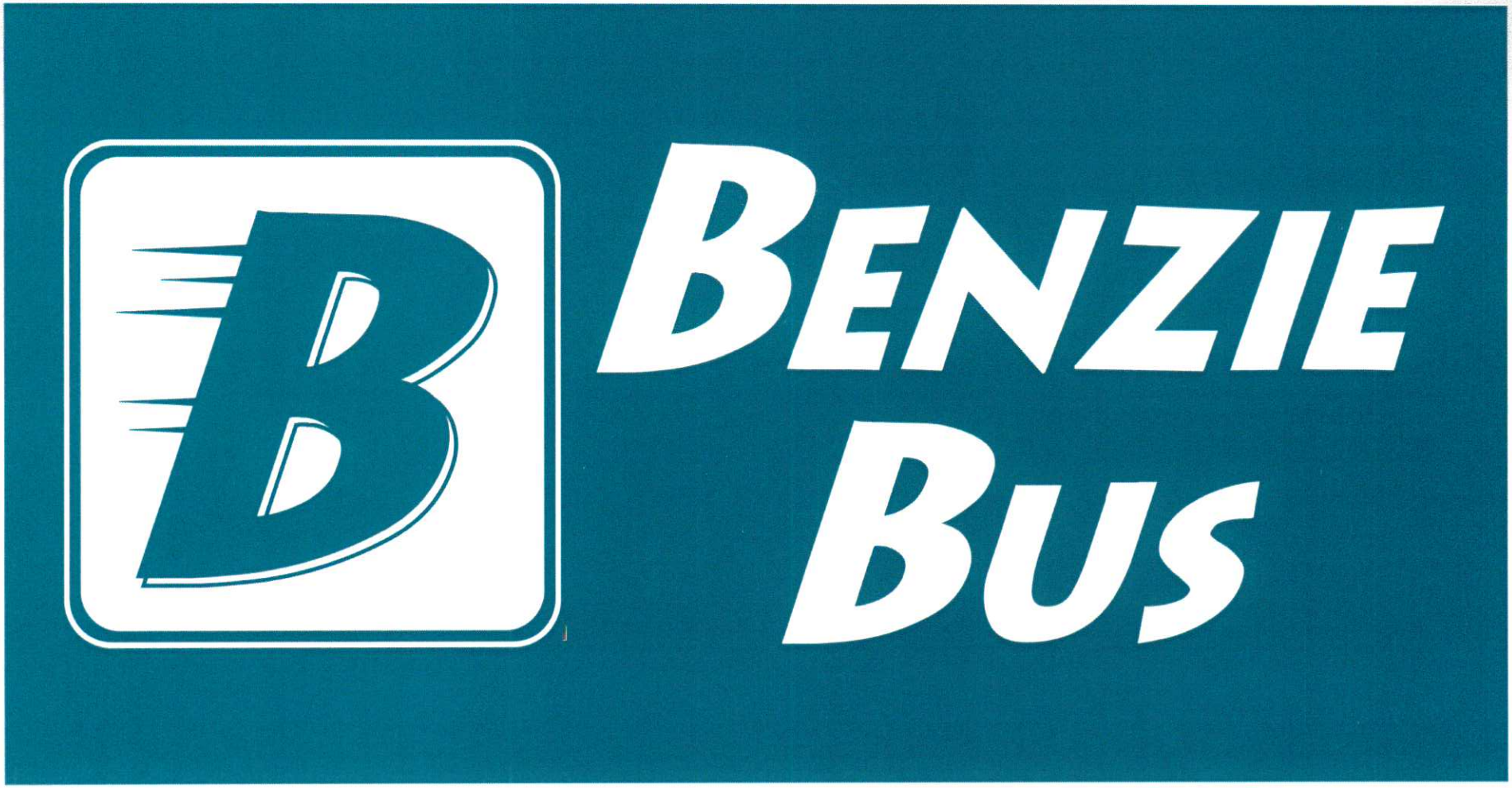
Public Input: John Zirkel asked about road funding from the millage and what roads are eligible.

Meeting was adjourned at 11:10 AM.

Minutes approved 6/23/16

Robert Rosa, Chairman

Kathleen A, Jordan, Clerk

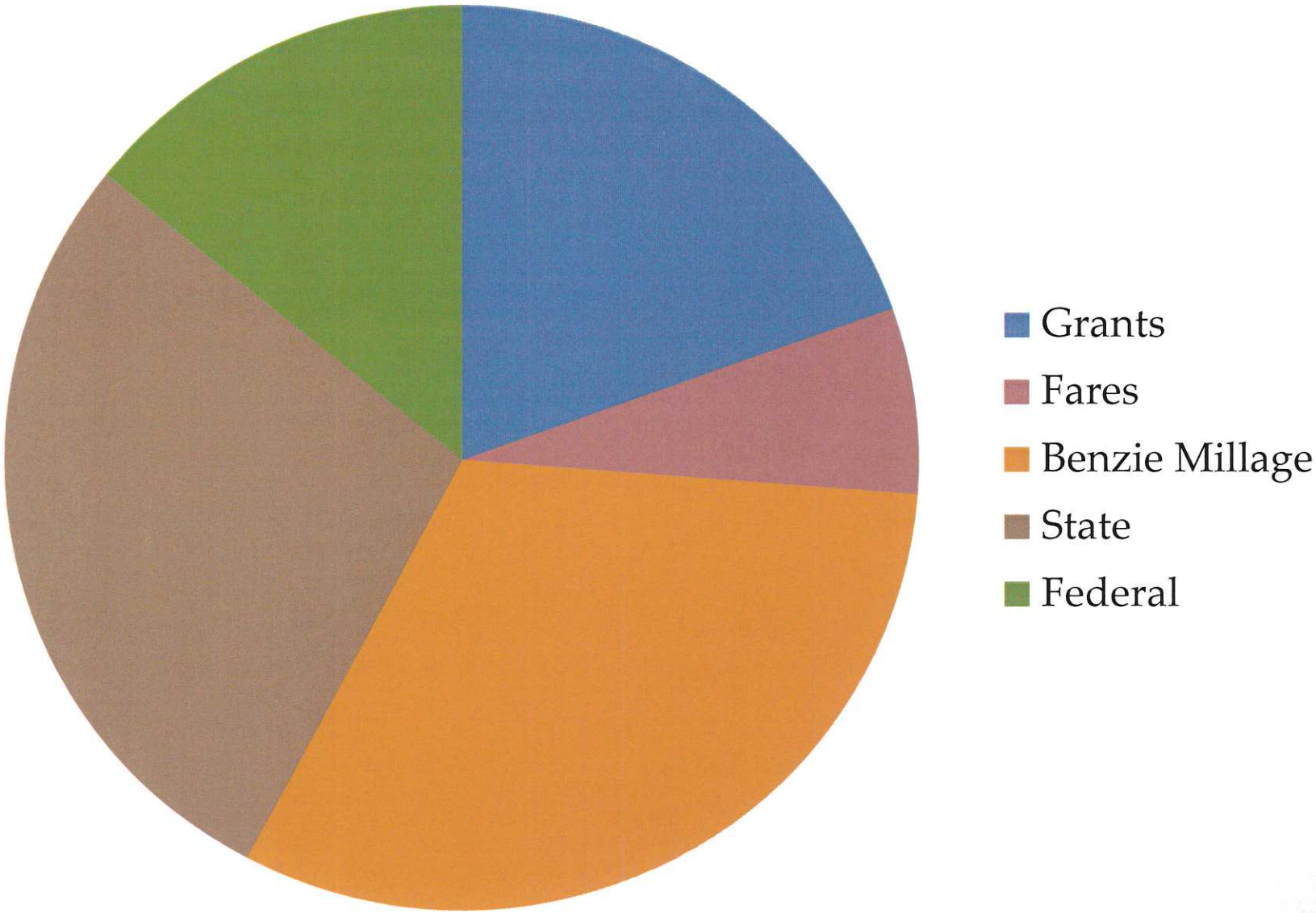


Serving Since 2007

How Many Passengers per Year?

1. 183,621
2. 33,202
3. 144,073
4. 76,203
5. 45,535 (Includes Transferred riders)

How Are We Funded?



Grants Written 2015-2016	Awarded
Rotary Charities NEMT (3-years)	$35,000
New Freedom Shelters	$36,000
New Freedom Mobility Manager	$30,000
3 county Rural Task Force (3 Vans)	$142,500
MMRMA Vehicle Surveillance	$3,019
MMRMA Back-up Cameras	$3,889
MMRMA Building Surveillance	$6,000
RTAP Ergonomic Dispatcher Furniture	$3,511
Graceland Fruit School Bus Wraps	$5,000
CMAQ Mid-Sized Bus Replacement	$134,000
New Freedom Shelters FY 2017	$18,000
Frankfort DDA Summer Shuttles	$5,000
New Freedom Mobility Manager FY 2017	$27,500
Annual CMAQ Bus Replacement	$80,774
	$530,193
Pending	
Jobs Access Reverse Commute JARC FY 2017	$61,824
5-years CMAQ '17-'21	$403,870
	$614,194

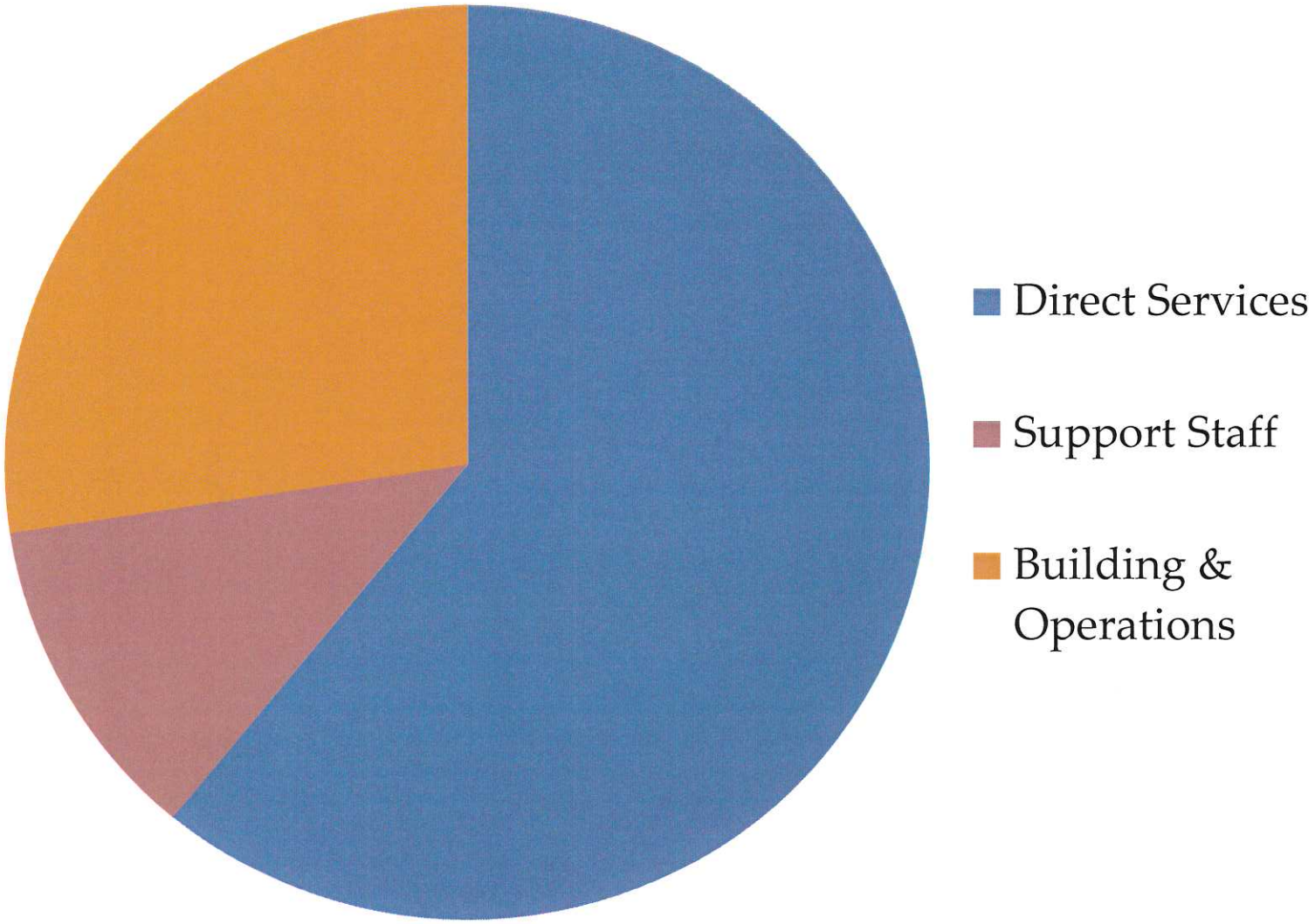

HUSKIES


GROW
BENZIE
FARMER'S
MARKET
BENZIE BUS

Fare Structure

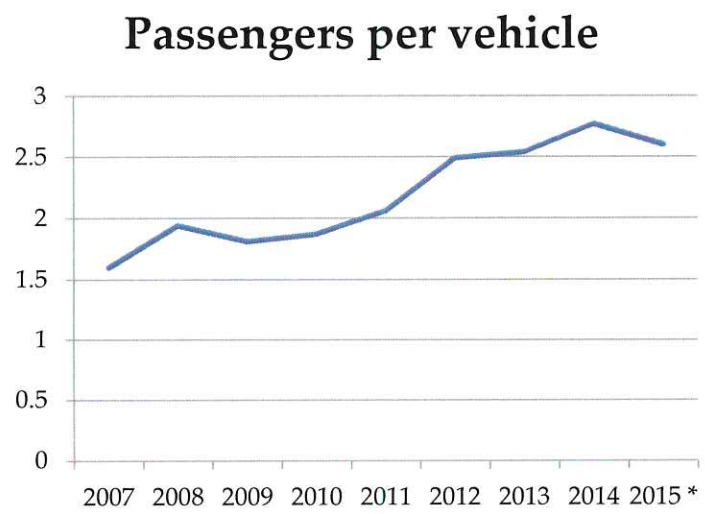
Dial-a-ride	$3.00
Seniors (65 +) & Students	$1.50
Disabled	$1.50
Flex-Route Show-up-& Ride	$2.00
TC X (Express)	$5.00
Frankfort Park-n-Ride	$1.00

How is it Spent?



Dashboards

	Rides	Miles	Riders/ mi.	Hrs.	Riders/ hr.	Gas	LP	Gal/ Rider
May '16	6623	39958	0.166	2281	2.903551	2373	1390	0.5682
May '15	5982	42088	0.142	2323	2.575118	2254	1841	0.6846
	10%	6%	15%	2%	12%			18%



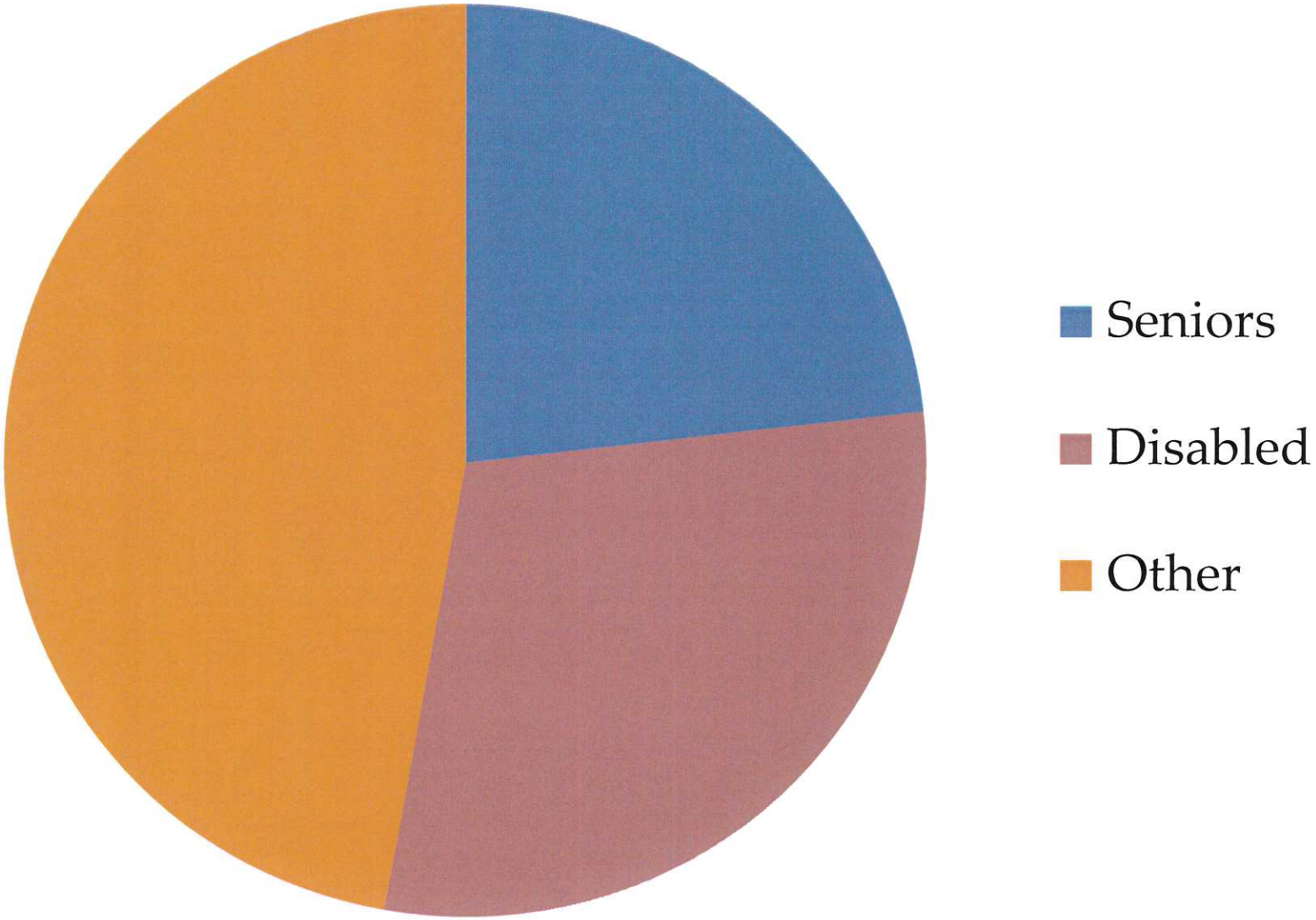
On Average - How Many Riders each Day?

130ish 181 243 304 366

What percentage of the Budget goes "On the Road"?

32% 56% 72% 83%

Who Rides?



County-Wide Needs Assessment

- Fixed Routes through busiest areas
- Increased TC X Express Service &
  Job Access Reverse Commute JARC
- Help reduce parking congestion
- Non-Emergency Medical Transportation NEMT
- Manistee Growth Opportunities
- Partnering with Private/Public Organizations

Movin' On

Transparency & Annual Reports
Ford Transits
More Bus Shelters
Magical History Tours
Beach Bums Shuttles
Mobility Manager for growing services

Great Team

"5 more years!"
the voters declared...