CITY OF MONROE, MICHIGAN

RETIREE HEALTH CARE PLAN

Effective January 1, 2013 (except as otherwise provided herein)

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Table of Contents

Table of Contents
(continued)

ARTICLE I
PREAMBLES

Section 1.01 **Adoption of Plan**. The City of Monroe, Michigan ("City"), established the City of Monroe, Michigan Retiree Health Care Plan ("Plan"), as previously maintained and described through City Policy Number 002, Section 400 (last revised September 19, 2011), which policy is now being replaced and wholly superseded by the terms of this written Plan document adopted by the City effective January 1, 2013.

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

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

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

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

ARTICLE II
DEFINITIONS

Section 2.01 "**Administrator**" means the City Manager of Monroe, Michigan, (or any other party delegated and authorized in writing by the Manager to act on his or her behalf as the Administrator for this Plan). The Administrator is charged with the responsibility to administer and oversee the day to day operations of the Plan and can be contacted as follows: City of Monroe, Managers Officer, 120 E. First St., Monroe, Michigan 48161, 734-384-9144.

Section 2.02 **Benefits Guide**. The actual plan documents, including insurance contracts, benefits-at-a-glance documents, booklets, summaries, administrative services

agreements or collective bargaining agreements, entered into by the City and that govern the retiree health care benefits described in this document and are hereby incorporated by reference into this document. Various Retiree Groups may receive different plan design and cost sharing structures from other Retiree Groups. As a result, the Benefits Guide will differ from one Retiree Group to another. The Employer will provide you with copies of the Benefits Guide that pertains to your Retiree Group when you first become a Participant under the Plan. You also should request updated copies of such Benefits Guides as changes may be made after the date initially distributed to you. Please also review Appendices A and B.

Section 2.03 **"City"** means the City of Monroe, Michigan, which acts through the City Council and Mayor. The City sponsors and maintains the Plan for the benefit of Employees who become eligible for retiree health care benefits hereunder.

Section 2.04 "**City Council**" means the City Council of Monroe, Michigan.

Section 2.05 **"Code"** means the Internal Revenue Code of 1986, as amended. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provision of any legislation which amends or replaces such section or subsection.

Section 2.06 "**Eligible Dependent**" means:

(a) The Retiree's Spouse; and

(b) The Retiree's dependent child who qualifies as the Retiree's dependent under Code Section 152 (without regard to the earnings limit under §152(d)(1)(B), the special exclusions under §152(b)(1) or (2), or the age or student status requirements under §152(c)(3), provided that such qualifying child is age 26 or under during the entire Plan Year). As used herein, "child" shall only include a Retiree's unmarried natural child, adopted child, child lawfully placed with the Retiree for adoption, or child for whom legal guardianship has been awarded to the Retiree. Notwithstanding anything in this Plan to the contrary, if a Benefits Guide has a more restrictive definition of Eligible Dependent (e.g. contains additional dependent eligibility conditions), then the more restrictive conditions under the Benefits Guide will apply, but only to the extent they are consistent with applicable federal law.

Section 2.07 **"Employee"** means:

(a) a non-union common law employee of the City who was employed on a regular, full-time basis by the City **on or before June 30, 2008**, and is a contributing member of the Retirement System; or

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

The term "Employee" shall exclude any (i) non-union common law employee hired by the City on or after July 1, 2008; (ii) non-union common law employee rehired by the City on or after July 1, 2008, unless such rehired employee is receiving coverage under this Plan immediately

prior to his or her reemployment commencement date; (iii) union employee whose collective bargaining agreement does not require retirement health care benefits or hired or reemployed by the City on or after a date specified in the applicable collective bargaining agreement, (iv) any other employee not eligible to participate under the Retirement System, or (iv) individual for whom the City designates as an independent contractor, leased or contract employee, or self-employed individual, regardless of a finding by the City or any third party as to the common law employment status or reclassification of any such person.

Section 2.08 "**Mandatory Contributions**" are contributions that are mandatorily reduced from an Employee's payroll and contributed to the Trust Fund, as set forth under Sections 7.03 and 7.04 below and the attached Appendix B.

Section 2.09 **"Participant"** means a Retiree and his/her Eligible Dependents who are covered by and entitled to retiree health care benefits under the terms of the Plan.**"Plan"** means the City of Monroe, Michigan Retiree Health Care Plan as described in this document and any subsequent amendments, and any Benefit Guide incorporated by reference into the Plan.

Section 2.11 **"Plan Year"** means the period commencing on January 1st and ending on December 31st.

Section 2.12 **"Retiree"** means an Employee who satisfies the eligibility requirements of Article III.

Section 2.13 **"Retirement System"** means the Monroe City Employees' Retirement System (as set forth in Chapter 127 of the Monroe City Ordinances, as amended).

Section 2.14 **"Spouse"** means a Retiree's Spouse by legal marriage at the time of the Employee's retirement, if recognized under the laws of Michigan, but specifically excluding (i) any common law marriages or same sex marriages, even if recognized under the laws of the Retiree's state of domicile, or (ii) any individual for whom a decree of divorce, separate maintenance or legal separation from the Retiree has been entered. For these purposes, the legal married status between a Retiree and his/her Spouse must have existed at the time of the Retiree's initial enrollment under the Plan (or death as applicable) and also at the time that the expense was incurred for which reimbursement is claimed. After the Retiree's initial enrollment period, he/she will not be permitted to enroll a spouse (e.g. he may not enroll a new spouse or a spouse he/she failed to initially enroll for any reason).

Section 2.15 "**Third Party Administrator**" means the organization or insurance carrier that has been engaged or contracted by the City to perform benefit claims processing or other administrative services on behalf of the Plan.

Section 2.16 **"Trust"** means the Trust Agreement Resolution for the Post-Retirement Health Care Fund.

ARTICLE III
BENEFIT ELIGIBILITY

Section 3.01 **Eligible Retirees**. An Employee (as defined in Section 2.07 above) is eligible to enroll in the Plan and continue to receive coverage during a Plan Year only if he/she satisfies **each** of the following conditions:

(a) The Employee (i) separates for purposes of retirement from employment with City or (ii) is eligible and elects to participate in the deferred retirement option plan (DROP) under the Retirement System.

(b) The Employee, as of the date immediately prior to the date of his/her retirement or becoming a DROP member, was contributing member contributions to the Retirement System.

(c) As of the date of retirement and severance from employment with the City, the Employee is entitled and immediately (and simultaneously with participation under this Plan) commences receiving his or her retirement allowance from the Retirement System or commences participation in the DROP under the Retirement System. A retired Employee who does not elect immediate commencement of regular retirement benefits or DROP membership under the Retirements System shall not be eligible to commence benefits under this Plan at a later date. Employees who are only entitled to a deferred retirement pension under the Retirement System are not eligible for coverage under this Plan.

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

(e) When the Retiree becomes entitled to Medicare (e.g. at age 65), he/she timely enrolls in Medicare Part B. (Note: The Retiree and, where applicable, the Retiree's Eligible Dependent, shall be responsible for all associated costs of Medicare Part B enrollment and participation.)

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

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

(h) The Employee elects to receive retiree coverage under the Plan in writing by the date specified by the Administrator, but in no event later than **60 days** after his/her severance from employment with the City for retirement (or commencement of

participation in the DROP under the Retirement System). If an Employee fails to timely elect retiree coverage under this Plan (or is not eligible to elect retiree coverage as of the date of his/her severance from employment), such Employee and his/her Eligible Dependent will not be eligible to elect or receive retiree coverage under the Plan at any later date.

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

NOTE: Employees hired by the City on or after July 1, 2008, are not eligible to receive retiree coverage under this Plan for themselves and/or Eligible Dependents. Additionally, individuals who are reemployed by the City on or after July 1, 2008, generally will not be eligible for retiree coverage under this Plan unless he/she was receiving coverage under this Plan upon his/her reemployment commencement date. Such employees instead may be required to participate in the City's Retiree Health Care Savings Program. Please review the applicable plan documents to determine your rights, obligations and benefits under such Retiree Health Care Savings Program.

Section 3.02 Eligible Dependent Coverage. A Retiree also may enroll his or her Eligible Dependent(s) (as defined in Sections 2.06 and 2.14) in the same benefit options under the Plan only if each of the following conditions are satisfied:

(a) Subject to Sections 3.03 and 3.04 below, the Retiree has timely enrolled himself/herself in retiree coverage under the Plan as well as the Eligible Dependent in accordance with the enrollment procedures established by the Administrator.

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

(c) The Retiree's Eligible Dependent is not currently eligible to participate in his/her own past or present employer-sponsored group health plan or, as determined in the sole discretion of the City, is provided or eligible for lesser health care benefit coverage than what the City provides.

(d) Subject to Sections 3.03 and 3.04 below, or the terms of an applicable collective bargaining agreement or Benefits Guide, such individual must have qualified as the Retiree's Eligible Dependent as of the date of the Retiree's retirement or commencement in DROP under the Retirement System. A Retiree will not be entitled to subsequently enroll any other individual (e.g. a new or existing Eligible Dependent who was not initially enrolled due to other coverage or for other reasons) after the Retiree's initial enrollment period has closed connected to his/her retirement from employment date.

(e) The Employee agrees in writing to and actually makes any required monthly contribution for Eligible Dependent's coverage, which cost is determined by the City from time to time. If a Retiree fails to timely pay the required contribution, Eligible Dependent coverage will end and not thereafter be reinstated.

NOTE: For all retiree groups, other than the Police and Firefighter Retiree Groups, coverage of Eligible Dependent-Children under the Plan will be at the sole expense of the Retiree (or his/her Spouse). For the Police and Firefighter Groups, their collective bargaining agreements may allow for City subsidized coverage of such Dependent-Children, which terms are incorporated by reference herein.

Section 3.03 Surviving Eligible Dependent' Coverage.

(a) *Death in Service.* The current Eligible Dependent of an Employee who dies during his/her employment with the City shall be eligible to enroll in this Plan as long as:

(i) The surviving Eligible Dependent elects to enroll in the Plan in writing by the date specified by the Administrator, but in no event later than **60 days** after the Retiree's death.

(ii) The surviving Eligible Dependent is eligible to receive and immediately commences survivor benefits under the Retirement System.

(iii) The surviving Eligible Dependent agrees in writing to and actually makes any required monthly contribution for surviving Eligible Dependent coverage, which cost is determined by the City from time to time. If the surviving Eligible Dependent fails to timely pay the required contribution, this Eligible Dependent coverage will end and not thereafter be reinstated.

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

(v) The surviving Eligible Dependent is not currently eligible to participate in his/her own past or present employer-sponsored group health plan. or, as determined in the sole discretion of the City, is provided or eligible for lesser health care benefit coverage than what the City provides.

A surviving Eligible Dependent who is not eligible or otherwise fails any of the conditions set forth above at the time of the Retiree's death shall not subsequently be entitled enroll under this Plan.

(b) *Retiree's Death During Coverage Under this Plan.* An Eligible Dependent who is enrolled under the Plan at the time of a Retiree's death may continue to participate in the Plan as long as he or she continues to satisfy the eligibility conditions set forth above in Section 3.02 and continues to receive the Retiree's survivor benefits under the Retirement System. [In other words, if a Retiree elects a straight life annuity form of payment (Option A) under the Retirement System without any survivor annuity benefits, then his/her surviving Eligible Dependents shall not receive any extended, survivor coverage under the Plan (but may be eligible to elect COBRA continuation pursuant to Section 5.02 below).] If the Eligible

Dependent-Spouse remarries after the Retiree's death, his/her coverage may continue under this Plan, but coverage shall not be available to the new Eligible Dependent.

Section 3.04 Coverage Under Other Employer-Sponsored Health Care Programs. Notwithstanding anything in this Plan to the contrary, the special provisions below apply when the Retiree or his/her Eligible Dependent are eligible for coverage under another employer-sponsored group health:

(a) Each Retiree shall annually provide the Administrator a signed affidavit indicating whether or not the Retiree and his/her Eligible Dependent is employed and/or receiving health care benefits through another source. Retirees who fail to report such employment and/or receipt of health care benefits from another source, or falsify such affidavit, shall forfeit all health care benefits and rights under this Plan for themselves and their Eligible Dependents. To receive benefits under this policy, Retirees and Eligible Dependents must cooperate in the coordination of coverage to limit the City's expense.

(b) In the event a Retiree obtains employment with another employer after his/her retirement from the City and is eligible for or provided health care benefits equal to or better (as determined in the sole discretion of the Administrator) than those provided to the Retiree by the City through that employment, the City shall not provide coverage to the Retiree and his/her Eligible Dependent while the Retiree is so employed. Upon termination of this subsequent employment, the Retiree, after giving notice to the City, shall be eligible to have his/her coverage and his/her Eligible Dependent's coverage reinstated under this Plan.

(c) Notwithstanding paragraph (b), if the Retiree is employed long enough to obtain retiree health benefits through another employer and such benefits are equal to or greater than those provided to Retirees under this Plan, the City shall have no further obligation to provide health care benefits to this Retiree and his/her Eligible Dependent.

Section 3.05 Determining Eligibility. Subject to Article X, the Administrator has full and final discretion to determine if a retired employee or his/her Eligible Dependent satisfy the eligibility requirements for coverage under this Plan, including determining if they had been timely enrolled in the manner which satisfies Plan requirements. The Administrator also has the right, retroactively or prospectively, to terminate coverage for a Retiree and/or his/her Eligible Dependent as of the date that they no longer satisfy the Plan's eligibility requirements and receive reimbursement from such individuals for any benefits when the Plan's eligibility requirements are not satisfied.

ARTICLE IV
PARTICIPATION

Section 4.01 Commencement of Participation. A Participant shall begin receiving benefits under the Plan on the first day he or she satisfies the eligibility requirements of Article III, provided the individual has timely enrolled for coverage on such date in the manner and by the deadline established by the Administrator. If a Retiree fails to timely and accurately complete the enrollment process, the Retiree and/or his/her Eligible Dependent will not be covered under the Plan at any future date (except as otherwise permitted under Section 3.04).

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

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

ARTICLE V
TERMINATION OF PARTICIPATION

Section 5.01 Termination Events. Except as provided in Section 5.02, a Participant's coverage and participation in the Plan shall terminate in accordance with the Plan and/or Benefits Guide on the earliest of:

(1) the City's termination of the Plan, in whole or in part;

(2) an Employee's or Participant's non-payment of any required contributions under the Plan or to the Trust;

(3) the loss of eligibility status;

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

(5) the death of such Participant; or

(6) in the case of the Retiree's death, the surviving Eligible Dependent may receive or continue to receive coverage under this Plan only under the limited circumstances described in Section 3.03 above regarding surviving Eligible Dependent coverage or Section 5.02 regarding COBRA coverage.

Notwithstanding anything to the contrary, if a Participant permits another person who is not a qualified Participant to use any identification card issued by the Third Party Administrator or the Participant otherwise fraudulently claims a benefit or falsifies information on a benefit claim form, the Administrator or Third Party Administrator may give such Participant written notice that he or she is no longer a covered Participant for benefits under the Plan. If the Administrator or Third Party Administrator gives such written notice, the Retiree and his/her Eligible Dependents will cease to be eligible for the benefits under the Plan as of the date specified in such written notice, and no benefits will be paid after that date. Any action by the Administrator or Third Party Administrator under this provision is subject to review in

accordance with the Claims and Claims Review Procedures under the Plan. Coverage under the Plan also will end on any other date specified in the Benefits Guide.

Section 5.02 COBRA Continuation Coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). At the time that an Employee retired from employment with the Employer, such Retiree and his/her covered Eligible Dependents elected retiree coverage under this Plan in lieu of, and thereby waived, all rights to COBRA coverage under this federal law. The only exception to this waiver of COBRA rights is if the coverage of the Retiree's Eligible Dependent under this Plan terminates as a result of any event which is deemed a "qualifying event" under COBRA. In which case, such covered Eligible Dependent may elect COBRA continuation coverage under this Plan in accordance with the remaining provisions of this Section 5.02.

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

(b) *Qualifying Events*. COBRA coverage is available to a covered Eligible Dependent, if his or her coverage under this Plan would otherwise end due to:

- divorce or legal separation from the Retiree; or
- the Retiree's death or Medicare entitlement.

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

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

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

Failure to timely provide written notice to the Administrator will cause the Retiree's covered Eligible Dependent to lose the right to receive COBRA coverage.

(d) *Electing COBRA*. The Administrator generally will notify, through the COBRA Qualifying Event Notice and Election form, a covered Eligible Dependent of his or her right to elect COBRA continuation coverage, but only if the Administrator has received timely notice of the Qualifying Event that results in a loss of coverage, as explained above. If continuation coverage is desired, the Eligible Dependent must elect COBRA continuation coverage within **60 days** of the date that the Administrator sent the COBRA Qualifying Event Notice and Election form to such Eligible Dependent. If a covered Eligible Dependent does not timely elect to purchase COBRA continuation coverage (or does not timely notify the Administrator of a Qualifying Event), such Eligible Dependent's coverage under the Plan will end and no future COBRA continuation rights will be available to him/her. In considering whether to elect COBRA continuation coverage, an Eligible Dependent should take into account that a failure to continue his/her group health plan coverage will affect future rights under federal law. First, an Eligible Dependent can lose the right to avoid having a pre-existing condition exclusions applied to her or him by other group health plans if such Eligible Dependent has more than a 63-day gap in health coverage, and election of continuation coverage may help an Eligible Dependent not have such a gap. Second, an Eligible Dependent may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if such Eligible Dependent does not get COBRA continuation coverage for the maximum time available to him or her. Finally, the Eligible Dependent should take into account that he or she has special enrollment rights under federal law. An Eligible Dependent has the right to request special enrollment in another group health plan for which he or she otherwise is eligible (such as a plan sponsored by an Eligible Dependent's employer) within 30 days after an Eligible Dependent's group health coverage ends because of the Qualifying Event listed above. A covered Eligible Dependent also will have the same special enrollment right at the end of COBRA continuation coverage if such Eligible Dependent gets continuation coverage for the maximum time available to him or her.

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

(f) *Making Premium Payments*. For coverage to continue, the first premium must be received by the date stated in the notice. Normally this date will be 45 days after the

continuation coverage is elected. Premiums for every following month of continuation coverage must be paid monthly on or before the premium due date stated in the notice. There is a 30 day grace period for these monthly premiums. If the premium is not paid within 30 days after the due date, continuation coverage will end on the first day of that period of coverage. Coverage cannot be reinstated. A COBRA continuee will not receive a monthly bill/voucher for such COBRA premiums. The COBRA continuee has the sole obligation and responsibility to make timely payment of COBRA premium(s).

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

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

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

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

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

Section 5.03 Conversion Privilege. To the extent the Plan is fully-insured through an insurance contract, a Participant may, if permitted by and in accordance with the terms of such insurance contract, convert his or her coverage under the Plan to an individual medical expense policy with the insurance carrier, without the necessity of a medical examination and with no interruption in coverage. The cost of such individual conversion coverage shall be paid solely by the affected individual. To the extent conversion rights are applicable to the benefit options available under this Plan, it is the Participant's sole responsibility to timely contact and apply for individual conversion coverage in accordance with the terms of the insurance contract.

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

Section 6.01 Federal Laws Unless City Opts Out. Unless the City has timely elected to opt out of compliance with these laws or is otherwise exempt from these laws, the Plan shall comply with the following:

(a) The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

(1) 48 hours following a vaginal delivery; and

(2) 96 hours following a delivery by cesarean section.

However, the Plan may pay for a shorter stay if the attending provider (e.g., your physician) after consultation with the mother, discharges the mother or newborn earlier. Also, the Plan may not set the level of benefits or out-of-pocket costs so that any portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-approval. For information on pre-approval, refer to the Benefits Guide that applies to the health care option elected.

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

- all stages of reconstruction of the breast on which the mastectomy was performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

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

(c) The Plan shall not:

- Use genetic information to determine eligibility for coverage or to impose pre-existing condition exclusions;
- Adjust a Participant's premium and contribution amounts on basis of genetic information;
- Request or require a Participant or a family member to undergo a genetic testing;
- Request, require or purchase genetic information for underwriting purposes; or
- Request, require or purchase genetic information about an individual prior to or in connection with an individual's enrollment under the Plan (except as otherwise permitted by law for wellness programs).

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

- Financial requirements and treatment limits applicable to mental health and substance abuse are no more restrictive than those limits and requirements on medical/surgical (e.g. deductibles, copays, coinsurance, out-of-pocket, treatment limits, not just annual and lifetime dollar limits);
- Out-of-Network Benefits provided for medical/surgical also must be available for mental health and substance abuse; and
- Criteria for medical necessity and reason for claim denials must be made available.

The Benefits Guide will provide an explanation of the covered and excluded benefits, which will indicate if the City is exempt from or will comply with the Mental Health Parity Act provisions.

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

These new market reforms and consumer protection provisions **DO NOT** apply to this Plan, because this Plan covers only retired employees of the City (and their Eligible Dependent), and does not cover any active employees of the City. The Department of Health and Human

Services (along with the Department of Labor and Internal Revenue Service) issued guidance that confirms that retiree-only health plans will not be subject to the new market reform and consumer/patient protection provisions of the new Health Care Reform legislation.

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

ARTICLE VII
BENEFITS AND FUNDING

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

The benefit structure, coverage options and other cost sharing requirements for each benefit option offered under the Plan (including copays, coinsurance, out-of-pocket maximums, deductibles, etc.) vary for different Retiree Groups depending on such Retiree's status as a non-union employee or union employee as of your retirement date, age at retirement, and/or date of retirement. As a result, your Benefits Guide may differ from other Retiree Groups. The Employer will provide you with a copy of the Benefits Guide that pertains to your Retiree Group when you become a Participant. Please also review Appendices A and B.

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

Section 7.03 Funding and Mandatory Contributions. At this time, the Plan provides retiree medical and prescription drug benefits through a self-insured arrangement. Self-insured means that the benefits are not insured through an insurance carrier, but rather are paid by the City through the Trust or other general assets of City. Certain Employee Groups also are required to make mandatory contributions, through current pre-tax payroll deductions, to the Trust, as provided in Appendix B and each applicable collective bargaining agreement. Such

Mandatory Contributions shall be treated as Employer contributions for the purpose of determining tax treatment under the United States Internal Revenue Code (the "Code").

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

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

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

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

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

Any Employee also may, at the time established by the Administrator, voluntarily and irrevocably waive retiree health care benefits under the Plan for himself/herself, and such waiver automatically will include, without consent, a waiver on behalf of his/her Eligible Dependent. The Employee must complete the waiver form provided by the City. Upon executing a voluntary, irrevocable waiver of retiree health care benefits under this Plan for the Employee (and his/her Eligible Dependent), no additional Mandatory Contributions from the Employee will be deducted from his/her payroll. The Administrator also shall calculate the value of all Mandatory Contributions paid to the Trust by such Employee, plus accumulated interest; which amounts shall be refunded to the Employee who irrevocably waives retiree health care benefits under this Plan. The refund of any retiree health care contributions shall be made to the Employee within forty-five (45) days of the Employee's properly completed and submitted waiver of retiree health care benefits to the Administrator.

ARTICLE VIII
COORDINATION OF BENEFITS

Section 8.01 General Rule. The City intends that the Plan shall provide each Participant with payment for eligible health care expenses incurred by the Participant as a Retiree

and, if eligible, the Retiree's Eligible Dependent. The City does not intend that payment under this Plan and any other health care plan shall exceed the amount of the expenses incurred. For this reason, the Plan coordinates benefits with other health care plans in accordance with the State of Michigan's Coordination of Benefits Act as set forth in MCLA § 550.251.

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

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

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

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

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

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

If a Participant signs-up for Medicare Part D coverage, such Medicare Part D coverage will be coordinated with this Plan's coverage.

Section 8.05 Subrogation. The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a Participant in a time of need, the Plan may pay covered expenses that may be or become the responsibility of another person, with the intent that the Plan later receive reimbursement for those payments (hereinafter called "Reimbursable Payments"). Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a Participant expressly agrees to, and becomes subject to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

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

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

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

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

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

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

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

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

Failure by a Participant to follow the above terms and conditions may result, at the discretion of the Administrator, in a reduction from future benefit payments available to the Participant under

the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

ARTICLE IX
ADMINISTRATION

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

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

ARTICLE X
CLAIMS PROCEDURE

Section 10.01 How to File a Claim. A claim for benefits under the Plan must be submitted in writing to the Administrator in accordance with procedures established by the Administrator as communicated in writing to Participants. The arbitration provisions set forth in Section 10.02 shall apply only if no claims procedures are set forth in the Benefit Guide or as required by an applicable collective bargaining agreement.

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

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

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

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

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

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

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

ARTICLE XI
TERMINATION OR AMENDMENT

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

ARTICLE XII
MISCELLANEOUS PROVISIONS

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

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

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

Section 12.04 Return of Dividends, Premiums or Reserves. Because the amount of employee or participant contributions is fixed each year and the City makes up the difference between those contributions and the costs of the Plan, any dividends, returned premiums, service fees or reserves, credited by a service provider or insurer are the property of the City.

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

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

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

Section 12.08 Right of Verification. If an Employee or a Participant omits or provides any false information with respect to the Plan or on a benefit claim form, such person may be

disqualified from receiving benefits under the Plan. In addition, an Employee may be subject to disciplinary action and/or termination of employment.

ARTICLE XIII
HIPAA PRIVACY AND SECURITY AMENDMENT

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

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

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

Section 13.02 Protected Health Information (PHI). PHI includes information that the Plan creates or receives that relates to the past, present, or future health or medical condition of an individual that could be used to identify the individual. Electronic PHI is PHI that is transmitted by or maintained in electronic media (e.g. memory devices in computers, removable/transportable digital memory medium, etc..).

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

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

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

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

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

- use or further disclose PHI only as permitted by and consistent with this Plan Document and HIPAA;
- ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to City with respect to such information;
- not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan;
- report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware;
- make available information in accordance with the HIPAA Rules regarding individual access to PHI;
- make available PHI for amendment in accordance with the HIPAA Rules;
- make available the information required under the HIPAA Rules to provide an accounting of non-routine disclosures to the individual;
- make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules;
- if feasible, return or destroy all PHI received from the Plan that City still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- ensure adequate separation between the Plan and City; and
- To the extent required by HIPAA, ensure compliance with the safeguard and other requirements specified under 45 CFR 164.105(a) relating to hybrid entities and the healthcare component of the Plan.

The City further agrees that if it creates, receives, maintains or transmits any electronic PHI on behalf of the Plan, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The City will report to the appointed Security Official any security incident of which it becomes aware and it will implement reasonable and appropriate security measures for electronic PHI to ensure that the adequate separation provisions of Section 13.06 are satisfied.

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

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

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

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

Section 13.07 Violations of Privacy or Security Rules. If the City becomes aware of violations of these HIPAA privacy or security rules, it shall arrange for the HIPAA Privacy or

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

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

EXECUTION PAGE

In Witness Whereof, the City of Monroe, Michigan, through its City Mayor and Council, has caused this Plan to be restated effective as of January 1, 2013, and, hereby agrees to the provisions of this Plan.

MAYOR OF THE CITY OF MONROE, MICHIGAN

Dated: 2-4, 2013

By: Robert E. Clark
Its: Mayor

CITY COUNCIL OF MONROE, MICHIGAN

Dated: 2-4, 2013

By: Charles Evans
Its: Clerk/Treasurer for the City of Monroe, Michigan

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

ADMINISTRATOR

Dated: 2-4, 2013

By: George Brown
Its: City Manager

APPENDIX A

TO THE
MONROE CITY
RETIREE HEALTH CARE PLAN

SCHEDULED BENEFITS FOR 2013

You should ask the Administrator for the most recent version of this Appendix A and the Benefits Guide that applies to your Retiree Group as the benefits described below and in such Benefits Guide change from time to time (e.g. the Administrator may increase the cost sharing requirements, including premiums, co-pays, coinsurance and/or deductible requirements). Please also review the main provisions of this Plan document.

(a) **Retiree Benefit Groups.** The benefit structure, coverage options and other cost sharing requirements for the retiree medical, prescription drug and dental benefits (including retiree premium/contribution share; deductibles; copays; coinsurance; out-of-pocket maximums; etc.) vary for different Retiree Groups depending on such Retiree's status as a non-union employee or union employee as of the retirement date, age at retirement, and/or date of retirement. As a result, the provisions set forth in this Plan document and in the applicable Benefits Guide will vary from one Retiree Group to another. The Employer will provide you with a copy of the Benefits Guide that pertains to your Retiree Group when you become a Participant. The Retiree Benefit Groups consist of the following main groups and then may have subsets within such groups depending on the retirement date of such Retiree:

(1) **Non-Union Retiree Group**

(2) **Teamsters Retiree Group**

(3) **COMEA Unit I Retiree Group**

(4) **COMEA Unit II Retiree Group**

(5) **Command Officers Retiree Group**

(6) **Firefighter Retiree Group**

(7) **Police Officer Retiree Group**

(b) **Retiree Dental Benefits.** With respect to all Retirees (including non-union and union Retiree Groups regardless of the date of retirement), a Retiree and his/her covered Eligible Dependents are solely responsible to pay the entire cost for any dental coverage available and selected under the Plan. The Benefits Guide that is applicable to your Retiree Group will set forth the benefits and other cost-sharing requirements for such dental coverage and the Administrator will notify you during each annual enrollment period of the retiree premium/contribution cost for such coverage.

(c) **Retiree Medical and Prescription Benefits**. As mentioned above, the benefit structure, coverage options and other cost sharing requirements for the retiree medical and prescription drug benefits vary for different Retiree Groups depending on such Retiree's status as a non-union employee or union employee as of the retirement date, age at retirement, and/or date of retirement.

(1) For Union Retiree Groups – the terms of the Collective Bargaining Agreement in effect at the time of a Retiree's retirement shall set forth the benefit structure and cost sharing requirements (except as otherwise modified through mutual agreement between the City and respective union as permitted under the Collective Bargaining Agreement). The pertinent terms of such Collective Bargaining Agreements dealing with retiree health and dental benefits are incorporated by reference as part of this Plan document.

(2) For Non-Union Retiree Groups – the City retains the right to decide from year to year the benefit structure and cost sharing requirements available to existing and future Non-Union Retirees. The Administrator will furnish details regarding the benefit structure and cost sharing requirements in the annual enrollment materials and applicable Benefit Guide. The City also maintains an Administrative Policy for Retiree Health Care Benefit Structure and Cost Sharing Requirements ("Administrative Policy") which sets forth the benefit structure and cost for each Retiree Group, and any sub-set therein (based on retirement dates and grandfathering), which Policy explains the differences amongst the retiree groups and is incorporated by reference as part of this Plan document.

(d) **General Rules**. The following provisions apply to all Retiree Groups:

(1) The Administrator shall have the sole discretion to determine the monthly illustrated premium cost and any other retiree contribution cost for these purposes.

(2) The term "credited service" used for purposes of determining the retiree premium/contribution cost for any Retiree Group (as set forth in the annual enrollment materials of the Administrative Policy) shall have the same meaning ascribed under the City of Monroe Employees' Retirement Ordinance.

(3) Upon Medicare eligibility, the Participant is required to timely enroll in both Medicare Parts A and B and shall be moved to a Medicare Supplement or other similar type program of the Administrator's choosing. It is the Participant's sole responsibility to consult with the local Social Security office and obtain details regarding Medicare. Failure to timely enroll in Medicare Parts A and B shall cause the Participant to lose coverage under this Plan.

(4) The City generally will pay the same percentage share of the cost of such Medicare Supplemental and prescription drug benefits for Retirees and Eligible Dependents becoming entitled to Medicare as the City paid on the Retiree's behalf prior to Medicare eligibility. Retirees and/or Eligible Dependents shall pay the remaining portion of such costs, if any, through automatic withholding from their monthly pension benefits. In the event that the Retiree's required contributions toward the premium exceeds the Retiree's monthly pension benefit payments under the Retirement System,

the Retiree and/or covered Eligible Dependent is responsible for submitting on a monthly basis the remaining balance. The City generally may decide to invoice the Retiree or his/her covered Eligible Dependent for such remaining balance of the necessary payments, but it is the Retiree's and Eligible Dependent's sole responsibility to ensure timely payment is made to the City. For the purposes of this provision, credited service shall be defined under the City of Monroe Employees' Retirement Ordinance.

(5) The City will terminate the retiree health care coverage under this Plan of a Retiree and/or his/her Eligible Dependents, if the Retiree or Eligible Dependent fails to timely pay all applicable monthly premiums within (30) days of the due date. A Retiree's or Eligible Dependent's failure to receive an invoice from the City does not constitute just cause for not making timely payments.

The City hereby expressly and unqualifiedly reserves the right to modify this Appendix A, change the cost sharing requirements and benefit structure under the Plan for the Retiree and his/her Eligible Dependents, or terminate the Plan.

APPENDIX B
TO THE
MONROE CITY
RETIREE HEALTH CARE PLAN

MANDATORY CONTRIBUTIONS

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

Employee Classification	Amount of Mandatory Contribution (Percentage of annual Compensation)*	Effective Date of When Mandatory Contributions Began Under the Plan
Benefit Group Police Officers, Command Officers or Fire Fighters hired on or before June 30, 2008.	3.0% contribution (pre-taxed) of the average annualized base wages of all regular full-time employees.	January 1, 2013
Benefit Group Non-Union, Teamsters, COMEA Unit I, and COMEA Unit II	1.5% contribution (pre-taxed) of the average annualized base wages of all regular full-time employees and an additional 1.5% contribution for a total of 3.0% (pre-taxed).	1.5% - July 1, 2014; an additional 1.5% - December 31, 2014 for a total of 3.0%

* Annual Compensation means the average annualized base wages of all regular full-time Employees of the City, which amount shall be calculated based upon the wages paid on June 30th of each year. Once this amount is determined for the 12-month period beginning on a June 30, it shall not be adjusted until the next following June 30. The employee's contribution shall be paid through automatic payroll withholdings in 26 equal biweekly increments during the 12-month period commencing July 1 extending through and including the following June 30. If the Employee quits or leaves City employment for any reason and is ineligible for retiree health care benefits, the Employee shall be refunded the amount he contributed to the Retiree Health Care Fund. Interest will be credited in the same manner as Mandatory Contributions to the pension fund.

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