1. City Council Regular Meeting Agenda

   Documents: 10-16-12 FINAL AGENDA.PDF

2. City Council Regular Meeting Packet

   Documents: 10-16-12 PACKET.PDF

CITY OF YPSILANTI
COUNCIL MEETING AGENDA
CITY COUNCIL CHAMBERS - ONE SOUTH HURON ST.
YPSILANTI, MI 48197
TUESDAY, OCTOBER 16, 2012
7:00 P.M.

I. CALL TO ORDER –

II. ROLL CALL –

Council Member Bodary	P A	Council Member Robb	P A
Council Member Jefferson	P A	Council Member Vogt	P A
Council Member Murdock	P A	Mayor Schreiber	P A
Mayor Pro-Tem Richardson	P A		

III. INVOCATION –

IV. PLEDGE OF ALLEGIANCE –

"I pledge allegiance to the flag, of the United States of America, and to the Republic for which it stands, one nation, under God, indivisible, with liberty and justice for all."

V. INTRODUCTIONS –

VI. AGENDA APPROVAL –

VII. PRESENTATIONS –

1. Proposal 12-3**:** A Proposal to Amend the State Constitution to Establish a Standard for Renewable Energy - Liz Wozniak, League of Conservation Voters and Gillian Ream, Michigan Suburbs Alliance

2. Ypsilanti Housing Commission Recovery Plan – Willie Garrett, Director, Office of Public Housing – Detroit Field Office

VIII. AUDIENCE PARTICIPATION –

IX. REMARKS BY THE MAYOR –

X. MINUTES –

Resolution No. 2012-218, approving the minutes of October 2, 2012.

XI. CONSENT AGENDA – Resolution No. 2012-219

1. Resolution No. 2012-220, authorizing the Human Resources Department to retain Basic to provide the Flexible Spending Account to City employees for the calendar year of January 1, 2013 through December 31, 2013.

2. Resolution No. 2012-221, approving an ordinance to amend Chapter 106, Article V, Section 106-454(b) of the Code of Ordinances to increase water rates in the City of Ypsilanti. ***(Second Reading)***

3. Resolution No. 2012-222, approving an ordinance to amend Chapter 106, Article V, Section 106-455(a) of the Code of Ordinance to increase sewage disposal service rates in the City of Ypsilanti. ***(Second Reading)***

4. Resolution No. 2012-223, approving the Memorandum of Understanding (MOU) between the City of Ypsilanti and Eastern Michigan University regarding Ainsley Street and authorizing the Mayor and City Clerk to sign all necessary documents.

XII. RESOLUTIONS/MOTIONS/DISCUSSIONS –

1. Resolution No. 2012-199, approving the YHC Recovery Agreement***. (Vote to reconsider approved October 2, 2012.)***

2. Resolution No. 2012-224, amending Resolution No. 2009-119 to reduce the membership size of the joint YDDA Board.

3. Resolution No. 2012-225, approving appointment to YDDA.

4. Resolution No. 2012-226, supporting the merger of the Ypsilanti and Willow Run Public Schools.

XIII. LIASON REPORTS -

A. SEMCOG Update
B. Washtenaw Area Transportation Study
C. Washtenaw Metro Alliance
D. Washtenaw County Land Bank Authority
E. Washtenaw Urban County
F. Freight House

XVI. COUNCIL PROPOSED BUSINESS –

XV. COMMUNICATIONS FROM THE MAYOR –

Nominations:

Human Relations Commission
Arika Lycan (reappointment)
226 W. Michigan #2
Ypsilanti, MI 48197
Term Expires: 11/1/2015

Human Relations Commission
John Shuler (reappointment)
316 E. Forest
Ypsilanti, MI 48198
Term Expires: 11/1/2015

Ypsilanti Community Utilities Authority
Andrew Cameron (reappointment)
1313 W. Cross
Ypsilanti, MI 48197
Term Expires: 12/1/2015

Ypsilanti Housing Commission
Tabitha Boone (resident commissioner)
951 Madison
Ypsilanti, MI 48197
Term Expires: 10/21/2016

Ypsilanti Housing Commission
Ariel Moore (new appointment)
1 Oakwood
Ypsilanti, MI 48197
Term Expires: 12/31/2012

XVI. COMMUNICATIONS FROM THE CITY MANAGER –

XVII. AUDIENCE PARTICIPATION -

XVIII. REMARKS FROM THE MAYOR –

XIX. ADJOURNMENT –

A. Resolution No. 2012-227, adjourning the City Council Meeting.

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XVII. AUDIENCE PARTICIPATION -

XVIII. REMARKS FROM THE MAYOR –

XIX. ADJOURNMENT –

A. Resolution No. 2012-227, adjourning the City Council Meeting.

PROPOSAL 12-3

A PROPOSAL TO AMEND THE STATE CONSTITUTION TO ESTABLISH A STANDARD FOR RENEWABLE ENERGY

This proposal would:

· Require electric utilities to provide at least 25% of their annual retail sales of electricity from renewable energy sources, which are wind, solar, biomass, and hydropower, by 2025.

· Limit to not more than 1% per year electric utility rate increases charged to consumers only to achieve compliance with the renewable energy standard.

· Allow annual extensions of the deadline to meet the 25% standard in order to prevent rate increases over the 1% limit.

· Require the legislature to enact additional laws to encourage the use of Michigan made equipment and employment of Michigan residents.

Should this proposal be approved?

SOUTHEAST MICHIGAN REGIONAL ENERGY OFFICE

25 X '25 RENEWABLE ENERGY STANDARD

WHAT IS THE 25 X '25 RENEWABLE ENERGY STANDARD?

The 25 x '25 Renewable Energy Standard (25 x '25) is a ballot initiative (Proposal 3), which will appear before Michigan voters in November 2012.

Michigan's current renewable energy standard, signed into law in 2008, requires that 10% of the energy used in Michigan comes from renewable sources such as wind, solar and biomass by 2015. Proposal 3 would increase Michigan's renewable energy standard to 25% by 2025. The Southeast Michigan Regional Energy Office has endorsed the proposal.

WHY IS THE INITIATIVE IMPORTANT?

The 25 x '25 Renewable Energy Standard will support Michigan's economy and create jobs – primarily operations, maintenance and construction jobs.

Over 60% of the electricity used in the state comes from coal, which is imported from other states to the tune of $1.7 billion a year.[i] Diversifying energy sources within the state will reduce our dependence on coal imports from other states, encourage innovation and competition, spur energy sector job growth in Michigan and keep tax dollars in our state. It is estimated that this initiative could create more than 74,000 new jobs in Michigan. [ii]

WHO IS SUPPORTING THE INITIATIVE?

The initiative is supported by a broad-based, bipartisan coalition that includes business, faith, labor, environmental, conservation and health organizations. Over 250 Michigan businesses endorse the initiative, including the American Wind Energy Association (AWEA). AWEA is the national trade association of America's wind industry and represents 2,000 member companies, including 70 businesses in Michigan.

Other notable supporters include the Michigan League of Conservation Voters, 5 Lakes Energy, the Michigan Nurses Association, the NAACP and over a dozen unions. Visit www.MiEnergyMiJobs.com for a full list of supporters and endorsing organizations.

More than thirty states, including several Great Lakes states, have adopted standards similar to Michigan's ballot initiative.

SOUTHEAST MICHIGAN REGIONAL ENERGY OFFICE

WHAT CAN MY COMMUNITY DO?

Your community can help move Michigan's economy forward by adopting a resolution in support of the 25x'25 Renewable Energy Standard ballot initiative. Our municipal leaders are a compelling voice in favor of long-term strategies that reduce the cost of energy. By joining voices in support of this new legislation, your community can lead the way in securing a more sustainable energy future for your residents, the region and the state.

IS MICHIGAN MEETING ITS CURRENT STANDARD OF 10% BY 2015?

The state is on track, per a report issued in February by the Michigan Public Service Commission (MPSC). The percentage of the State's energy coming from renewable sources has been rising by approximately 1.4 percent per year.

The 25 x '25 Renewable Energy Standard would keep the state on track, requiring the renewable proportion to increase by 1.5 percent per year.

WHY IS 25 x '25 PRESENTED AS A BALLOT MEASURE?

The legislature and the Governor have both announced they do not plan to revisit the issue of renewable energy until the current program is fully implemented at the end of 2015. However, utilities are making decisions now about their long-term investments.

Michigan citizens will help fund these investments, and should have the opportunity to encourage utilities to invest in clean energy options that provide employment opportunities for Michigan residents while also protecting ratepayers from drastic increases.

QUESTIONS?

Contact Energy Programs Director Samuel G. Offen at 866.402.1061 x709 or sam@regionalenergyoffice.org.

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[i] Michigan Public Service Commission

[ii] Michigan State University Jobs and Investment Impact Study, August 2012. Available online at: http://mienergymijobs.com/EconomicImpact.aspx

Based on information from *www.MiEnergyMiJobs.com*. Visit the site for more information.

Resolution No. 2012 – 218
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the Minutes of October 2, 2012 be approved.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

Draft

CITY OF YPSILANTI
COUNCIL MEETING AGENDA
CITY COUNCIL CHAMBERS - ONE SOUTH HURON ST.
YPSILANTI, MI 48197
Tuesday, October 2, 2012
7:00 P.M.

I. CALL TO ORDER –

The meeting was called to order at 7:02 p.m.

II. ROLL CALL –

Council Member Bodary	Present	Council Member Robb	Present
Council Member Jefferson	Present	Council Member Vogt	Present
Council Member Murdock	Present	Mayor Schreiber	Present
Mayor Pro-Tem Richardson	Absent		

Council Member Murdock moved, supported by Council Member Vogt to excuse the absence. On a voice vote the motion carried and the absence was excused.

III. INVOCATION

The Mayor asked all to stand for a moment of silence.

IV. PLEDGE OF ALLEGIANCE

"I pledge allegiance to the flag, of the United States of America, and to the Republic for which it stands, one nation, under God, indivisible, with liberty and justice for all."

V. INTRODUCTIONS

The Mayor introduced Fire Chief Jon Ichesco, Director of Public Services Stan Kirton and Legal Counsel Jessie O'Jack.

VI. AGENDA APPROVAL

Council Member Murdock moved, supported by Councilmember Robb to reconsider Resolution 2012-199 (YHC Recovery Agreement) at the October 16, 2012 meeting and add this item to the agenda today as item #3 under Resolutions/Motions/Discussions.

On a roll call, the vote to add Resolution No. 2012-199 (YHC Recovery Agreement) to the agenda for reconsideration at the next meeting was as follows:

Council Member Bodary	Yes	Council Member Robb	Yes
Council Member Jefferson	Yes	Council Member Vogt	Yes
Council Member Murdock	Yes	Mayor Schreiber	No
Mayor Pro-Tem Richardson	Absent		

VOTE:

Yes: 5 No: 1 (Schreiber) Absent: 1 (Richardson) Vote: Carried

On a roll call, the vote to add Resolution No. 2012-199 (YHC Recovery Agreement) to Resolutions/ Motions/Discussions was as follows:

Council Member Jefferson	Yes	Council Member Vogt	Yes
Council Member Murdock	Yes	Mayor Schreiber	No
Mayor Pro-Tem Richardson	Absent	Council Member Bodary	Yes
Council Member Robb	Yes		

VOTE:

Yes: 5 No: 1 (Schreiber) Absent: 1 (Richardson) Vote: Carried

Council Member Murdock commented that city council has not received a response from the Ypsilanti Housing Commission and would like to give them a chance to respond.

Attorney John Barr commented that there is a Resolution No. 2012-199 on the agenda.

Mayor Schreiber asked if the Resolution No. 2012-199 on the agenda can be changed to 2012-217.

On a voice vote, Resolution No. 2012-199 on the agenda was changed to Resolution No. 2012-217.

On a voice vote, the agenda was approved as amended.

VII. PRESENTATIONS

Fire Prevention Week Proclamation – Mayor Schreiber

The Mayor read a proclamation declaring the week of October 7-13, 2012 Fire Prevention Week in the City of Ypsilanti.

VIII. AUDIENCE PARTICIPATION

1. Reagan Parker, 124 W. Michigan Ave. said she is a candidate for the YDDA Board. She said she is a long time resident of Ypsilanti, graduated with an MBA from EMU and would like an opportunity to serve on the YDDA Board.

IX. REMARKS BY THE MAYOR

Mayor Schreiber thanked Ms. Parker for her comments.

X. SHOW CAUSE HEARING

1. Dangerous Building Show Cause Hearing for 25 Bell Street

    A. Open show cause hearing.

    No one was present to speak.

B. Resolution No. 2012-~~199~~**217** to close the show cause hearing.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

THAT the Show Cause hearing regarding 25 Bell Street be officially closed.

OFFERED BY: Council Member Murdock
SUPPORTED BY: Council Member Vogt

Attorney Jesse O'Jack was present to give the background and answer questions from Council.

C. Resolution No. 2012-200, to accept the dangerous building order for 25 Bell Street.

Regarding the property located at: 25 Bell Street
Tax ID # 11-11-39-483-002
Case # DB 12-0001

WHEREAS Council has reviewed the report of findings and order of the hearing officer, and

WHEREAS Council has had an opportunity to hear testimony and evidence offered; now therefore

IT IS RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI that the Ypsilanti City Council hereby:

X **Approves the Hearing Officer's Order.**

_____ **Disapproves the Hearing Officer's Order.**

_____ **Modifies the Hearing Officer's Order as follows:**

OFFERED BY: Council Member Murdock
SUPPORTED BY: Council Member Bodary

On a voice vote, the motion to approve Resolution No. 2012-217, closing the public hearing carried.

On a roll call vote, the vote to approve Resolution No. 2012-200 was as follows:

Council Member Jefferson	Yes	Council Member Vogt	Yes
Council Member Murdock	Yes	Mayor Schreiber	Yes
Mayor Pro-Tem Richardson	Absent	Council Member Bodary	Yes
Council Member Robb	Yes		

VOTE:

Yes: 6 No: 0 Absent: 1 (Richardson) Vote: Carried

XI. PUBLIC HEARING Ordinance 1181

1. An ordinance entitled "Ordinance to Extend AT&T Metro Act Permit to June 30, 2015.

A. Open public hearing.

No one was present to speak.

B. Resolution No. 2012-201, to close public hearing.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

THAT the public hearing on an ordinance entitled, "Ordinance to Extend AT&T Metro Act Permit to June 30, 2015" be officially closed.

C. Resolution No. 2012-211, approving an ordinance entitled, "Ordinance to Extend AT&T Act Permit to June 30, 2015. ***(Second Reading)***

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That an ordinance entitled, "Ordinance to Extend AT&T Metro Act Permit to June 30, 2015" be adopted on Second and Final Reading.

OFFERED BY: Council Member Bodary
SUPPORTED BY: Council Member Jefferson

On a voice vote, the motion to approve Resolution No. 2012-201, closing the public hearing carried.

On a roll call, the vote to approve Resolution No. 2012-211, an ordinance to extend the AT&T Metro Act Permit was as follows:

Council Member Murdock	Yes	Mayor Schreiber	Yes
Mayor Pro-Tem Richardson	Absent	Council Member Bodary	Yes
Council Member Robb	Yes	Council Member Jefferson	Yes
Council Member Vogt	Yes		

VOTE:

Yes: 6 No: 0 Absent: 1 (Richardson) Vote: Carried

XII. <u>ORDINANCES-FIRST READING</u> Ordinance No. 1182

1. An ordinance to amend Chapter 106, Article V, Section 106-454(b) of the Code of Ordinances to increase water rates within the City of Ypsilanti.

   A. Resolution No. 2012-202, determination.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the proposed ordinance to amend Chapter 106, Article V, Section 106-454(b) of the Code of Ordinances to increase water rates within the City of Ypsilanti, be approved at First Reading.

OFFERED BY: Council Member Robb
SUPPORTED BY: Council Member Bodary

B. Open the public hearing.

No one was present to speak.

C. Resolution No. 2012-203, to close public hearing.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the public hearing on the proposed ordinance to amend Chapter 106, Article V, Section 106-454(b) of the Code of Ordinances to increase water rates within the City of Ypsilanti, be officially closed.

OFFERED BY: Council Member Robb
SUPPORTED BY: Council Member Bodary

On a voice vote, the motion to approve Resolution No. 2012-203, closing the public hearing carried.

On a roll call vote, the vote to approve Resolution No. 2012-202 was as follows:

Mayor Pro-Tem Richardson	Absent	Council Member Bodary	Yes
Council Member Robb	Yes	Council Member Jefferson	Yes
Council Member Vogt	Yes	Council Member Murdock	Yes
Mayor Schreiber	Yes		

VOTE:

Yes: 6 No: 0 Absent: 1 (Richardson) Vote: Carried

Ordinance No. 1183

2. An ordinance to amend Chapter 106, Article V, Section 106-455(a) of the Code of Ordinances to increase sewage disposal service rates.

A. Resolution No. 2012-204, determination.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the proposed ordinance to amend Chapter 106, Article V, Section 106-455(a) of the Code of Ordinances to increase sewage disposal service rates within the City of Ypsilanti, be approved on first reading.

OFFERED BY: Council Member Jefferson
SUPPORTED BY: Council Member Bodary

B. Open the public hearing.

No one was present to speak.

C. Resolution No. 2012-205, to close public hearing.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the public hearing on the proposed ordinance to amend Chapter 106, Article V, Section 106-455(a) of the Code of Ordinances to increase sewage disposal service rates within the City of Ypsilanti, be officially closed.

OFFERED BY: Council Member Jefferson
SUPPORTED BY: Council Member Bodary

On a voice vote, the motion to approve Resolution No. 2012-205, closing the public hearing carried.

On a roll call, the vote to approve Resolution No. 2012-204 was as follows:

Council Member Robb	Yes	Council Member Jefferson	Yes
Council Member Vogt	Yes	Council Member Murdock	Yes
Mayor Schreiber	Yes	Mayor Pro-Tem Richardson	Absent
Council Member Bodary	Yes		

VOTE:

Yes: 6 No: 0 Absent: 1 (Richardson) Vote: Carried

Ordinance No. 1184

3. An ordinance to repeal Section 2.66 of the City Code: Residency Requirements for City Manager.

   A. Resolution No. 2012-206, determination.

   RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

   That an ordinance entitled "An ordinance to repeal residency requirements for City Manager, repealing City Code Sections 2-66 through 2-70" be approved on First Reading.

OFFERED BY: Council Member Robb
SUPPORTED BY: Council Member Vogt

   B. Open the public hearing.

   No one was present to speak.

   C. Resolution No. 2012-207, to close public hearing.

   RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

   That the public hearing on an ordinance entitled "An ordinance to repeal residency requirements for City Manager, repealing City Code Sections 2-66 through 2-70" be officially closed.

OFFERED BY: Council Member Robb
SUPPORTED BY: Council Member Vogt

Council Member Robb commented that he thinks city council should make the residency requirement person specific.

Attorney Barr commented that the state statute has eliminated the residency requirement unless it is negotiated in union contracts.

City Manager Lange commented that he is residing with a friend in Ypsilanti and lives less than five minutes away. He said that his family has discussed the option of moving to Ypsilanti but he candnot afford two residencies.

Council Member Robb asked to table the item until the next meeting.

Attorney Barr commented that this issue will need to be addressed before Mr. Lange's 90 days are up.

Council Member Robb said that Mr. Lange's 90 day contract can be extended if needed.

Council Member Robb asked for the item to be tabled.

Council Member Jefferson said he does not see anything wrong with a 25 mile radius.

Council Member Bodary moved, supported by Council Member Jefferson to table Resolution 2012-206.

On a voice vote, the motion to approve Resolution No. 2012-207, closing the public hearing carried.

On a roll call vote, the vote to table Resolution No. 2012-206 indefinitely was as follows:

Council Member Vogt	Yes	Council Member Murdock	Yes
Mayor Schreiber	Yes	Mayor Pro-Tem Richardson	Absent
Council Member Bodary	Yes	Council Member Robb	Yes
Council Member Jefferson	Yes		

VOTE:

Yes: 6 No: 0 Absent: 1 (Richardson) Vote: Carried

Resolution No. 2012-206 was tabled until the next regular meeting of October 16, 2012.

XIII. MINUTES

Resolution No. 2012-208, approving the September 18, 2012 minutes.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the Minutes of September 18, 2012 be approved.

OFFERED BY: Council Member Murdock
SUPPORTED BY: Council Member Jefferson

On a voice vote, the minutes of September 18, 2012 were approved.

XIV. CONSENT AGENDA

Resolution No. 2012-209

1. Resolution 2012-210, authorizing the City Clerk to cast the ballot for the 2012 Michigan Municipal League (MML) Board of Directors election.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

THAT the City Clerk is authorized to cast the ballot for the 2012 Michigan Municipal League (MML) Board of Directors election.

2. Resolution No. 2012-213, approving contract with Saladino Construction Co., Inc. for Sidewalk Ramp Replacement Program.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

Whereas, bids were duly advertised for The Sidewalk Ramp Replacement Program; and

Whereas, five (5) bids were publicly opened on Thursday, June 7, 2012 at 2:00 p.m. and reviewed for compliance with bidding qualifications and project specifications; and

WHEREAS, the bid submitted by Saladino Construction Co., Inc., 3303 N. Territorial Road, Ann Arbor, MI 48106, best meets the project specifications and qualifications and is in the best interests of the City; and

WHEREAS, Metro Act Funds and Community Development Block Grant Funds have been allocated for the Sidewalk Ramp Replacement Program.

NOW THEREFORE BE IT RESOLVED That the City awards the bid to Saladino Construction Co., Inc. in the amount of $94,000.00 for the construction of ADA sidewalk ramps throughout the City during the 2012-2013 construction season; and

THAT the Mayor and City Clerk are authorized to sign the necessary contract documents, subject to approval by the City Attorney, to facilitate the completion of this work.

3. Resolution No. 2012-212, approving a contribution of $1,000 to the Washtenaw Health Initiative.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

WHEREAS, nearly 29,000 individuals in Washtenaw County are without health insurance; and

WHEREAS, the Washtenaw Health Initiative (WHI), a volunteer group, has organized to prepare the county for the full implementation of the federal health care reform and to increase access to insurance; and

WHEREAS, the WHI's mission is to improve the health of low-income, uninsured and Medicaid recipients in Washtenaw County by bringing together organizations to coordinate and leverage resources, generate innovative ideas and foster collaboration; and

WHEREAS, the WHI has helped over 700 residents receive and keep their coverage and state assistance.

NOW THEREFORE BE IT RESOLVED THAT the Ypsilanti City Council supports the mission of the WHI and authorizes the City Clerk to make a $1,000 contribution (Charter Membership) on behalf of the City; funds to be allocated from the City Council Membership and Dues account 101-7-1010-958-00.

4. Resolution No. 2012-216, regarding Proposal 12-5.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

WHEREAS, the Michigan Supreme Court has ordered that a "Super-Minority" Constitutional Amendment be placed on the November 6, General Election ballot; and

WHEREAS, this Constitutional Amendment (Proposal 12-5) would end simple majority democracy on tax issues in Lansing and allow a minority of just one-third of the members of the House or Senate to block important tax reforms; and

WHEREAS, just 13 state Senators in Lansing would gain the power to block the votes of the other 135 members of the House and Senate making it nearly impossible to end tax breaks and loopholes currently in Michigan tax law that benefit rich and powerful special interests and their lobbyists over ordinary taxpayer; and

WHEREAS, only seven other states have the provision in their constitution; one state Mississippi, is the poorest state in the nation; another state, Nevada, has the nation's highest unemployment rate; and one the states, California, failed to balance its state budget on time in 16 to 20 years because the requirement creates partisan gridlock and makes it nearly impossible for politicians to solve problems cooperatively; and

WHEREAS, if this "Super-Minority" Constitutional Amendment should pass on November 6, our local taxes would almost certainly increase, and in addition, the state's credit rating would almost certainly plummet, forcing taxpayers at the state and local levels to pay more to cover the costs of borrowing to pay for roads, bridges, schools and other critical infrastructure needs.

NOW THEREFORE BE IT RESOLVED, the City Council of Ypsilanti hereby supports a "NO" vote on (Proposal 12-5), a "Super-Minority" Constitutional Amendment and call upon all citizens and taxpayers of the City of Ypsilanti to defeat this deceitful and dangerous hijacking of the State Constitution by voting a resounding "NO" on this proposed amendment at the polls on November 6, 2012.

OFFERD BY: Council Member Bodary
SUPPORTED BY: Council Member Jefferson

On a voice vote, the motion to approve Resolution No. 2012-209 carried.

XV. RESOLUTIONS/MOTIONS/DISCUSSIONS

1. Resolution 2012-194, approving request to Municipal Employees Retirement System (MERS) to adopt MERS Pension Plan (Division 15) reallocating certain divisional market assets between two divisions. ***(Tabled 9/18/12)***

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

WHEREAS, the City of Ypsilanti has been a participating municipality in the Municipal Employees' Retirement System of Michigan ("MERS"); and

WHEREAS, pursuant to Municipal Employees' Retirement Board requirements, since December 31, 1994, asset accounting had been separate for each division, instead of aggregate for the entire municipality; and

WHEREAS, over time, significant disparities have arisen in the City's MERS plan as a result of allocating the fair market value of plan assets on a divisional basis instead of on an aggregate basis, which disparities the City of Ypsilanti wishes to eliminate; and

WHEREAS, in order to address the anticipated increase in unfunded liability for pensions to be provided participants in the defined benefit plan that is likely to occur as a result of diminished contributions to that plan, the City wishes to reallocate certain divisional market assets between the two divisions.

NOW THEREFORE BE IT RESOLVED, that the governing body of the City of Ypsilanti, a participating municipality as defined in the Municipal Employees' Retirement Act as recodified by Act No. 427 of the Public Acts of 1984, as amended, and as the employer, hereby requests MERS to reallocate the total market value of assets of $96,584 of Employer Assets from Division 01's General Non Union Employer Reserve to Division 15's City Manager after 7/1/2012 Employer Reserve as of July 1, 2012 enabling the actuary to prepare the 2012 actuarial valuation with the transferred assets.

OFFERED BY: Council Member Bodary
SUPPORTED BY: Council Member Jefferson

City Manager Lange gave the background for the request and answered questions from Council. He said the MERS account is currently significantly overfunded.

Council Member Murdock clarified that this resolution would approve transferring money that was earned in one account to another account.

Mr. Lange answered yes and said this is a one-time start up deal. He said it would be tweaked annually. He said currently the only person who retired out of the general fund MERS was Ed Koryzno so there was no pension.

Council Member Murdock clarified that in the years following the city would not have to make a contributions to MERS and the City Manager would begin making the 5% contribution.

Mr. Lange answered yes and said making the transfer now would save the city money.

Council Member Robb stated that $516,000 in liability was paid for Mr. Koryzno for his entire career and the city is being asked to pay $96,000 in liability for Mr. Lange and he has only been on the job for two months. He said in Mr. Koryzno's career he was underfunded for 13 years so he doesn't know why the city can't leave Mr. Lange underfunded for two months and not use general fund dollars. He said he doesn't feel the correction has to be made immediately and spend general fund money.

On a roll call, the vote to approve Resolution No. 2012-194 was as follows:

Mayor Schreiber	Yes	Mayor Pro-Tem Richards	Absent
Council Member Bodary	Yes	Council Member Robb	No
Council Member Jefferson	Yes	Council Member Vogt	Yes
Council Member Murdock	Yes		

VOTE:

Yes: 5 No: 1 (Robb) Absent: 1 (Richardson) Vote: Carried

2. Resolution No. 2012-214, approving appointments to Boards and Commission.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

THAT, the following individuals be appointed to the City of Ypsilanti Boards and Commissions as indicated below:

NAME	**BOARD**	**TERM TO EXPIRE**
Anthony Bedogne **717 Stanley** **Ypsilanti, Michigan 48198**	**Zoning Board of Appeals (replacing Greg Johnson)**	**5/1/2012~~4~~**
David Kabat **7257 Glacier Pointe Drive** **Ypsilanti, Michigan 48197**	**YDDA**	**7/7/2014**
~~**Ellen Clement**~~ ~~**2722 Radcliffe Ave.**~~ ~~**Ann Arbor, Michigan 48104**~~	~~**YDDA**~~	~~**7/7/2013**~~
Eric Maes **1004 Sherman Street** **Ypsilanti, Michigan 48197**	**Recreation Commission (replacing Heather Cataldo)**	**5/1/2014**

OFFERED BY: Council Member Vogt
SUPPORTED BY: Council Member Bodary

Mayor Schreiber stated that Ellen Clement cannot fulfill the YDDA position so her name is being removed from the resolution at this time. He also stated that because Mr. Kabat is a non-resident it requires a 2/3rd vote to approve so the question should be divided.

Council Member Robb pointed out that the expiration date of Anthony Bedogne should be corrected.

Mr. Bedogne's expiration date was changed from 5/1/2012 to 5/1/2014.

The changes were accepted and supported by Council Members Vogt and Bodary, the makers of the motion, and there were no objections from Council.

On a roll call, the vote to appoint Anthony Bedogne to the Zoning Board of Appeals and Eric Maes to the Recreation Commission was as follows:

Council Member Bodary	Yes	Council Member Robb	Yes
Council Member Jefferson	Yes	Council Member Vogt	Yes
Council Member Murdock	Yes	Mayor Schreiber	Yes
Mayor Pro-Tem Richardson	Absent		

VOTE:

Yes: 6 No: 0 Absent: 1 (Richardson) Vote: Carried

Added: Resolution No. 2012-218 approving the appointment of David Kabat to the YDDA

THAT David Kabat be appointed to the YDDA with a term ending 7/7/2014.

OFFERED BY: Council Member Vogt
SUPPORTED BY: Council Member Jefferson

Mayor Schreiber stated that Mr. Kabat owns and operates HAABs restaurant.

Council Member Robb commented that the median age for YDDA members is 54 and he thought the DDA was trying to have a younger age median. He said adding Mr. Kabat doesn't help. He said Mr. Kabat is also a restaurant owner and the board currently has four restaurant owners and no retail owners. He said appointing Mr. Kabat negates the fact that Council is looking to shrink the board.

Council Member Murdock asked if the YDDA is having a retreat on October 3rd.

Mayor Schreiber answered yes.

Council Member Murdock said that maybe Council should wait until after the retreat to appoint members.

Mayor Schreiber commented that the YDDA needs 8 to operate and currently they are operating below state limits and can't do business.

Council Member Bodary commented that he has received calls from YDDA members who stated sometimes they can't do business because members are not at the meetings. He said he is becoming more lenient towards having more members so that business can be done. He said he supports the current nomination and future members.

On a roll call, the vote to approve Resolution No. 2012-218 appointing David Kabat to the YDDA was as follows:

Council Member Jefferson	Yes	Council Member Vogt	Yes
Council Member Murdock	No	Mayor Schreiber	Yes
Mayor Pro-Tem Richardson	Absent	Council Member Bodary	Yes
Council Member Robb	No		

VOTE:

Yes: 4 No: 2 (Murdock, Robb) Absent: 1 (Richardson) Vote: Carried

7. Resolution No. 2012-199 approving HUD Recovery Agreement and Action Plan.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

THAT the Recovery Agreement and Action Plan between Ypsilanti Housing Commission, the Unites States Department of Housing and Urban Development and the City of Ypsilanti be approved with the following additions:

1. **Add additional language to Section GO01c of the Action Plan: *"And the evaluations be submitted to City Council when completed".***

2. **Add Section XXV to Recovery Agreement and also GO05:**
"That all reports and communications referenced in or pertaining to this agreement and recovery plan by HUD or the Ypsilanti Housing Commission be simultaneously sent to the Ypsilanti City Clerk for distribution to City Council."

3. **Add Section I(a) to the Recovery Agreement and GO06 to the Action Plan with an initial report date of 12/18/2012 stating:**
"HUD, the Ypsilanti Housing Commission and the City of Ypsilanti will explore with Washtenaw County, the City of Ann Arbor and others the feasibility of a regional Housing Entity"

4. **Add to Action Plan: *"Submission of a chronology timeline of the Section 8 financials from 2007 to present."***

OFFERED BY: Council Member Murdock
SUPPRTED BY: Council Member Robb

On a roll call, the vote to reconsider Resolution No. 2012-199 (YHC Recovery Agreement) was as follows:

Council Member Murdock	Yes	Mayor Schreiber	No
Mayor Pro-Tem Richardson	Absent	Council Member Bodary	Yes
Council Member Robb	Yes	Council Member Jefferson	Yes
Council Member Vogt	Yes		

VOTE:

Yes: 5 No: 1 (Schreiber) Absent: 1 (Richardson) Vote: Carried

Council Member Murdock moved, supported by Council Member Robb to table Resolution No. 2012-199 to the October 16, 2012 meeting.

On a roll call, the vote to table Resolution No. 2012-199 to the October 16th meeting was as follows:

Council Member Murdock	Yes	Mayor Schreiber	No
Mayor Pro-Tem Richardson	Absent	Council Member Bodary	Yes
Council Member Robb	Yes	Council Member Jefferson	Yes

Council Member Vogt Yes

VOTE:

Yes: 5 No: 1 (Schreiber) Absent: 1 (Richardson) Vote: Carried

XV. LIASON REPORTS

A. SEMCOG Update (Richardson) - None
B. Washtenaw Area Transportation Study (Murdock) – reported there was no discussion on the proposed separation from SEMCOG, however they did receive the City's resolution opposing it.
C. Washtenaw Metro Alliance (Robb) - None
D. Urban Counties (Schreiber) - None
E. Freight House (Murdock) reported that the meeting for the final plans has been moved.

XVI. COUNCIL PROPOSED BUSINESS

MURDOCK

Council Member Murdock moved, supported by Council Member Robb to bring a resolution to Council to take the DDA Board from 12 members including the Mayor to 10 members and the Mayor. He said he would have a resolution at the next meeting.

BODARY

Council Member Bodary asked about Cross Street. He said the update has been steady now.

JEFFERSON

Council Member Jefferson commented about the pothole on Jefferson Ave. and said it needs to be repaired.

Council Member Jefferson also commented about not receiving the bi-weekly reports from the Housing Commission.

XVII. COMMUNICATIONS FROM THE MAYOR

XVIII. COMMUNICATIONS FROM THE CITY MANAGER

City Manager Lange commented on the following:

- Mr. Lange explained why the closed session was removed.
- City's Master 5-Year Turnaround Sustainability Plan is being worked on. Looking into each fund and seeing how they function alone. He said he is working with Finance Director Marilou Uy and John Kaczor and they are getting close. He explained they are developing a base line budget to work from in order to see what the future looks like. He said he will soon present the core data and make recommendations to City Council on how he thinks they should proceed.
- He said the SEMCOG Management Audit team will be coming to city hall soon to work with staff on how the city can save money and options will be shared with city council for approval and then implementation.
- He said after the budget is settled, staff will move forward with economic development.

XIX. AUDIENCE PARTICIPATION

None

XX. REMARKS FROM THE MAYOR

Nomination:

Ypsilanti Downtown Development Authority

Regan L. Parker (resident board member replacing Dawn Gendich)
124 W. Michigan Ave, #203
Ypsilanti, Michigan 48197
Term Expires: 7/7/2015

XXI. ~~CLOSED SESSION~~

~~Closed Session to discuss personnel matter. (OMA 15.268, Section 8(a))~~

XXII. ADJOURNMENT

Resolution No. 2012-215, adjourning the City Council meeting.

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the City Council Meeting be adjourned, on call, by the Mayor or two (2) members of Council.

OFFERED BY: Council Member Jefferson
SUPPORTED BY: Council Member Vogt

On a voice vote, the motion to adjourn the meeting carried.

The meeting adjourned at 8:49 p.m.

Resolution No. 2012 – 219
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI,

That the following items be approved:

1. Resolution No. 2012-220, authorizing the Human Resources Department to retain Basic to provide the Flexible Spending Account to City employees for the calendar year of January 1, 2013 through December 31, 2013.

2. Resolution No. 2012-221, approving an ordinance to amend Chapter 106, Article V, Section 106-454(b) of the Code of Ordinances to increase water rates in the City of Ypsilanti. Ordinance No. 1182 ***(Second Reading)***

3. Resolution No. 2012-222, approving an ordinance to amend Chapter 106, Article V, Section 106-455(a) of the Code of Ordinance to increase sewage disposal service rates in the City of Ypsilanti. Ordinance No. 1183 ***(Second Reading)***

4. Resolution No. 2012-223, approving the Memorandum of Understanding (MOU) between the City of Ypsilanti and Eastern Michigan University regarding Ainsley Street and authorizing the Mayor and City Clerk to sign all necessary documents.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

REQUEST FOR LEGISLATION
October 16, 2012

To: Mayor and Council

From: Judi Smith, Human Resources

Subject: Adoption of Basic as the City's Flexible Spending Account (FSA) Provider

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City staff is requesting the adoption of Basic as its Flexible Spending Account (Cafeteria Plan under Section 125 of the Internal Revenue Code of 1986) provider beginning January 1, 2013, and ending December 31, 2013. This FSA is funded solely by the employee's salary payroll contribution.

In the past, participation in the program was approved administratively by the City Manager. City Staff is bringing this to Council because Basic has requested an approved resolution from City Council to continue to offer this program to city employees.

The City believes it is in the best interest of its employees to continue to offer a Flexible Spending Account and is requesting City Council approve the attached resolution to retain Basic as it's FSA provider.

RECOMMENDED ACTION: Approval

CITY MANAGER APPROVAL: _____ COUNCIL AGENDA DATE: 10-16-12

CITY MANAGER COMMENTS: _____

FISCAL SERVICES DIRECTOR APPROVAL: _____

Resolution No. 2012-220
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

WHEREAS, City Council of the City of Ypsilanti deems it to be in the best interest of its employees to continue to offer its Cafeteria Plan under Section 125 of the Internal Revenue Code of 1986, as amended, and

WHEREAS, the City Council acknowledges and does hereby declare the intention of Basic to continue the Flexible Spending Account, but reserves the right to terminate or amend the Plan at any time with Basic; and

RESOLVED, that the Human Resources Department of the City of Ypsilanti will make this benefit known to all City employees and provide them with contact information to enroll in this supplemental benefit.

NOW THEREFORE BE IT RESOLVED THAT the Ypsilanti City Council authorizes the Human Resources Department to retain Basic to provide the Flexible Spending Account to City employees for the calendar year of January 1, 2013 through December 31, 2013.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

RESOLUTION OF THE BOARD OF DIRECTORS OF
City of Ypsilanti

WHEREAS, the Board of Directors of City of Ypsilanti deems it to be in the best interest of its employees and officers to adopt, amend or restate its Cafeteria Plan under Section 125 of the Internal Revenue Code of 1986, as amended, be it

RESOLVED, that the Board of Directors hereby adopts and approves this Cafeteria Plan as amended or restated to become effective as of 01/01/2012 pursuant to the Adoption Agreement and Cafeteria Plan which are attached hereto;

RESOLVED FURTHER, that the President of the City of Ypsilanti shall have the authority to:

a. execute this Adoption Agreement and Amended Cafeteria Plan, and other documents and agreements as may be necessary to implement the Plan;
b. appoint a plan administrator for such plan, and change such administrator from time to time with the advice and consent of the Board of Directors;
c. contract with BASIC to provide assistance to the plan administrator in establishing and maintaining such plan; and

RESOLVED FURTHER, that the Secretary of the Board is directed to enter a copy of this Adoption Agreement and this Cafeteria Plan, as amended, into the records of this Institution, and into the minutes of this meeting.

CERTIFICATION

The foregoing is a true copy of a resolution duly adopted by the Board of Directors at a meeting on _____ and entered in the minutes of such meeting in the Institution's minutes book.

Dated: _____

_____, Secretary

City of Ypsilanti
Section 125 Cafeteria Plan
ADOPTION AGREEMENT

Effective Date: 01/01/2012

Item I: Adoption

The Employer hereby establishes a Qualified "Cafeteria Plan" as set forth pursuant to Section 125 of the Internal Revenue Code. The Benefit Package Options listed in Item V below have been incorporated into this Plan by reference. Nothing in this Adoption Agreement shall be intended to override the terms of the Plan Document to which this Adoption Agreement is attached.

Item II: Employer Organization

Name of Organization:	City of Ypsilanti
Federal Employer ID Number:	38-6004750
Address:	One South Huron St.
City, State, Zip:	Ypsilanti, MI 48197
Form of Organization:	Government
Organized in the state of:	MI
Employer Affiliates:	

Item III: Plan Elections

Plan Information

Plan No.:	501
Plan Name:	City of Ypsilanti Cafeteria Plan
Original Effective Date:	07/01/2008
Plan Year Runs*:	01/01 - 12/31
Plan Restated and Amended:	01/01/2012

*This Plan is designed to run on a 12-month plan year period as stated above. A Short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.

Plan Administrator:	City of Ypsilanti
Plan Service Provider:	BASIC
Street Address:	9246 Portage Industrial Drive
City, State, Zip:	Portage, MI 49024
Phone:	(888) 472-0777

Item IV: Eligibility Requirements

For all plan years, eligibility is:
based on health care.

Item V - Benefit Package Options

The following Benefit Package Options are offered under this Plan:

Core Health Plans.

The terms, conditions, and limitations of the Core Health Benefits offered will be as set forth in and controlled by the Group/Individual Medical Insurance Policy or Policies.

Health Flexible Spending Account.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each Participant may elect in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any Plan Year thereafter, to be reimbursed from the Employer for Unreimbursed Medical Expenses incurred during that year by him to the extent described and defined in the Plan Document.

Dependent Care Reimbursement Account.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each Participant may elect in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any Plan Year thereafter, to be reimbursed from the Employer for Dependent care cost incurred during that year by him to the extent described in the Plan Document.

Item VI - Flexible Spending Account Elections

A. The Active Employee Run-Out is the period of time that begins the day after the Plan Year ends during which the employee can submit claims for payment of Qualified Expenses incurred during the Plan Year. See Item X for Run-Out information.

B. The Terminated Employee/Coverage Run-Out is the period of time after an employee terminates employment (or loses eligibility to participate in the Plan) during which the employee can submit claims for expenses incurred while the employee remained a participant. See Item IX for Run-Out information.

Amounts contributed for reimbursement benefits are segregated for record keeping and accounting purposes only, and this process does not constitute a separate fund or entity as the reimbursements are made from the general assets of the plan sponsor.

Health FSA

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is $2500.00.

(b) The maximum annual reimbursement amount that a Participant may receive during the year is the annual reimbursement amount elected by the Employee on the Salary Reduction Agreement for Health FSA coverage, not to exceed the amount set forth in (a) above.

(c) Minimum Contribution for this Benefit per Plan Year per Employee is $0.00.

(d) In order to receive reimbursement under the Health FSA, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Run-Out Period, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as $1.00.

(e) COBRA Administrator: City of Ypsilanti

Street Address: One South Huron St.

City, State, Zip: Ypsilanti, MI 48197

(f) Limited-Scope Option: Employees may elect during the initial enrollment and/or annual enrollment period the limited-scope option of reimbursement under the Health FSA, as set forth in the SPD, so that the employee and/or a spouse may participate in a Health Savings Account as defined in Code Section 223.

(g) Spousal Exclusion: Employees may elect during the initial enrollment and/or annual enrollment period to exclude the spouse from coverage under the Health FSA, as set forth in the SPD, so that the spouse may participate in a Health Savings Account as defined in Code Section 223.

Dependent Care Assistance Plan

(a) The maximum annual reimbursement amount a Participant may elect under the Dependent Care Assistance Plan for any Plan Year is the lesser of the maximum established by the Plan described in (b) below or the statutory maximum specified in Code Section 129 (as described in Appendix A of the Plan).

(b) The maximum annual reimbursement amount established by the Dependent Care Assistance Plan is as follows: $5000.00 for married filing jointly or single and $2500.00 for married filing separately.

(c) The maximum annual reimbursement that a Participant may receive during the year is the annual reimbursement amount elected by the Participant on the Salary Reduction Agreement, not to exceed the amount in (b) above.

(d) Minimum Contribution for the Benefit per Plan Year per Employee is $0.00.

(e) In order to receive reimbursement under the Dependent Care Assistance Plan, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Run-Out Period, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as $1.00.

Item VII: Benefits Debit Card

As part of the Plan, a Benefits Debit Card is offered to you as a alternative reimbursement method.

Item VIII: Plan Entry Date

The Plan Entry Date is the date when an employee who has satisfied the Eligibility Requirements may commence participation in the Plan. The Plan Entry Date is the later of the date the Employee files a Salary Reduction Agreement or Date requirements are met.

Item IX: Grace Period & Run-Out Information

The Employer has the option to adopt a grace period on any or all of your benefits. Please view this section to determine which, if any, of your benefits include this grace period.

If a grace period has been adopted and an HSA is one of the Benefit Package options offered under this Plan, the Employer will convert its general purpose health FSA to an HSA-compatible option during the Grace Period for all health FSA participants.

- A limited-scope health FSA (that reimburses expenses only for preventive care and permitted coverage, such as dental and vision care).
- A post-deductible health FSA (that reimburses medical expenses only if they are incurred after the minimum annual deductible for the HDHP is met).

If a grace period has been adopted, it will begin on the first day of the next Plan Year and (depending on the benefit) will end up to two (2) months and fifteen (15) days later. To view a list of benefits and associated grace information, please see below.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- (for Health FSA) A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year.

  For example, assume that $200 remains in your Health FSA account at the end of the 2005 Plan Year, and further assume that you have elected to allocate $2400 to the Health FSA for the 2006 Plan Year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred on January 15, 2006, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the 2005 Plan Year and the remaining $300 will be paid out of amounts allocated to your Health FSA for 2006.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period described in this SPD. The run-out period applies to claims, incurred both during the previous plan year and the grace period, that are reimbursable from the previous plan year. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-out Period. To see a list of benefits and associated Run-Out information, see below.

You may not use Health FSA amounts to reimburse Eligible Day Care Expenses (and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses).

Benefit	Grace Adopted	Grace End Date	Grace Cap	Active Employee Run-Out Date	Terminated Employee / Coverage Run-Out Date / Days
Dependent Care Reimbursement Account	No			03/31	90 days
Medical Reimbursement Account	No			03/31	90 days

Item X: Contacts and Responsibilities

Benefits Coordinator

Name:	Judith A. Smith
Phone:	(737) 482-4300
Company Name:	City of Ypsilanti
Street Address:	One South Huron St.
City, State, Zip:	Ypsilanti, MI 48197

Acceptance of Legal Process

Name:	Marylou Uy
Phone:	(737) 482-4300
Company Name:	City of Ypsilanti
Street Address:	One South Huron St.
City, State, Zip:	Ypsilanti, MI 48197

Item XI - Incorporation by Reference

The actual terms and conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

Signature: _____ Date: / /
Name:
Title:

Executed at: City of Ypsilanti
One South Huron St.
Ypsilanti, MI 48197

CAFETERIA PLAN

PREMIUM REDUCTION OPTION *PLUS*

FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY
CITY OF YPSILANTI

TABLE OF CONTENTS

SUMMARY PLAN DESCRIPTION

PART 1. GENERAL INFORMATION ABOUT THE PLAN

Your employer identified in the Plan Information Summary (Part 9) (the "Employer") is pleased to sponsor an employee benefit program known as the Cafeteria Plan (the "Plan") for you and your fellow employees. It is so-called because it allows you to choose from several different benefit programs (which we refer to as "Benefit Options") according to your individual needs, and allows you to reduce your pay before taxes are deducted ("Pre-tax Contributions") to pay for the Benefit Options that you choose by entering into a salary reduction agreement with your Employer. This Plan helps you because the Benefit Options you elect are nontaxable (i.e., you save Social Security and income taxes on the amount of your salary reduction). However, you may choose to pay for any of the available benefits with after-tax payroll deductions to the extent set forth in your enrollment materials.

> This SPD describes Information relating to the Plan that is specific to your Employer as described in the Plan Information Summary. For example, you can find the identity of the Plan Service Provider, the Employer, and the Plan Administrator in the Plan Information Summary as well as the Plan Number and any applicable contact information. Each summary and the attached Appendices constitute the Summary Plan Description for the Cafeteria Plan. The SPD (collectively, the Summary Plan Description or "SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a plan document into which the SPD has been incorporated. However, if there is a conflict between the official plan document and the SPD, the plan document will govern. Certain terms in this Summary are capitalized. Capitalized terms reflect important terms that are specifically defined in this Summary or in the Plan Document into which this SPD is incorporated. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator (who is identified in the Plan Information Summary).

PART 2. CAFETERIA PLAN SUMMARY

Q-1. What is the purpose of the Cafeteria Plan?

The purpose of the Cafeteria Plan is to allow eligible employees to pay for Benefit Options with Pre-tax Contributions. The Benefit Options to which you may contribute with Pre-tax Contributions under this Cafeteria Plan are described in the Plan Information Summary. Rules regarding Pre-tax Contributions are described in more detail below.

Q-2. Who can participate in the Cafeteria Plan?

Each Employee of the Employer (or an Affiliated Employer identified in Part 9, the Plan Information Summary) who satisfies the Plan's Eligibility Requirements and who is also eligible to participate in any of the Benefit Options will be eligible to participate in this Plan. If you meet these requirements, you may become a Participant on the Plan Entry Date. The Eligibility Requirements and the Plan Entry Date are described in the Plan Information Summary. Those employees who actually participate in the Plan are called "Participants". (See below for instructions on how to become a Participant.) You may use this Plan to pay for Benefit Options covering only yourself and your tax dependents as defined in Code Section 152 (except as otherwise defined in Code Section 105(b)). The terms of eligibility of this Plan do

not override the terms of eligibility of each of the Benefit Options. In other words, if you are eligible to participate in this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options. For details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Options, please refer to the plan summary for each Benefit Option. If you do not have a summary for a Benefit Option, you should contact the Plan Administrator for information on how to obtain a copy.

Q-3. When does my participation in the Cafeteria Plan end?

Your coverage under the Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;
(ii) The date that you no longer satisfy the Eligibility Requirements of this Plan or all of the Benefit Options;
(iii) The date that you terminate employment with the Employer; or
(iv) The date that the Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will *automatically* cease, and you will not be able to make any more Pre-tax Contributions under the Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g., a severance arrangement where the former employee is permitted to continue paying for a Benefit Option out of severance pay on a pre-tax basis). If you are re-hired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections if you are re-hired or become eligible again more than 30 days after your employment terminated or you otherwise lost eligibility (subject to any limitations imposed by the Benefit Option(s)). If you are re-hired or again become eligible within 30 days, your Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4. How do I become a participant?

If you have otherwise satisfied the Eligibility Requirements, you become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an "Election Form") on which you agree to pay your share of the cost of the Benefit Options that you choose with Pre-tax Contributions. You will be provided a Salary Reduction Agreement on or before your Eligibility Date. You must complete the form and submit it to the Plan Administrator (per the instructions provided with your Salary Reduction Agreement) during one of the election periods described in **Q-6.** below. You may also enroll during the year if you previously elected not to participate and you experience an event described below that allows you to become a participant during the year. If that occurs, you must complete an election change form during the Election Change Period described in **Q-8.** below. The Plan Administrator is identified in the Plan Information Summary.

In some cases, the Employer may *require* you to pay your share of the Benefit Option coverage that you elect with Pre-tax Contributions. If that is the case, your election to participate in the Benefit Option(s) will constitute an election under this Plan.

You may be required to complete a Salary Reduction Agreement via telephone or voice response technology, electronic communication, or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an

authorization form authorizing issuance of a personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5. What are tax advantages and disadvantages of participating in the Cafeteria Plan?

You save federal income tax, FICA (Social Security) and state income taxes (where applicable) by participating in the Plan. Consider the following example to illustrate the potential tax savings under a cafeteria plan:

Example: You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the employee-only premium, plus $2,000 for family coverage under the Employer's major medical insurance plan). You earn $50,000 and your spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan		**If you do not participate in the Cafeteria Plan**
1. Gross Income	**$50,000**		**$50,000**
2. Salary Reductions for Premiums	**$2,400 (pre-tax)**		**$0**
3. Adjusted Gross Income	**$47,600**		**$50,000**
4. Standard Deduction	**($9,700)**		**($9,700)**
5. Exemptions	**($9,300)**		**($9,300)**
6. Taxable Income	**$28,600**		**$31,000**
7. Federal Income Tax (Line 6 x applicable tax schedule)	**($3,590)**		**($3,950)**
8. FICA Tax (7.65% x Line 3 Amount)	**($3,641)**		**($3,825)**
9. After Tax Contributions	**($0)**		**($2,400)**
10. Pay after taxes and contributions	**$40,369**		**$39,825**
11. Take Home Pay Difference	**$544**		

Plan participation will reduce the amount of your taxable compensation. However, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable compensation.

Q-6. What are the election periods for entering the Cafeteria Plan?

The Cafeteria Plan basically has three election periods: (i) the “Initial Election Period,” (ii) the “Annual Election Period,” and (iii) the “Election Change Period, which is the period following the date you have a Change in Status Event (described below). The following is a summary of the Initial Election Period and the Annual Election Period. The Election Change Period is described in Q-8 below.

6a. What is the Initial Election Period?

If you want to participate in the Plan when you are first hired, you must enroll during the "Initial Election Period" described in the enrollment materials you will receive. If you make an election during the Initial Election Period, your participation in this Plan will begin on the later of your Eligibility Date or Plan Entry Date. The effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event described in **Q-8.** below. If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. Failure to make an election under this Plan generally results in no coverage under the Benefit Options; however, the Employer may provide coverage under certain Benefit Options automatically. These automatic benefits are called “Default Benefits”. Any Default Benefits provided by your Employer will be identified in the enrollment material. In addition, your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a pre-tax basis. You will be notified in the enrollment material whether there will be a corresponding Pre-tax Contribution for such default benefits.

6b. What is the Annual Election Period?

The Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status Event described below. If you fail to complete, sign, and file a Salary Reduction Agreement during the Annual Election Period, you may be deemed to have elected to continue participation in the Plan with the same Benefit Option elections that you had on the last day of the Plan Year in which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election". Alternatively, the Plan Administrator may deem you to have elected not to participate in the Plan for the next Plan Year if you fail to make an election during the Annual Election Period. **Special Rule for Flexible Spending Accounts and Health Savings Accounts (if offered under the Plan): Evergreen Elections do not apply to Flexible Spending Accounts and, if offered under the Plan, Health Savings Account elections. Consequently, you must make an election each Annual Election Period in order to participate in the Flexible Spending Accounts and/or to contribute to a Health Savings Account during the next Plan Year.**

The Plan Year is generally a 12-month period (a short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. How is my Benefit Option coverage paid for under this Plan?

You may be *required* to pay for any Benefit Option coverage that you elect with Pre-tax Contributions. Alternatively, your Employer may allow you to pay your share of the contributions with after-tax contributions. The enrollment material you receive will indicate whether you have to pay with Pre-Tax Contributions or whether you have the option to pay with after-tax contributions.

When you elect to participate both in a Benefit Option and this Plan, an amount equal to your share of the annual cost of those Benefit Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use Pre-tax Contributions (or it is a plan requirement), the deduction is made before any applicable

federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Options you choose with Employer Contributions. The amount of Employer Contributions that is applied by the Employer towards the cost of the Benefit Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward at the Employer's sole discretion at any time. The Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Employer Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in the Plan Information Summary.

The Employer may provide you with Employer Contributions over which you have discretion to allocate the contributions to one or more Benefit Options available under the Plan. These elective employer contributions are called “Flexible Credits” or “Benefit Credits”. The Flexible or Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

Q-8. Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Plan during the Plan Year. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Plan or under all of the Benefit Options that you have chosen.

Second, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

(a) You experience a “Change in Status Event” that affects your eligibility under this Plan and/or a Benefit Option; or

(b) You experience a significant cost or coverage change; and

(c) You complete and submit a Salary Reduction Agreement to the Plan Administrator within 30 days of the event.

The following is a summary of the applicable Change in Status Events and cost or coverage changes. Note: These rules do not apply to a Code Section 223 Health Savings Account offered under the Cafeteria Plan. See Part 7 below for more information regarding election changes related to the Health Savings Account.

1. **Changes in Status**. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of, and correspond with, the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse),
- Change in the number of your tax Dependents or eligible Dependent children (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),
- Any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or

commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit,

- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a certain age), or
- Change in your, your Spouse's, or your Dependent's place of residence.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for Pre-Tax Contributions within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of, and corresponds with, the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of, and corresponds with, a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for the Dependent Care FSA, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan.

In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, and Health FSA benefits), a special rule governs which type of election change is consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not

consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- However, you may increase your election to pay for COBRA coverage under the Employer's plan for yourself (if you still have pay) or any other individual who lost coverage but is still a tax dependent or your child (e.g. a child who has lost eligibility under the Plan). [Note: You cannot pay for COBRA coverage from your Health FSA.]
- *Gain of Coverage Eligibility under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Dependent Care FSA Benefits*. With respect to the Dependent Care FSA benefit (when offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year, when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits.* In the case of group term life insurance or disability income and dismemberment benefits, if you experience any Change in Status (as described above), you may elect to either increase or decrease coverage.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights**. If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (such as legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical

coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days back to the date of the birth, adoption, or placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights.

Effective April 1, 2009, if an unenrolled but otherwise eligible Employee or such Employee's dependent (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act due to a loss of eligibility for coverage under Medicaid or CHIP; or (2) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the Employee is entitled to special enrollment rights under a Benefit Plan Option that is a group health plan and an election change to correspond with the special enrollment right is permitted. However, you must request enrollment **within 60 days** after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for premium assistance subsidy, as applicable. Thus, for example, if an otherwise eligible Employee has medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, the Employee may be able to elect medical coverage under a Benefit Option for the Employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee and/or dependent gains eligibility for group health plan premium assistance from SCHIP or Medicaid, the employee may also be able to enroll the Employee, and the Employee's Dependent, provided that a request for enrollment is made within the 60 days from the date of the loss of other coverage or eligibility for premium assistance. Please refer to the group health plan summary description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees, and Orders**. If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the Plan Administrator notifies you that the cost of your coverage under the Plan significantly increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of employees), you may make certain election changes. If the cost significantly increases, you may choose either (a) to make an increase in your contributions, (b) revoke your election and receive coverage under another Benefit Package Option which provides similar coverage, or (c) drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For insignificant increases or decreases in the cost of Benefit Package Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are met. **The Change in Cost provisions do not apply to Health FSA benefits.**

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed you may revoke your election and elect coverage under another Benefit Package Option which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the newly-added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are satisfied. **The Change in Coverage provisions do not apply to Health FSA benefits.**

With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospectively effective from the date of the election or such later time as determined by the Plan Administrator. Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law**.**

If coverage under a Benefit Option ends, the corresponding Pre-tax Contributions for that coverage will automatically end. No election is needed to stop the contributions.

Q-9. What happens to my participation under the Cafeteria Plan if I take a leave of absence?

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Options) during a leave of absence. The specific election changes that you can make under this Plan following a leave of absence are described in the Status Change Matrix and the rules regarding coverage under the Benefit Options during a leave of absence will be described in the Benefit Option summaries. If there is a conflict between the Status Change Matrix/Benefit Option Summaries and this Q-9, the Status Change Matrix or Benefit Option summary, whichever is applicable, controls.

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the Employer will continue to maintain your Benefit Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all health coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

(i) With after-tax dollars while you are on leave,

(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave pay by making a special election to that effect before the date such pay would normally be made available to you. However, pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year (except as otherwise permitted by law).

(iii) By other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave).

The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA, and the Employer's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator. The Election Change Chart will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan and the Benefit Option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Option offered under this Plan, then you will continue to participate and the contribution due 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 Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-10. How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Q-11. What happens if my request for a benefit under this Cafeteria Plan (e.g., an election change or other issue germane to Pre-tax Contributions) is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedures Appendix for a detailed summary of the Claims Procedures under this Plan.

PART 3. CASH BENEFITS

During any one Plan Year, the maximum salary reduction amount a Participant can elect under this Plan cannot exceed the sum of the cost of the Benefit Options offered under this Plan (as identified in Part 9 below). Any part of this maximum salary reduction amount that you do not elect will be paid to you as regular, taxable compensation. Except to the extent set forth in the Enrollment material, any Benefit Credits not used towards the cost of Benefit Options made available under the Plan will revert back to the employer.

PART 4. HEALTH CARE PREMIUM REIMBURSEMENT BENEFITS

If listed as a Benefit Option offered under the Plan in Part 9 below, you can elect to allocate pre-tax salary reduction amounts for reimbursement of health care premiums (HCPR).

Q-1 Who can elect Health Care Premium Reimbursement (HCPR)?

If you are eligible to be a participant in the Cafeteria Plan, you can elect to make pre-tax salary reductions for certain employer approved individual insurance policies. If you do make a proper election, amounts equal to Health Care Premium Expenses that you incur or pay will be withheld from your pay and you will be reimbursed (either directly or indirectly) for such expenses with these amounts.

Q-2 What are Health Care Premium Expenses?

Health Care Premium Expenses are the premiums that you pay for an individual insurance policy(ies) that you purchase outside of any employer plan. Such expenses must meet the following conditions: (a) the individual insurance policy must be determined by the Plan Administrator to be a "Qualified Benefit" before the beginning of the Plan Year or, if you are a new hire, before the effective date of your participation in the Plan. For purposes of the HCPR, a Qualified Benefit is an individual insurance policy that provides accident and health insurance described in Code Section 106, (b) the contract must be an individually purchased contract and not an employer-sponsored insurance plan; and (c) you must be the policyholder of the insurance policy.

Q-3 How do I become a Participant?

During the applicable Enrollment Periods described in Part 2, Q-6 you must submit a Salary Reduction Agreement wherein you elect the amount you want withheld for reimbursement of Health Care Premium Expenses. In addition, you must (a) provide the Plan Administrator with a copy of the individual accident or health insurance policy that you have purchased for yourself outside of any employer plan and (b) indicate on the Salary Reduction Agreement the premium amount that you will expect to pay during the Plan Year for such policy. The Plan Administrator will notify you if the insurance policy is determined to be a "Qualified Benefit" under the Plan. See Part 9 below for your effective date of participation. The effective date of coverage may vary by Enrollment Period. If you elect Health Care Premium Expense Reimbursement (HCPR), a record will be kept of all salary reductions made for reimbursement of Health Care Premium Expenses as well as all actual reimbursements.

Q-4 What happens if I fail to return my Salary Reduction Agreement?

If you fail to return a Salary Reduction Agreement electing Health Care Premium Reimbursement (whether you are currently participating or not) before the end of the applicable Enrollment Period, it will be assumed that you have elected to forgo Health Care Premium Reimbursement (HCPR) and receive an equal amount of your pay as taxable compensation. See Part 2. Q-6 above for further discussion regarding elections.

Q-5 How do I receive Reimbursement under a Health Care Premium Reimbursement Program?

If you elect to participate in the HCPR, you will have to take certain steps to be reimbursed for your Eligible Health Care Premium Expenses. You will be supplied with the necessary claim forms. In addition to the claim form, you must submit to the Plan Administrator a statement from the insurance carrier indicating that you have paid the Eligible Health Care Premium Expenses for which you are requesting reimbursement unless the Employer is paying the carrier directly. In that case, you must submit a statement or invoice from the carrier indicating the amount of the premium and the period of coverage. If the Employer is paying the carrier directly, the insurance carrier will be paid the premium (up to the amount of pre-tax contributions you have set aside for that period) in the next check processing cycle. Your Plan Administrator will advise you how often the checks are processed. The Employer, the Plan, the Plan Administrator, and the Plan Service Provider are not responsible for any coverage that you lose for failure to pay a premium if your salary reduction election for Health Care Premium Expenses is insufficient to cover the premium amount.

The salary reduction amount for such benefits cannot exceed the amount of premiums you are required to pay for such coverage. The amount of your reimbursement cannot exceed the amount of your salary reductions made at that time for Eligible Health Premium Expenses, reduced by prior reimbursements. If your salary reduction amount to date is equal to or less than your claim, your claim for eligible expenses will be reimbursed in full. If the amount that you have salary reduced is less than your claim amount, the excess part of the claim will be carried over into the following pay cycles during the year (or as otherwise permitted by applicable law) to be paid up to your balance. In other words, as additional salary reduction amounts are made, a reimbursement check will be processed automatically for any unpaid portions of any previously submitted claims (to the extent such claims are eligible for reimbursement). Remember, no expenses can be reimbursed that exceed the salary reductions you have made up to that date reduced by any previous reimbursements. You cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Salary Reduction Agreement becomes effective, or after the end of the Plan Year (or as otherwise permitted by applicable law), whichever is applicable. Also, no reimbursement will be provided if the reimbursement amount is less than the Minimum Check Amount (specified in Part 9, the Plan Information Summary (if any)). The Minimum Check Amount will not apply for processing the final checks during any Plan Year.
At the end of the Plan Year, you will have a Run-Out period (as stated in Part 9, the Plan Information Summary) to turn in claims for premiums incurred during the Plan Year. No claims can be submitted for reimbursement after that time. Your Employer may set a different claims submission grace period for terminated employees; if so, you will find this information in Part 9.

Q-6 Can I change the election during the year?

You can change elections during the year only if you experience one of the Change in Status events listed in Part 2, Q-8 and follow the procedures outlined within that section.

Q-7 What happens if my salary is reduced more than my actual Health Care Premium Expenses at the end of the Plan Year?

The cafeteria plan rules prohibit the return of any salary reductions that are not used for Health Care Premium Expenses incurred during the Plan Year (or as otherwise permitted under the applicable law). The Employer will use the forfeitures to offset administration expenses. Also, any uncashed reimbursement checks will be forfeited if not cashed within 90 days of issue.

PART 5. HEALTH FSA SUMMARY

Q-1. Who can participate in the Health FSA?

Each Employee who satisfies the Eligibility Requirements is eligible to participate on the Plan Entry Date. The Eligibility Requirements and Plan Entry Date are described in Part 9, the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the Eligibility requirements, you become a participant in the Health FSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods described in Part 2, the Cafeteria Plan Summary. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Health FSA elections.

You may also become a participant if you experience a change in status event that permits you to enroll mid-year (see **Q-8.** of Part 2, Cafeteria Plan Summary, for more details regarding mid-year election changes and the effective date of those changes).

Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the Health FSA, Eligible Dependents are the following:

(i) Your legal Spouse (as determined by state law to the extent consistent with the federal Defense of Marriage Act);
(ii) Your child, until the end of the year in which your child turns age 26; and
(iii) any other individuals who would qualify as a tax Dependent under Code Section 105(b).

For purposes of (ii) above, your “child” means your son, daughter, stepchild, foster child, or legally adopted child, regardless of such child’s tax dependent status, marital status, employment status, student status or residency. If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree, or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan’s procedures governing qualified medical child support orders.

NOTE: Your participation in this Health FSA will disqualify you and/or your spouse from establishing and making/receiving tax favored contributions to a Health Savings Account as defined in Code Section 223 unless you have elected the Limited Purpose Health FSA reimbursement option described in Q-11.

Q-3. What is my "Health Care Account"?

If you elect to participate in the Health FSA, the Employer will establish a "Health Care Account" to keep a record of the reimbursements to which you are entitled, as well as the Pre-tax Contributions you elected to pay for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Health FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4. When does coverage under the Health FSA end?

Your coverage under the Health FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;
(ii) The last day of the Plan Year unless you make an election during the Annual Election Period;
(iii) The date that you no longer satisfy the Health FSA Eligibility Requirements;
(iv) The date that you terminate employment; or
(v) The date that the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage (as described in **Q-16.** below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on the earliest of the following to occur:

(i) The date your coverage ends;
(ii) The date that your dependents cease to be eligible dependents (e.g. you and your spouse divorce);
(iii) The date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Health FSA.

You and/or your covered dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail below.

Q-5. Can I ever change my Health FSA election?

You can change your election under the Health FSA in the following situations:

(i) *For any reason during the Annual Election Period*. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) *Following a Change In Status Event*. You may change your Health FSA election during the Plan Year only if you experience an applicable Change in Status Event. See **Q-8.** of Part 2, the Cafeteria Plan Summary, for more information on election changes. **NOTE: You may not make Health FSA election changes as a result of any cost or coverage changes**.

Q-6. What happens to my Health Care Account if I take an approved leave of absence?

Refer to Q-9, Part 2 of the Cafeteria Plan Summary to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either (a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or (b) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-7. What is the maximum annual Health Care Reimbursement that I may elect under the Health FSA, and how much will it cost?

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount described in the Plan Information Summary. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-8. How are Health Care Reimbursement benefits paid for under this Plan?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Benefit Credits, to the extent available. Your enrollment material will indicate if Benefit Credits are available for Health FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Benefit Credits allocated to your Health Care Account.

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you (this check may be written off a Plan Service Provider account; however, all benefits are paid as needed from the Employer's general assets); (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the participant); (iii) benefits debit card, if offered, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's right of reimbursement)

Q-9. What amounts will be available for Health Care Reimbursement at any particular time during the Plan Year?

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

Q-10. How do I receive reimbursement under the Health FSA?

Under this Health FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, if offered under the plan you can use an benefits debit card to pay the expense. In order to be eligible for the Benefits Debit Card, you must agree to abide by the terms and conditions of the Benefits Debit Card Program (the "Program") including any fees applicable to participate in the program, limitations as to card

usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's Plan Service Provider by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Plan Service Provider. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

1. Name of person receiving service
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription or prescribed over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

The Plan Service Provider will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the Run-Out Period following the end of the Plan Year (or if applicable, the Claims Submission Grace Period following the date that you cease to be a participant). The Run-Out Period (and the Claims Submission Grace Period) is described in Part 9, the Plan Information Summary.

You may have a claim submitted by means of a provider supplied electronic claim file ("Import"). In other words, the claim is provided directly to the Plan Service Provider by the provider or health plan. In that case, you do not need to file a claim with the Plan Service Provider; it is deemed filed when the Plan Service Provider receives the claim. You will be notified in the enrollment material of this Plan or the applicable Benefit Option if claims will be provided directly to the Plan Service Provider of this Plan. If you elect this option when made available to you, you must hereby agree not to seek reimbursement for an imported claim from any other source.

Benefits Debit Card. Alternatively, you may be able to use, if offered as a Plan option in Part 9, the Benefits Debit Card MasterCard® to pay the expense. In order to be eligible for the Benefits Debit Card, you must agree to abide by the terms and conditions of the Benefits Debit Card Program (the "Program") as set forth in Part 8 and in the Cardholder Agreement including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.

Q-11. What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

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

The Code generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Through the end of 2010, this includes, but is not limited to, both prescription and over-the-counter drugs (and over-the-counter products and devices). Effective January 1, 2011, over-the-counter drugs and medicines will not longer constitute an Eligible Medical Expense unless prescribed by a physician. Over-the-counter products and devices other than drugs or medicine will still constitute an Eligible Medical Expense even if

not prescribed by a physician. Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Service Provider/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. "Stockpiling" of over-the-counter drugs (even with a prescription) and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long-term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

If you currently maintain or wish to establish a personal Health Savings Account you may be able to make an election to limit the scope of your coverage as set forth below but only to the extent Limited Purpose Health FSA is identified as an option in the Plan Information Summary.

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA participant (and any covered dependents) will not be able to make/receive tax favored contributions to a Code Section 223 HSA unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (to the extent such expenses constitute "medical care" as defined in Code Section 213(d)):

(i) Services or treatments for dental care (excluding premiums)
(i) Services or treatments for vision care (excluding premiums)

To the extent identified as an option in the Plan Information Summary (Part 9), you may elect the Limited Purpose Health FSA during Initial and/or Annual Enrollment Period.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Q-12. When must the expenses be incurred in order to receive reimbursement?

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

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Health FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period," if adopted, will be described in Part 9, the Plan Information Summary.

Q-13. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a Health Care Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the Run-Out Period described in the Plan Information Summary. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Health FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year and during the grace period will be forfeited. The sole exception to this rule is the "Qualified Reservist Distribution," described in Q-14.

Q-14 What happens if a Claim for Benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedure Appendix, Appendix I, for a detailed summary of the Claims Procedures under this Plan.

Q-15. What happens to unclaimed Health Care Reimbursements?

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) within 90 days after reimbursement is made shall be forfeited.

Q-16. What is COBRA continuation coverage?

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the employer is a "small employer" or the Health FSA is a church Plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law

will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse, and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee's Termination of employment or reduction in hours of employment	√	√	√
2. Divorce or Legal Separation		√	
3. Child ceasing to be an eligible dependent			√
4. Death of the covered employee		√	√

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health FSA upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the COBRA Administrator (if a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) the date of the event (ii) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has

occurred (e.g. divorce decree).

An employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within 60 days from the date you would lose coverage for one of the reasons described above, or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);
- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if you become entitled to Medicare; or
- if the employer no longer provides group health coverage to any of its employees.

Q-17. What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD, or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification; (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i) – (iii), the Plan Administrator will notify the Employer

that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

Q-18. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

Q-19. How long will the Health FSA remain in effect?

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

Q-20. How does this Health FSA interact with a Health Reimbursement Arrangement (HRA) Sponsored by the Employer? (Only if Applicable)

Typically, a Health FSA is the payer of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an HRA sponsored by the Employer that covers expenses covered by this Health FSA, the employer may require the Health FSA pay first, rather than the HRA. If the Health FSA pays first, you must exhaust your Health Care Account before using funds allocated to your HRA. Your HRA enrollment material will let you know whether the HRA or the Health FSA pays first.

MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

ERISA Rights (not applicable to non-ERISA Plans)

The Health FSA Plan may be an ERISA welfare benefit plan if your employer is a private employer. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse, or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents will have to pay for such coverage. You should review **Q-16.** of this Health FSA Summary for more information

concerning your COBRA continuation coverage rights.

(To the extent the Health FSA is subject to HIPAA's portability rules) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and have the claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

PART 6. DEPENDENT CARE FSA COMPONENT SUMMARY

Q-1. Who can participate in the Plan?

Each employee who satisfies the Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Plan Entry Date. The Eligibility Requirements and the Plan Entry Date are described in Part 9, the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the Eligibility Requirements, you become a participant in the Dependent Care FSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in **Q-6.** of Part 2, the Cafeteria Plan Summary. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections.

You may also become a participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year (see **Q-8.** of Part 2, the Cafeteria Plan Summary, for more details regarding mid-year election changes and the effective date of those changes).

Q-3. What is my "Dependent Care Account"?

If you elect to participate in the Dependent Care FSA, the Employer will establish a "Dependent Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4. When does my coverage under the Dependent Care FSA end?

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

(i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;
(ii) The last day of the Plan Year unless you make an election during the Annual Election Period;
(iii) The date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;
(iv) The date that you terminate employment; or
(v) The date that the Plan is terminated or you, or the class of eligible employees of which you are a member, are specifically excluded from the Plan.

If you terminate employment or you cease to be eligible during the Plan Year, you may submit for reimbursement of Eligible Day Care Expenses incurred through the end of the plan year up to the amount of your Dependent Care Account. All eligible claims must be submitted by the end of the Plan Run-Out period as stated in the Plan Information Summary.

Q-5. Can I ever change my Dependent Care FSA election?

You can change your election under the Dependent Care FSA in the following situations:

(i) *For any reason during the Annual Election Period*. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) *Following a Change In Status Event or Cost or Coverage Change*. You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable

Change in Status Event or there is a significant cost or coverage change. See **Q-8.** of Part 2, the Cafeteria Plan Summary, for more information on election changes.

Q-6. What happens to my Dependent Care Account if I take an unpaid leave of absence?

Refer to Q-9, Part 2 of the Cafeteria Plan Summary to determine what, if any, specific changes you can make during a leave of absence.

Q-7. What is the maximum annual Dependent Care Reimbursement that I may elect under the Dependent Care FSA?

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year if you:

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

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

Your Spouse will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is

(i) physically or mentally incapable of caring for himself or herself, or
(ii) a full-time student (as defined by Code Section 21).

Q-8. How Do I Pay for Dependent Care Reimbursements?

When you complete the Salary Reduction Agreement, you specify the amount of Dependent Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Benefit Credits, to the extent available. Your enrollment material will indicate if Contributions or Benefit Credits are available for Dependent Care FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Benefit Credits allocated to your Dependent Care Account.

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you (this check may be written off a Plan Service Provider account; however, all benefits are paid as needed from the Employer's general assets); (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the participant); (iii) benefits debit card, if offered, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's right of reimbursement).

Q-9. What is an "Eligible Day Care Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses ("Eligible Day Care Expenses"). Generally, an expense must meet <u>all</u> of the following conditions for it to be an Eligible Employment Related Expense:

1. The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual". A Qualifying Individual is:

(i) An individual age 12 or under who is a “qualifying child” of the Employee as defined in Code Section 152(a)(1). Generally speaking, a “qualifying child” is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support; or

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

Note: there is a special rule for children of divorced parents. The child is a qualifying individual of the “custodial parent”, as defined in Code Section 152(e).

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your Spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your Spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a “child” (as defined in Code Section 152(f)(1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent. Moreover, the day care cannot be provided by a parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Employment Related Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address, and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-10. How do I receive reimbursement under the Dependent Care FSA?

Under this Dependent Care FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement ("traditional paper claim") or, alternatively, if offered under the Plan, you can use an benefits debits card to pay the expense. The following is a summary of how both options work.

Traditional Paper Claims: If you have elected to participate in the Dependent Care FSA, you must take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an Eligible Employment Related Expense, you submit a written or electronic claim to the Plan's Administrator. You may obtain a Request for Reimbursement form from the Plan Administrator or Plan Service Provider. You must include this form with your request for Reimbursement. If there are enough credits to your Dependent Care Account, you will be reimbursed for your Eligible Employment Related Expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current Dependent Care Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, you cannot be reimbursed for any total expenses above your available, annual credits to your Dependent Care Account. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Employment Related Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

Benefits Debit Card. Alternatively, you may be able to use, if offered as a Plan option in Part 9, the Benefits Debit Card MasterCard® to pay the expense. In order to be eligible for the Benefits Debit Card, you must agree to abide by the terms and conditions of the Benefits Debit Card Program (the "Program") as set forth in Part 8 and in the Cardholder Agreement including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.

Q-11. When must the expenses be incurred in order to receive reimbursement?

Eligible Day Care Expenses must be incurred ***during*** the Plan Year. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year.

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period", if adopted, will be described in the Plan Information Summary.

Q-12. What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred, on the one hand, and the annual Dependent Care Reimbursement you have elected and paid for, on the other. Any amount credited to a Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by the end of the Run Out period following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or as otherwise permitted under applicable law.

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year and the grace period will be forfeited.

Q-13. Will I be taxed on the Dependent Care Reimbursement benefits I receive?

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

Q-14. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

Q-15. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.
Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

Q-16. What happens to unclaimed Dependent Care Reimbursements?

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment Related Expense was incurred shall be forfeited.

Q-17. What happens if my claim for reimbursement under the Dependent Care FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan

Q-18. What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Dependent Care FSA that exceed the amount of Eligible Employment Related Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of such notification; (ii) The Plan Administrator may offset the excess reimbursement against any other eligible Employment Related Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursements by the means set forth in (i) – (iii), the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse tax consequences to you.

Q-19. How long will the Dependent Care FSA remain in effect?

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

PART 7. HEALTH SAVINGS ACCOUNTS

Q-1. What is a Health Savings Account for which contributions can be made under this Plan?

A Health Savings Account ("HSA") is a personal savings account established with a Custodian or Trustee to be used primarily for reimbursement of "eligible medical expenses" you (the Account Beneficiary) and your eligible tax dependents (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) incur, as set forth in Code Section 223. The HSA is administered by the HSA Custodian or Trustee or its designee, and the terms of the HSA are set forth in the Custodial or Trust Agreement. The HSA is not an Employer sponsored employee benefit plan. The Employer's role with respect to the HSA is limited to making an HSA available to you and to making contributions to the HSA on your behalf through this Plan (through non-elective Employer contributions and/or pre-tax salary reductions elected by the Account Beneficiary). The fact that contributions to the HSA are made through this Plan should not be construed as endorsement of the HSA by the Employer. The Employer has no authority or control over the funds deposited to the Account Beneficiary's HSA. As such, the HSA identified in the Plan Information Appendix is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Q-2. Who is eligible for an HSA?

Only individuals who satisfy the following conditions on the first day of a month are eligible for an HSA offered under this Plan for that month:

a. You are covered under a qualifying High Deductible Health Plan (HDHP) maintained by your Employer;
b. You have opened an HSA with the Custodian chosen by the Employer;
c. You are not covered under any other non-high deductible health plan maintained by the Employer that is determined by the Employer to offer disqualifying health coverage [Note that you are not eligible for an HSA if you are covered under any non-qualifying coverage whether maintained by the Employer or not (including but not limited to coverage maintained by your spouse's employer) and it is solely your responsibility to ensure that any other coverage you have that is not maintained by the Employer qualifies under Code Section 223] and
d. You cannot be claimed as a tax dependent by anyone else;

e. You are not enrolled in Medicare coverage; and
f. You are otherwise eligible for this Plan.

Q-3. Who is an Account Beneficiary?

An Account Beneficiary is an eligible Participant who has properly enrolled in an HSA in accordance with the terms of the applicable Custodial Agreement.

Q-4. Who is a Custodian or Trustee?

The Custodian or Trustee is the entity with whom the Account Beneficiary's HSA is established (for purposes of this Plan, use of the term "Custodian" includes reference to both Custodian and Trustee). The HSA is not sponsored by or maintained by the Employer. The Custodian or its designee will provide each Account Beneficiary with a Custodial Agreement and other information that describes how to enroll in the HSA and your rights and obligations under the HSA. The Employer may choose to restrict contributions made through this Plan to HSAs maintained by a particular Custodian; however, you will be permitted to rollover funds from the HSA offered under this Plan to another HSA of your choosing (in accordance with the terms of the Custodial Agreement).

Q-5. What are the rules regarding contributions made to an HSA under the Plan?

Contributions made under this Plan may consist of both employee pre-tax contributions made pursuant to a Salary Redirection Agreement and/or non-elective Employer contributions (if any). You may elect to contribute any amount to the HSA that you wish; however, the maximum amount of all contributions that can be made to the HSA through this Plan (including both Employer non-elective contributions and pre-tax salary reductions) during the Plan Year cannot exceed the sum of monthly limits for each month during the Plan Year that you are an eligible individual (as described in Q-2 above). The monthly limit is 1/12 of

- the maximum amount set forth in Code Section 223(b)

If the Account Beneficiary will be age 55 or older before the end of the tax year, and the Account Beneficiary properly certifies his or her age to the Employer, the maximum contribution amount described above may be increased by the "additional annual contribution" amount (as set forth in Code Section 223(b)(3)), but only to the extent set forth in the separate written HSA material provided by the Employer and/or the Custodian.

To the extent set forth in the Plan's enrollment material or the HSA communication material, the Employer may automatically withhold pre-tax contributions from your compensation to contribute to an HSA unless you affirmatively indicate that you do not wish to contribute to the HSA with pre-tax contributions. Pre-tax contributions will equal the maximum annual contribution amount set forth above (reduced by any Employer non-elective contributions) divided by the number of pay periods remaining during the Plan Year. Non-elective Employer contributions may be made at any time during the Plan Year in a lump sum amount or through periodic contributions (as determined in the sole discretion of the Employer) and communicated in Plan or HSA enrollment materials.

Your HSA election under this Plan will not be effective until the later of the date that you make your election or the date that you establish your HSA. Employer may adjust contributions made under this Plan as necessary to ensure the maximum contribution amount is not exceeded.

Any pre-tax contributions that cannot be made to the HSA because you have been determined to be ineligible for such contribution will be returned to you as taxable compensation or as otherwise set forth in the Plan enrollment material. Any non-elective contributions that cannot be made to the HSA because the employee is not eligible for such contribution will be returned to the Employer except as otherwise set forth in the applicable communication material.

Q-6. What are the election change rules under this Plan for HSA elections?

You may change your HSA contribution election at any time during the Plan Year for any reason by submitting an election change form to the Plan Administrator (or its designee). Your election change will be prospectively effective as of the first day of the next pay period following the day that you properly submit your election change (or such later date as uniformly applied by the Plan Administrator to accommodate payroll changes). Your ability to make pre-tax contributions under this Plan to the HSA ends on the date that you cease to meet the eligibility requirements under this Plan.

Q-7. Where can I get more information on my HSA and its related tax consequences?

For details concerning your rights and responsibilities with respect to your HSA (including information concerning the terms of eligibility, qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA Custodial Agreement and/or the HSA communication material provided by your Employer.

PART 8. BENEFITS DEBIT CARD

The Benefits Debit Card allows you to pay for Eligible Expenses as defined by the Plan(s) in which you participate at the time that you incur the expense. Here is how the Benefits Debit Card works, if indicated as an option under the Plan in Part 9 below.

(a) *You must make an election to use the card.* In order to be eligible for the Benefits Debit Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Cardholder Agreement including any fees applicable to participate in the Program, limitations as to card usage (it can not be used at all MasterCard® acceptance locations and has no cash assess), the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each nnual Election Period. A Cardholder Agreement will be provided to you when your card is provided to you. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify, during the applicable Election Period, that the card will only be used for Eligible Expenses (i.e. medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) R*eimbursement under the card is limited to specific providers.* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.) identified by the Plan Administrator or its designee as an eligible merchant. In addition, the Card will be administered in accordance with applicable IRS guidance. Use of the card for DCAP expenses is limited to merchants who are child card providers. Use of the card for other Plan expenses may be limited to merchants of qualified classifications. The card can not be used at all MasterCard® acceptance locations.

(e) *You swipe the card at the provider like you do any other credit or debit card.* When you incur an Eligible Expense at a qualified merchant, you swipe the card much like you

would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Plan (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Plan is being made is an Eligible Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source. If you are using the card for DCAP expenses, you certify that you are using the card for services already incurred (and the payment is not made in advance of the date services will be provided).

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over the counter item other than a drug or medicine (e.g., bandages), the written statement must indicate the name of the item. If the name of the item is abbreviated heavily, please include a copy of the box top or packaging so the receipt abbreviation can be tied to the actual over-the-counter item purchased.. If the expense is for a DCAP payment, the written statement must indicate the tax ID number of the provider.
- The date the expense was incurred or the period during which the services were provided (for example, DCAP expenses should show the period during which the services were provided if payment is made for than one day).
- The amount of the expense.

You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement or as otherwise permitted under applicable law and associated guidance). You will receive written notice from the Plan Service Provider that a third party statement is needed in order to substantiate the expense. If requested by the Plan Service Provider, you must provide the third party statement within 21 days (or other period specified in the notice) of the request.

(g) *There are situations where the third party statement will not be required to be provided to the Plan Service Provider.* There are many situations in which you will not be required to provide the written statement to the Plan Service Provider. Situations in which you may not be required to submit the third party statement are detailed in the Cardholder Agreement.

Note: You must obtain the third party receipt for ALL card transactions when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Plan Service Provider or the IRS requests it.

(h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Plan Service Provider, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is determined by the Plan Administrator. If you do not repay the Plan the amount may be withheld from your pay (as specified in the Cardholder Agreement), or the remaining unpaid amount will be included in your gross income as taxable "wages".

(i) You may only use the Card to pay for Eligible Day Care Expenses incurred after you have properly substantiated an initial Day Care expense (the "Original Day Care Expense) for which you do not receive reimbursement under the Plan. Once you have "incurred" the Original Day Care Expense at a particular day care provider, you should submit the appropriate substantiation regarding this expense to the Third Party

Administrator on or after the period during which the day care provider provided services or treatments (the "Service Duration"). If the Original Day Care Expense is determined to be an Eligible Day Care Expense, the Third Party Administrator will allocate to your Card an amount equal to the lesser of the amount of the Original Day Care Expense or the Dependent Care Account balance. The Third Party Administrator will continue to allocate amounts equal to the lesser of the Original Day Care Expense or your Dependent Care Account balance each time you use the card at the same day care provider, for the same or lesser amount, and during the same Service Duration periods. Any increase in the amount, day care provider and/or service duration period will require you to begin the process over with a new Original Day Care Expense before you can use the Card again.

(j) *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit most of your eligible claims. If you elect not to use the benefits debit card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the benefits debit card has been used cannot be submitted as Traditional Paper Claims.

IMPORTANT: Because the benefits debit card is unable to differentiate between when an over-the-counter medicine or drug has been prescribed and when it is purchased without a prescription, you will not be able to use your card to purchase any over-the-counter medicines or drugs as of January 1, 2011, even if prescribed by a physician. You will have to keep your receipt, which must indicate the name of the drug, and follow the procedures for traditional paper claims described above. If the name of the drug is abbreviated heavily, please include a copy of the box top or packaging so the receipt abbreviation can be tied to the actual over-the-counter drug item purchased.

PART 9. PLAN INFORMATION SUMMARY

1. Employer Organization

Name of Organization:	City of Ypsilanti
Federal Employer ID Number:	38-6004750
Address:	One South Huron St.
City, State, Zip:	Ypsilanti, MI 48197
Form of Organization:	Government
Organized in the state of:	MI
Employer Affiliates:	

2. Plan Elections

Plan Number:	501
Plan Name:	City of Ypsilanti Cafeteria Plan
Original Effective Date:	07/01/2008
Plan Year Runs*:	01/01 - 12/31
Plan Restated and Amended:	01/01/2012

*This Plan is designed to run on a 12-month plan year period as stated above. A Short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.

Plan Administrator:	City of Ypsilanti
Plan Service Provider:	BASIC
Street Address:	9246 Portage Industrial Drive
City, State, Zip:	Portage, MI 49024
Phone:	(888) 472-0777

Benefits Coordinator

Name:	Judith A. Smith
Phone:	(737) 482-4300
Company Name:	City of Ypsilanti
Street Address:	One South Huron St.
City, State, Zip:	Ypsilanti, MI 48197

Acceptance of Legal Process

Name:	Marylou Uy
Phone:	(737) 482-4300
Company Name:	City of Ypsilanti
Street Address:	One South Huron St.
City, State, Zip:	Ypsilanti, MI 48197

The appointed Plan Service Provider in conjunction with the Plan Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

3. Eligibility Requirements

For all plan years, eligibility is:

based on health care.

4. Plan Entry Date

The Plan Entry Date is the date when an employee who has satisfied the Eligibility Requirements may commence participation in the Plan. The Plan Entry Date is the later of the date the Employee files a Salary Reduction Agreement during the applicable Enrollment Period or Date requirements are met.

5. Benefit Package Options

The following Benefit Package Options are offered under this Plan:

Core Health Plans.

The terms, conditions, and limitations of the Core Health Benefits offered will be as set forth in and controlled by the Group/Individual Medical Insurance Policy or Policies.

Health Flexible Spending Account.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each Participant may elect in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any Plan Year thereafter, to be reimbursed from the Employer for Unreimbursed Medical Expenses incurred during that year by him to the extent described and defined in the Plan Document.

Dependent Care Reimbursement Account.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each Participant may elect in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any Plan Year thereafter, to be reimbursed from the Employer for Dependent care cost incurred during that year by him to the extent described in the Plan Document.

6. Flexible Spending Account Elections-Run-Out

A. The Active Employee Run-Out is the period of time that begins the day after the Plan Year ends during which the employee can submit claims for payment of Qualified Expenses incurred during the Plan Year. See Part 9, Sec. 8 for Run-Out information.

B. The Terminated Employee/Coverage Run-Out is the period of time after an employee terminates employment (or loses eligibility to participate in the Plan) during which the employee can submit claims for expenses incurred while the employee remained a participant. See Part 9, Sec. 8 for Run-Out information.

Amounts contributed for reimbursement benefits are segregated for record keeping and accounting purposes only, and this process does not constitute a separate fund or entity as the reimbursements are made from the general assets of the plan sponsor.

A. Health FSA

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is $ 2500.00.

(b) The maximum annual reimbursement amount that a Participant may receive during the year is the annual reimbursement amount elected by the Employee on the Salary Reduction Agreement for Health FSA coverage, not to exceed the amount set forth in (a) above.

(c) In order to receive reimbursement under the Health FSA, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except those claims submitted for reimbursement during the last month of the Plan Year or during the Run-Out, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as $1.00.

(d) COBRA Administrator: City of Ypsilanti

Street Address: One South Huron St.

City, State, Zip: Ypsilanti, MI 48197

(e) **Limited Purpose Option:** If offered in Part 5 above, employees may elect during the initial enrollment period and/or the annual enrollment period the limited purpose option of reimbursement under the Health FSA, as set forth in the SPD, so that the employee and/or a spouse may participant in a Health Savings Account as defined in Code Section 223.

B. Dependent Care Assistance Plan

(a) The maximum annual reimbursement amount a Participant may elect under the Dependent Care Assistance Plan for any Plan Year is the lesser of the maximum established by the Plan described in (b) below or the statutory maximum specified in Code Section 129 (as described in your summary plan description).

(b) The maximum annual reimbursement amount established by the Dependent Care Assistance Plan is as follows: $5000.00 for married filing jointly or single and $2500.00for married filing separately.

(c) The maximum annual reimbursement that a Participant may receive during the year is the annual reimbursement amount elected by the Participant on the Salary Reduction Agreement, not to exceed the amount in (b) above.

(d) In order to receive reimbursement under the Dependent Care Assistance Plan, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Run-Out, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as $1.00

7. Benefits Debit Card

The Benefits Debit Card is offered as a reimbursement method under the plan.

8. Grace Period and Run-Out Information

The Employer has the option to adopt a grace period on any or all of your benefits. Please view this section to determine which, if any, of your benefits include this grace period.

If a grace period has been adopted, it will begin on the first day of the next Plan Year and (depending on the benefit) will end no later than two (2) months and fifteen (15) days later. To view a list of benefits and associated grace information, please see below.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- (for Health FSA) A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year.

  For example, assume that $200 remains in your Health FSA account at the end of the 2005 Plan Year, and further assume that you have elected to allocate $2400 to the Health FSA for the 2006 Plan Year. If you submit, for reimbursement, an Eligible Medical Expense of $500 that was incurred on January 15, 2006, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the 2005 Plan Year and the remaining $300 will be paid out of amounts allocated to your Health FSA for 2006.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period described in this SPD. The run-out period applies to claims, incurred both during the previous plan year and the grace period, that are reimbursable from the previous plan year. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-out Period. To see a list of benefits and associated Run-Out information, see Part 9, Sec. 8.

You may not use Health FSA amounts to reimburse Eligible Day Care Expenses (and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses).

Benefit	Grace Adopted	Grace End Date	Grace Cap	Active Employee Run-Out Date	Terminated Employee / Coverage Run-Out Date / Days
Dependent Care Reimbursement Account	No			03/31	90 days
Medical Reimbursement Account	No			03/31	90 days

9. Benefit Plan Option Documents

The actual terms and the conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content.

APPENDIX I

CLAIMS REVIEW PROCEDURE APPENDIX

The Plan has established the following claims review procedures in the event you are denied a benefit under this Plan. The procedure set forth below does not apply to benefit claims filed under the Benefit Options other than the Health FSA and Dependant Care FSA.

Step 1: *Notice is received from Plan Service Provider.* If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Plan Service Provider, the Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Plan Service Provider must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

a. the reason(s) for the denial and the Plan provisions on which the denial is based;
b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Plan Service Provider and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from Plan Service Provider.* If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Plan Service Provider.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Plan Service Provider.

Step 6: *If you still disagree with the Plan Service Provider's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Plan Service Provider's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the Plan Service Provider. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Important Information

Other important information regarding your appeals:

- (Health FSA Only) Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

City of Ypsilanti

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

This matrix outlines the qualifying events under Section 125 which allow election changes during the Plan Year and the permissible changes allowed for each Plan Class. You will see codes, footnotes, or endnotes showing restrictions or qualifications following each action. The code definitions can be found on page 11. The endnotes (also defined on page 11) contain information that is referred to on more than one page. Information that only refers to one place is placed in footnotes with that information shown at the bottom of that particular page. The P/C column refers to Personal or Corporate events.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1. STATUS CHANGES											
1.1 Change in Employee's Legal Marital Status											
1.1.1 Employee Gains Spouse: Marriage	P-1	Add sp/dep: H1,C,T Drop dependents: C1 Drop Coverage: C1	Add sp/dep: H2,C,T Drop dependents: C1 Drop Coverage: C1	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Increase coverage: C,H2 Decrease coverage[i]: C	Add Coverage[ii]: C2 Increase coverage[ii]: C2 Drop Coverage[iii]: C2 Decrease coveraget[iii]: C2	Add sp/dep: C,H2,T Drop Coverage: C1 Drop sp/dep: C1	Add sp/dep: C,H2,T Drop Coverage: C1 Drop sp/dep: C1	Increase coverage: C,H2,T Drop Coverage: C1 Decrease coverage: C1
1.1.2 Lose Spouse: Divorce, Legal Separation, Annulment, Death of Spouse	P-2	Add Coverage[iv]: C,H1 Add dependents[iv]: H1,C Revoke election only for spouse: C	Add Coverage[iv]: C,H2 Add dependents[iv]: C,H2 Revoke election only for spouse: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Decrease coverage[v]: C,H2	Add Coverage[ii]: C2 Increase Coverage[ii]: C2 Drop Coverage[vi]: C2 Decrease coverage[vi]: C2	Add Coverage[iv]: C,H2 Add dependents[iv]: C,H2 Revoke election only for spouse: C	Add Coverage[iv]: C,H2 Add dependents[ii]: C,H2 Revoke election only for spouse: C	Add Coverage[iv]: C, H3 Increase coverage[iv]: C, H3 Revoke election only for spouse: C

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.2 Change in Number of Employee's Dependents											
1.2.1 Gain Dependent: Birth, Adoption, Legal Guardianship	P-3	Add Coverage: H1,T,C Add sp/dep: H1,T,C	Add Coverage: H2 T,C Add sp/dep: C,H2,T	No change allowed.	No change allowed.	No change allowed.	Add Coverage: C,H2 Increase coverage: C, H2	Add Coverage: C2,H2 Increase coverage C2, H3	Add Coverage: H2,T,C Add sp/dep: H2,T,C	Add Coverage: H2 T ,C Add sp/dep: H2,T,C	No change allowed.
1.2.2 Lose Dependent: Death, Placement for Adoption	P-4	Drop affected dependent: C	Drop affected dependent: C	No change allowed.	No change allowed.	No change allowed.	Decrease coverage[vii]	Decrease coverage[v]	Drop affected dependent: C	Drop affected dependent: C	No change allowed.
1.3 Change in Employment Status of Employee, Spouse, or Dependent that Affects Eligibility[1]											
1.3.1 Employee Gains Eligibility under Employer's Plan	P-5	Add Coverage: EY,C,T	Add Coverage: EY,C,T	Add Coverage: EY,C	Add Coverage: EY,C	Add Coverage: EY,C	Add Coverage: EY,C	Add Coverage: EY,C2	Add Coverage: EY,C,T	Add Coverage: EY,C,T	Add Coverage: EY,C
1.3.2 Employee Maintains Prior Eligibility under Employer's Plan after return from termination or unpaid leave within 30 days.	C-2	Reinstate prior election at termination unless another event has occurred that allows a change[viii]	Reinstate prior election at termination unless another event has occurred that allows a change[viii]	Reinstate prior election at termination unless another event has occurred that allows a change[viii]	Reinstate prior election at termination unless another event has occurred that allows a change[viii]:	Reinstate prior election at termination unless another event has occurred that allows a change[viii]	Reinstate prior election at termination unless another event has occurred that allows a change[viii ix]	Reinstate prior election at termination unless another event has occurred that allows a change[viii]	Reinstate prior election at termination unless another event has occurred that allows a change[viii]:	Reinstate prior election at termination unless another event has occurred that allows a change[viii]	Reinstate prior election at termination unless another event has occurred that allows a change[viii]
1.3.3 Employee Rehired or returns from unpaid leave after 30 days[xvii]	P-5	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.

[1] Can be such events as starting or ending employment; switching between part time and full time, hourly and salary; starting or ending strike/lockout; or any other event causing gain or loss of eligibility.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.3.4 Employee Loses Eligibility under Employer's Plan through Change in Employment	C-1	Drop Coverage[x]	Drop Coverage[x]	Drop Coverage[x]	Drop Coverage[x]	Drop Coverage[x]	Drop Coverage[x]	Drop Coverage[x]	Drop Coverage[x]	Drop Coverage[x]	Drop Coverage[x]
1.3.5 Spouse/Dependent Gains Eligibility under their Employer's Plan	P-6	Drop Coverage[xi] Drop sp/dep[xi]	Drop Coverage[xi] Drop sp/dep[xi]	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Drop coverage[xi] Decrease coverage[xi]	Add Coverage[xii] Increase coverage[xii] Drop Coverage[xi]	Drop Coverage[xi] Drop sp/dep[xi]	Drop Coverage[xi] Drop sp/dep[xi]	No change allowed
1.3.6 Spouse/Dependent Loses Eligibility under their Employer's Plan	P-7	Add Coverage[xiii]: T,H1 Add sp/dep[xiii]: T, H1,	Add Coverage[xiii]: T, H2 Add sp/dep[xiii]: T, H2	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Add Coverage[xiii]: H2 Increase coverage[xiii]: H2	Add Coverage[xiii] Increase coverage[xiii] Drop Coverage[xiv]	Add Coverage[xiii]: T, H2 Add sp/dep[xiii]: T, H2	Add Coverage[xiii]: T, H2 Add sp/dep[xiii]: T, H2	No change allowed
1.4 Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirement[2]											
1.4.1 Dependent Gains Eligibility under Employee's Plan	P-8	Add dependents: C,T	Add dependents: C,T	No change allowed.	No change allowed.	No change allowed.	Add Coverage[vii]: C Increase coverage: [vii] C	Add Coverage[vii]: C2 Increase coverage[vii]: C2	Add dependents: C,T	Add dependents: C,T	No change allowed.
1.4.2 Dependent Loses Eligibility under Employee's Plan	P-9	Drop affected dependent: C	Drop affected dependent: C	No change allowed.	No change allowed.	No change allowed.	Decrease coverage: [vii] C	Decrease coverage[vii]: C2	Drop affected dependent: C	Drop affected dependent: C	No change allowed.

[2] Can be such actions as attaining a specified age; switching between single and married, student or non-student, or any other event causing gain or loss of eligibility.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.5 Change in Place of Resident of Employee, Spouse, or Dependent											
1.5.1 Move by Employee Causes Gain of Eligibility	P-10	Add Coverage: EY,C	Add Coverage: EY,C	Not applicable[xv]	Not applicable[xv]	Not applicable [xv]	Increase coverage[xvi]: C Decrease coverage[xvi]: C	Not applicable[xv]	Add Coverage: EY,C	Add Coverage: EY,C	Not applicable[xv]
1.5.2 Move by Employee causes Loss of Eligibility	P-11	Drop and elect alternate coverage: E,C,D	Drop and elect alternate coverage: E, C,D	Not applicable[xv]	Not applicable[xv]	Not applicable[xv]	Increase coverage[xvi]: C Decrease coverage[xvi]: C	Not applicable[xv]	Drop and elect alternate coverage: E, C,D	Drop and elect alternate coverage: E, C,D	Not applicable[xv]
1.5.3 Spouse's or Dependent's move causes gain of eligibility	P-12	Add sp/dep: EY,C	Add sp/dep: EY,C	Not applicable[xv]	Not applicable[xv]	Not applicable[xv]	Increase coverage[xvi]: C Decrease coverage[xvi]: C	Not applicable[xv]	Add sp/dep: EY,C	Add sp/dep: EY,C	Not applicable[xv]
1.5.4 Spouse's or Dependent's move causes loss of eligibility	P-13	Drop sp/dep: E,C	Drop sp/dep: E,C	Not applicable[xv]	Not applicable[xv]	Not applicable[xv]	Increase coverage[xvi]: C Decrease coverage[xvi]: C	Not applicable[xv]	Drop sp/dep: E,C	Drop sp/dep: E,C	Not applicable[xv]

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
2. SMALL COST CHANGES[xvii]											
2.1 Small Cost Changes[xvii]											
2.1.1 Employer- Initiated Automatic Small Cost Changes: Includes Collective Bargaining	C-3	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	No change allowed.	Not applicable	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost
2.1.2 Employer- Initiated Automatic Small Cost Changes for Individuals[3]	C-4	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	No change allowed.	Not applicable	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost
2.1.3 Employee-Initiated Small Cost Changes: DCAP Provider or Personal Policy	P-14, 15	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Increase or Decrease Cost[4] [xvii]	Not applicable	Not applicable	Not applicable
3. SIGNIFICANT COST INCREASES[xvii]											
3.1 Significant Cost Increases[xvii]											
3.1.1a Employer-Initiated Change	C-3	Increase Costs	Increase Costs	Increase Costs	Increase Costs	Increase Costs	No change allowed.	Not applicable	Increase Costs	Increase Costs	Increase Costs
3.1.1b Permitted Response by Employee to Significant Cost Increase	P-16	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	No change allowed.	Not applicable	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D

[3] Includes pre-established cost change parameters such as increases in life insurance triggered by salary increase or credit provisions, changes resulting from employee satisfying requirement such as stop smoking, or any similar event which changes cost of premium.

4 No change allowed if day care provider is a relative of the employee.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
4. SIGNIFICANT CURTAILMENT OF COVERAGE											
4.1 Significant Coverage Curtailment											
4.1.1a Employer-Initiated Significant Coverage Curtailment	C-4	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	No change allowed.	No change allowed.	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment
4.1.1b Permitted Response by Employee to Significant Coverage Curtailment	P-17	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	No change allowed.	No change allowed.	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D
5. ADDITION OR ELIMINATION OF BENEFIT PACKAGE OPTION											
5.1 Change in Benefits Offered under Cafeteria Plan											
5.1.1a Employer Adds New Benefit or Option	C-6	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System
5.1.1b Permitted Response by Employee to Addition of New Benefit or Option	P-18	Add and make related election changes for other options providing similar Coverages	Add and make related election changes for other options providing similar Coverages	Add and make related election changes for other options providing similar Coverages	Add and make related election changes for other options providing similar Coverages	Add and make related election changes for other options providing similar Coverages	No change allowed.	Add and make related election changes for other options providing similar Coverages	Add and make related election changes for other options providing similar Coverages	Add and make related election changes for other options providing similar Coverages	Add and make related election changes for other options providing similar Coverages
5.1.2a Employer Drops Existing Benefit or Option	C-7	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
5.1.2b Permitted Response by Employee to Drop of Existing Benefit or Option	P-19	Elect another option and make related election changes for other options providing similar Coverages	Elect another option and make related election changes for other options providing similar Coverages	Elect another option and make related election changes for other options providing similar Coverages	Elect another option and make related election changes for other options providing similar Coverages	Elect another option and make related election changes for other options providing similar Coverages	No change allowed.	Elect another option and make related election changes for other options providing similar Coverages	Elect another option and make related election changes for other options providing similar Coverages	Elect another option and make related election changes for other options providing similar Coverages	Elect another option and make related election changes for other options providing similar Coverages
5.1.3a Employer Replaces one Benefit or Option with Similar Benefit or Option	C-8	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System
5.1.3b Permitted Response by Employee to Replacement of Benefit or Option	P-20	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	No change allowed.	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D	Drop and elect alternate coverage: D
5.1.7 Employee changes DCAP providers	P-21	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Change Deductions to reflect new rates[5]	Not applicable	Not applicable	Not applicable
6. CHANGE IN COVERAGE FOR SP/DEP UNDER OTHER EMPLOYER'S PLAN											
6.1 Change in Coverage of Spouse or Dependent under their Employer's Cafeteria Plan											
6.1.1 Other Employer-Initiated Change Adds or Increases Coverage	P-22	Drop Coverage[xviii] Drop sp/dep[xviii]	Drop Coverage[xviii] Drop sp/dep[xviii]	Drop Coverage[xviii] Decrease coverage[xviii]	Drop Coverage[xviii] Decrease coverage[xviii]	Drop Coverage[xviii] Decrease coverage[xviii]	No change allowed.	Drop Coverage[xviii] Decrease coverage[xviii]	Drop Coverage[xviii] Drop sp/dep[xviii]	Drop Coverage[xviii] Drop sp/dep[xviii]	Drop Coverage[xviii] Decrease coverage[xviii]

[5] Deductions can be changed to zero if relative is keeping child for free.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
6.1.2 Other Employer-Initiated Change Drops or Decreases Coverage	P-23	Add Coverage[xix] Add sp/dep[xix]	Add Coverage[xix] Add sp/dep[xix]	Add Coverage[xix] Increase coverage: [xix]	Add Coverage[xix] Increase coverage: [xix]	Add Coverage[xix] Increase coverage: [xix]	No change allowed.	Add Coverage[xix] Increase coverage: [xix]	Add Coverage[xix] Add sp/dep[xix]	Add Coverage[xix] Add sp/dep[xix]	Add Coverage[xix] Increase coverage: [xix]
6.1.3 Open Enrollment under Employer Plan of Spouse or dependent'	P-24	Add Coverage[xix] Add sp/dep[xix] Drop Coverage[xviii] Drop sp/dep[xviii]	Add Coverage[xix] Add sp/dep[xix] Drop Coverage[xviii] Drop sp/dep[xviii]	Add Coverage[xix] Increase coverage[xix] Drop Coverage[xviii] Decrease coverage[xviii]	Add Coverage[xix] Increase coverage[xix] Drop Coverage[xviii] Decrease coverage[xviii]	Add Coverage[xix] Increase coverage[xix] Drop Coverage[xviii] Decrease coverage[xviii]	No change allowed.	Add Coverage[xix] Increase coverage[xix] Drop Coverage[xviii] Decrease coverage[xviii]	Add Coverage[xix] Add sp/dep[xix] Drop Coverage[xviii] Drop sp/dep[xviii]	Add Coverage[xix] Add sp/dep[xix] Drop Coverage[xviii] Drop sp/dep[xviii]	Add Coverage[xix] Increase coverage[xix] Drop Coverage[xviii] Decrease coverage[xviii]
7. FMLA LEAVE											
7.1 Commencement of FMLA Leave											
7.1.1 Employee begins FMLA Leave	P-25	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA
7.2 Return from FMLA Leave											
7.2.1 Employee returns from FMLA Leave	P-26	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
8. COBRA EVENTS											
8.1 COBRA (or similar state law continuation) Events											
8.1.1 Employee COBRA Event with Employee remaining eligible for Cafeteria Plan[6]	P-27	Increase coverage[xx]	Increase coverage[xx]	No change allowed	No change allowed	No change allowed	No change allowed	No change allowed	Increase coverage [xx]	Increase coverage [xx]	No change allowed.
8.1.2 Spouse/Dependent COBRA Event[7].	P-28	Increase coverage [xx] [xxi]	Increase coverage[xx] [xxi]	No change allowed	No change allowed	No change allowed	No change allowed	No change allowed	Increase coverage [xx] [xxi]	Increase coverage [xx] [xxi]	Increase coverage [xx] [xxi]
9. JUDGEMENT, DECREE, OR ORDER											
9.1 Judgment, Decree, or Order Requires Coverage of Code § 152 Dependent Child to be Provided by Employee											
9.1.1 Judgment, Decree, or Order Requires Coverage under Employee's Plan	P-29	Add Coverage: C Add affected dependent	Add Coverage: C Add affected dependent	No change allowed.	No change allowed.	No change allowed.	Add Coverage: C Increase coverage	No change allowed.	Add Coverage: C Add affected dependent	Add Coverage: C Add affected dependent	No change allowed.
9.2 Judgment, Decree, or Order Requires Coverage of Code § 152 Dependent to be Provided by Spouse, Former Spouse, or Other Person											
9.2.1 Judgment, Decree, or Order Requires Spouse, Former Spouse, or Other Person to Provide Coverage	P-30	Drop affected dependent:	Drop affected dependent:	No change allowed.	No change allowed.	No change allowed.	Decrease coverage:	No change allowed.	Drop affected dependent	Drop affected dependent	No change allowed.
10. ENTITLEMENT TO MEDICARE, MEDICAID, OR OTHER FEDERAL/STATE AGENCY BENEFITS[8]											
10.1 Employee or Employee's Spouse or Dependent Becomes Entitled to Medicare, Medicaid, or Other Federal/State Agency Benefits[8]*											
10.1.1 Employee Becomes Entitled	P-31	Drop Coverage*	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Decrease coverage*	No change allowed.	No change allowed.	No change allowed.	No change allowed.

[6] Such as reduction in work hours resulting in employee no longer eligible for employer contribution credit.

[7] Such as dependent reaching maximum age under group plan and employee continues coverage for dependent under COBRA.

[8] Other than coverage solely for pediatric vaccines.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
10.1.2 Spouse/Dependent under Employer's Plan Becomes Entitled	P-32	Drop Coverage*	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Decrease Coverage*	No change allowed.	No change allowed.	No change allowed.	No change allowed.
10.2 Employee or Employee's Sp/dep Loses Eligibility for Medicare, Medicaid, or Other Federal/State Agency Benefits											
10.2.1 Employee Loses Eligibility	P-33	Add Coverage: C	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Increase coverage.	No change allowed.	No change allowed.	No change allowed.	No change allowed.
10.2.2 Spouse/Dependent under Employer's Plan Loses Eligibility	P-34	Add sp/dep: C	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Increase coverage.	No change allowed.	No change allowed.	No change allowed.	No change allowed.
11. ADMINISTRATIVE EVENTS											
11.1 Correcting Obvious Errors[9]											
11.1.1 Employee mistake in an making election	C-9	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.
11.1.2 Employer mistake in recording election	C-10	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.
11.2 Employee Fails Medical Underwriting											
11.2.1 Participant fails medical underwriting	C-11	Not applicable	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Not applicable	Not applicable	Not applicable	Not applicable	Revoke coverage as of date it was added.

[9] Must have "clear and convincing" evidence.

*Coverage cannot be dropped/decreased under this rule when group health coverage sponsored by a governmental or educational institution is gained.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.3 Adjustments to Meet Federal Requirements[xvii]											
11.3.1 Changes needed to maintain plan's status under Code § 125 or to prevent violation of the nondiscrimination rules.	C-11	Make administrative changes as needed:	Make administrative changes as needed:	Make administrative changes as needed:	Make administrative changes as needed:	Make administrative changes as needed:	Make administrative changes as needed:	Make administrative changes as needed:	Make administrative changes as needed:	Make administrative changes as needed:	Make administrative changes as needed:

Notes:

- Change in eligibility for non-employer-sponsored coverage (other than Medicare and Medicaid) will not allow a change.
- Dependent is defined to be a tax dependent under Code § 152 except, for accident or health coverage, any child to whom Code § 152(e) applies is treated as a dependent of both parents.
- Health FSA coverage can never be changed solely on account of a change in cost or coverage under another plan.
- Increase coverage can be increases in volume, dollar, or amount.
-

[i] If employee or dependents become eligible dependents under new spouse's health plan.
[ii] If change creates or increases need for child care.
[iii] If spouse is not employed or makes DCAP FSA election on her employer's Plan
[iv] If eligibility is lost under spouse's plan as a result of the divorce, legal separation, annulment or death
[v] To take into account expenses of affected spouse.
[vi] If change decreases or negates need for day care
[vii] To take into account expenses of affected dependent.
[viii] Can have Plan Documents prohibit participation until next plan year.
[ix] Balances and current annual election remain the same and employee cannot be made to make up missed contributions.
[x] Underlying coverages ceases in accordance with component plan.
[xi] If added to spouse's or dependent's coverage.
[xii] If spouse previously did not work.
[xiii] If dropped from spouse's or dependent's coverage.
[xiv] If spouse no longer works.
[xv] Eligibility is not generally affected by place of residence.
[xvi] If underlying health coverage change occurs.
[xvii] Must be addressed in plan documents.
[xviii] If employee, spouse, or dependent have received corresponding increased coverage or added coverage under other employer's plan.
[xix] If employee, spouse, or dependent have received corresponding decreased coverage or dropped coverage under other employer's plan.

[xx] To cover increased amount of employee's contribution.
[xxi] If individual still qualifies as tax dependent of employee.

Resolution No. 2012 – 221
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the proposed ordinance to amend Chapter 106, Article V, Section 106-454(b) of the Code of Ordinances to increase water rates within the City of Ypsilanti, be approved on Second and Final Reading.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

ORDINANCE NO. 1182

An Ordinance to amend Chapter 106, Article V, Section 106-454(b) of the Code of Ordinances to increase water rates within the City of Ypsilanti.

BE IT ORDAINED BY THE CITY OF YPSILANTI:

That Chapter 106, Article V, Section 106-454(b) of the Code of Ordinances shall be amended as follows:

(b) For all billings rendered prior to November 25, 2012, existing rates shall prevail. For all billings rendered from November 25, 2012, water charges shall be as follows for each bi-monthly (two month) period:

(1) Minimum bi-monthly readiness-to-serve rates based upon size of meter and use of up to the allowed usage of water:

Meter Size/Inch	**Allowed Usage Cubic Feet**	**Water Rate**
5/8 - 3/4	600	$ 22.53
1	1,000	40.93
1-1/2	2,100	106.10
2	4,000	233.00
3	9,000	478.55
4	16,200	906.40
6	36,000	1,881.75
8	66,000	3,432.06
10	102,000	5,218.71
12	150,000	8,637.35

(2) Bimonthly consumption rates in excess of allowed usage:

Rate per 100 C.F. Bi-monthly Water	After 11/25/12
All consumption in excess of allowed usage per 100 cf	$2.12

* * * * * * * *

This Ordinance shall take effect and be in full force upon publication in the _____.

MADE, PASSED AND ADOPTED BY THE YPSILANTI CITY COUNCIL THIS

_____ DAY OF _____, 2012.

_____
Paul Schreiber, Mayor

_____
Frances McMullan, City Clerk

ATTEST

I do hereby confirm that the above Ordinance No. ____ was published in the _____ on the _____ day of _____, 2012.

Resolution No. 2012 – 222
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the proposed ordinance to amend Chapter 106, Article V, Section 106-455(a) of the Code of Ordinances to increase sewage disposal service rates within the City of Ypsilanti, be approved on Second and Final Reading.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

ORDINANCE NO. 1183

An ordinance to amend Chapter 106, Article V, Section 106-455(a) of the Code of Ordinances, City of Ypsilanti, to increase sewage disposal service rates.

BE IT ORDERED BY THE CITY OF YPSILANTI, that:

That Section 106-455(a) of Chapter 106, Article V of the Code of Ordinances shall be revised as follows:

(a) For all billings rendered prior to November 25, 2012, existing rates for sewage disposal services shall prevail. For all billings rendered from November 25, 2012, rates for sewage disposal services shall be as shown in Schedule A:

Schedule A:

		CAPITAL CHARGE		OM&R		TOTAL	
Meter Size (inch)	Allowed Usage Cubic Feet	Contract Community	All Others	Contract Communities	All Others	Contract Community	All Others
5/8-3/4	600	$1.18	$1.18	$15.78	$19.53	$16.96	$20.71
1	1000	$1.99	$1.99	$26.38	$33.25	$28.37	$35.24
1-1/2	2100	$4.35	$4.35	$54.12	$68.36	$58.46	$72.71
2	4000	$7.90	$7.90	$104.40	$131.40	$112.30	$139.30
3	9000	$17.79	$17.79	$227.84	$294.01	$245.62	$311.80
4	16200	$32.02	$32.02	$434.62	$529.89	$466.64	$561.92
6	36000	$71.16	$71.16	$937.08	$1,179.27	$1,008.25	$1,250.43
8	66000	$130.42	$130.42	$1,710.28	$2,154.12	$1,840.70	$2,284.54
10	102000	$198.59	$198.59	$2,647.38	$3,333.39	$2,845.97	$3,531.98
12	150000	$296.43	$296.43	$3,896.83	$4,905.69	$4,193.26	$5,202.13

For all usage in excess of allowed usage the rate per 100 cubic feet shall be as follows:

	CAPITAL CHARGE	OM&R	TOTAL
Contract Communities	$0.199	$1.708	$1.907
All Others	$0.199	$1.800	$1.999

* * * * * * * * * *

This Ordinance shall take effect and be in full force upon local publication in _____ _____.

MADE, PASSED AND ADOPTED BY THE YPSILANTI CITY COUNCIL THIS _____

DAY OF _____, 2012.

_____
Paul Schreiber, Mayor

_____
Frances McMullan, City Clerk

ATTEST

I do hereby confirm that the above Ordinance No. ____ was published in the _____ on the _____ day of _____, 2012.

REQUEST FOR LEGISLATION
October 16, 2012

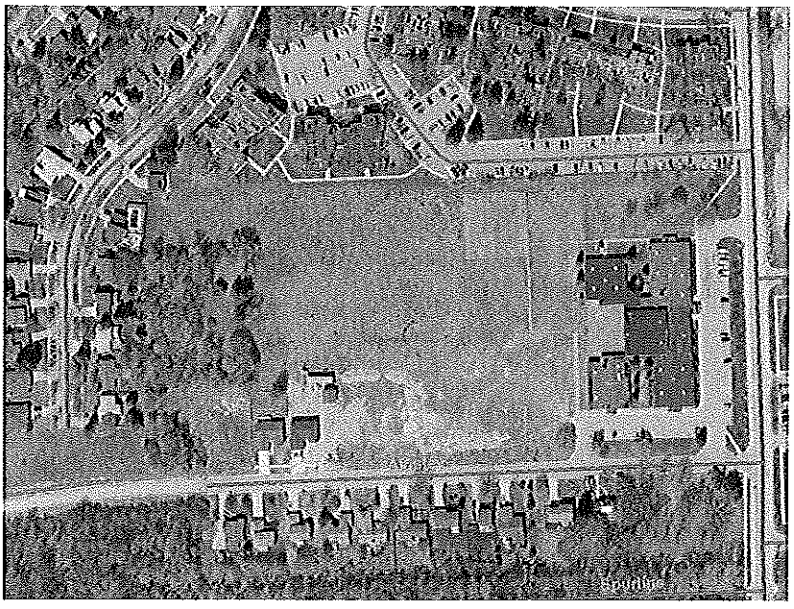
From: Ralph A. Lange, City Manager

Subject: Memorandum of Understanding between City of Ypsilanti and EMU regarding Ainsley Street access.

Background

Beginning in 2010, Eastern Michigan University approached the City regarding providing access to EMU property through Ainsely Street, which is currently blocked by a gate. Ainsley is a City street up to a certain point, when the property, including the roadway is owned by Eastern Michigan University.

EMU would like to install an automated gate to allow their facilities vehicles easier access in and out of the property. Additionally, access would be provided to emergency vehicles including City fire, police and DPS.



EMU has held three neighborhood meetings on the proposal, one in 2011 and two in 2012, with the most recent one held on July 27, 2012. At that meeting EMU presented options for the removal of the City gate, installation of the EMU gate and related landscaping to provide a buffer to residents on Louise Street. EMU proposed options, including a cul-de-sac, in response to resident suggestions and comments.

Staff has reviewed the request as well as the attached MOU and finds it satisfactory to meet both neighborhood concerns (limited access, no thru-traffic, means for larger vehicles to turn around as well as increased signage), and access for City emergency vehicles.

RECCOMMENDED ACTION: Approval

ATTACHMENTS:

- Memorandum of Understanding with attachment

CITY MANAGER APPROVAL: [redacted] COUNCIL AGENDA DATE: 10-16-12

CITY MANAGER COMMENTS: _____

FISCAL SERVICES DIRECTOR APPROVAL: _____

Resolution No. 2012 - 223
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

Whereas, the current barricade on Ainsley Street prevents public safety and public service vehicles from accessing the area; and

Whereas, Eastern Michigan University has invested significant money and time to improve the Fletcher School area, and has requested limited access for certain university vehicles through Ainsley Street to connect EMU's eastern and western campuses; and

Whereas, without the proposed MOU, EMU may build a private road behind Fletcher School, which would disturb trees reduce parkland currently used by the residents of Ainsley and Louisa Streets, and

Whereas, three public meetings were held with affected residents over a two year period of time, and

Whereas, the design and details proposed in the MOU reflect, almost in their entirety, ideas from the affected residents, and

Whereas, the proposed design will improve the aesthetics on Ainsley Street by removing an unsightly barricade, and will reduce illegal use of the road by reducing the opportunity for vehicles to bypass the new gate, and

Whereas, all of the design and construction associated with this project will occur on EMU property and will be paid for by EMU, at no cost to City taxpayers, and

Whereas, it is very important that the City of Ypsilanti and Eastern Michigan University cooperate and support each other on projects such as this one that are in the best interest of both entities.

NOW THEREFORE BE IT RESOLVED THAT the City approves the attached Memorandum of Understanding (MOU) regarding Ainsley Street between The City of Ypsilanti and Eastern Michigan University dated 10-16-2012; and

That the Mayor and City Clerk are authorized to sign the necessary document, subject to approval by the City Attorney, to allow this work to proceed within the terms and conditions stated in the attached MOU.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

Memorandum of Understanding (MOU)
Between the City of Ypsilanti and Eastern Michigan University

This Memorandum of Understanding ("MOU" or "Agreement") between the City of Ypsilanti ("City") and Eastern Michigan University ("EMU") (collectively, "the parties") pertains to the proposed changes on Ainsley Street including, but not limited to, the opening of Ainsley Street for limited traffic.

I. Project Description

EMU may remove the permanent traffic barrier on Ainsley Street (located to the southwest of Fletcher School) that was located on EMU's property at the time this MOU was executed after installing a new gate on EMU's property on Ainsley Street. The new gate will be controlled by EMU and the City to limit traffic flow to authorized vehicles as described below. If EMU constructs such a gate, EMU will also complete road improvements and landscaping along Ainsley Street. Subject to the terms and conditions outlined in this MOU, the City shall not install any new barriers or other obstacles that would prohibit traffic along Ainsley Street.

II. Purpose

The purpose of this MOU is to outline the roles and responsibilities between the parties should the project go forward. Nothing in this MOU requires the City or EMU to proceed with the project. Should the project proceed, however, each party agrees to fulfill its commitments as outlined in this MOU, and more specific terms regarding the parties' rights and responsibilities and other terms of the agreement may be formalized in a subsequent document.

III. Roles and Responsibilities

A. EMU may design, install, and maintain a new limited-access gate system on EMU's property on Ainsley Street. EMU agrees that:
   (1) if the work outlined in this section is completed, then the work outlined in Section III(B) must be completed; and
   (2) the work described in Section III(C) may not begin until the work outlined in this paragraph (Section III(A)) is completed.

B. If EMU pursues the work outlined in Section III(A), EMU must design, install, and maintain road improvements and/or landscaping along the portion of Ainsley Street owned by EMU and the surrounding land owned by EMU as deemed necessary by EMU to ensure proper operation of the new gate system described in Section III(A). These improvements must include, but are not limited to, the installation of boulders or other devices or obstacles near the new gate described in Section III(A) to impede vehicles from bypassing the gate. A proposed rendering of the road improvements, landscaping, and gate location is attached to this Agreement, but does not necessarily represent the scope of the final project.

C. After the work outlined in Section III(A) is complete, EMU may remove the permanent traffic barrier – as well as associated materials that support the barrier – that was located on Ainsley Street at the time this MOU was executed. To the extent that any of these materials are located on City property, the City shall not impede this work. The parties agree that the

guard rail that will be removed belongs to the City, and thus EMU shall return the guard rail to the City.

D. If the work outlined in Sections III(A) and (B) is completed, the City shall not install any new barriers that stop vehicle traffic along Ainsley Street. Nothing in this MOU shall prohibit the City from vacating Ainsley Street in its entirety or closing Ainsley Street to all vehicle traffic, subject to providing written notice to the President of Eastern Michigan University at least 210 days in advance of such action.

E. The gate system outlined in Section III(A) shall be maintained by EMU to ensure that it functions properly to limit vehicle traffic along Ainsley Street to the following: (1) vehicles used to support EMU activities; and (2) vehicles used to support City emergency and public service activities. If EMU chooses to utilize a remote controlled system to access the gate, EMU shall work with the City to ensure that the approved City vehicles can operate the gate. EMU shall not allow the gate to be opened by or for other vehicles for any extended period of time except in limited circumstances related to special EMU events, and only after notifying all households on Ainsley Street.

F. The City agrees that the design and construction of the new gate described in Section III(A) and associated road improvements and landscaping described in Section III(B) will occur on EMU's property, and thus such design and construction are not subject to City ordinances. Prior to initiating any of the work outlined in Section III(A), (B), or (C) of this Agreement, EMU shall provide the City with a final rendering of the proposed work for review by the City Manager or his/her staff designee.

G. EMU shall complete the work outlined in this Agreement on or before April 30, 2015, or else this Agreement shall become void; provided, however, that EMU may request, in writing, a one-time extension to extend the deadline to October 31, 2017, to complete the work outlined in this Agreement. A request from EMU for such an extension shall be granted by the City.

IV. Other

A. This MOU includes all terms agreed to by the City and EMU related to this project.

B. Modifications to this MOU are binding only if included in a written document signed by both parties.

SIGNATURES ON NEXT PAGE

AGREED:

EASTERN MICHIGAN UNIVERSITY

Printed Name: _____

Signature: _____

Job Title: _____ Date: _____

CITY OF YPSILANTI

Printed Name: _____

Signature: _____

Job Title: _____ Date: _____

AS ADOPTED
Resolution No. 2012 -199
September 18, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

THAT the Recovery Agreement and Action Plan between Ypsilanti Housing Commission, the Unites States Department of Housing and Urban Development and the City of Ypsilanti be approved with the following additions:

1. Add additional language to Section GO01c of the Action Plan: *"And the evaluations be submitted to City Council when completed".*

2. Add Section XXV to Recovery Agreement and also GO05:
"That all reports and communications referenced in or pertaining to this agreement and recovery plan by HUD or the Ypsilanti Housing Commission be simultaneously sent to the Ypsilanti City Clerk for distribution to City Council."

3. Add Section I(a) to the Recovery Agreement and GO06 to the Action Plan with an initial report date of 12/18/2012 stating:
"HUD, the Ypsilanti Housing Commission and the City of Ypsilanti will explore with Washtenaw County, the City of Ann Arbor and others the feasibility of a regional Housing Entity"

4. Add to Action Plan: *"Submission of a chronology timeline of the Section 8 financials from 2007 to present."*

OFFERED BY: Council Member Jefferson

SUPPORTED BY: Council Member Vogt

YES: 6 NO: 1 (Robb) ABSENT: 0 VOTE: Carried

I do hereby certify that the above resolution is a true and correct copy of Resolution 2012-199 as passed by the Ypsilanti City Council, at their meeting held on September 18, 2012.

_____
Frances McMullan, City Clerk

Resolution No. 2012-224
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That Resolution No. 2009-119 of June 16, 2009 be amended to change the membership size of the joint Ypsilanti Downtown Development Authority (YDDA) board membership to 10 members plus the Mayor from 12 members plus the Mayor.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

Resolution No. 2009-119
June 16, 2009

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

THAT pursuant to the Downtown Development Act, Section 125.1624, subsection 4(7), City Council hereby creates a single Downtown Development Authority board to govern both of Ypsilanti's Downtown Development Authorities;

AND FURTHER RESOLVED THAT such board will consist of twelve members plus the Mayor;

AND FURTHER RESOLVED THAT such board will be appointed as required by Section 125.1624;

AND FURTHER RESOLVED THAT the members of the combined DDA board filling a resident requirement or the requirement of "having an interest in property located in the downtown district or officers, members, trustees, principals, or employees of a legal entity having an interest in property located in the downtown district" will be equally divided between the two DDA districts;

AND FURTHER RESOLVED THAT at least one member of the combined DDA board shall be a representative of Eastern Michigan University (EMU);

AND FURTHER RESOLVED that the existing DDA boards will expire in thirty (30) days from passage of this resolution or upon the appointment of the combined DDA Board, whichever occurs first.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

Resolution No. 2012 –225
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

THAT, the following individual be appointed to the City of Ypsilanti Boards and Commissions as indicated below:

NAME	**BOARD**	**TERM TO EXPIRE**
	YDDA	
Regan L. Parker (resident member replacing Dawn Gendich) 124 W. Michigan Ave, #203 Ypsilanti, Michigan 48197		7/7/2015

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

September 13, 2012

Ypsilanti Downtown Development Authority
Attn: Mayor Paul Schreiber
32 N. Washington Street, Ste. 14
Ypsilanti, MI 48197

Dear Mayor Schreiber,

Recently I was informed there may be a position available for a current Ypsilanti resident on the Ypsilanti Downtown Development Authority Board. Please accept this letter as my expressed interest in serving this role.

I have lived in the greater Ypsilanti/Ypsilanti Township area for over 11 years and I've frequented the city's many restaurants, shops, and cultural events. Needless to say, I've fallen in love with our beautiful, funky little town. Recently, I moved to a loft apartment located at 124 W. Michigan Ave and have found myself even more engrained in the day-to-day hustle and bustle of Ypsilanti. Over the past few years, during my time as both a Business School student at EMU and a happy resident, I've witnessed how our city has come to life . . . how people are taking notice . . . how much she has to offer if people just pay attention. I've seen the growth of the Ypsilanti Convention and Visitors Bureau and I am impressed with the work they do to bring people into our city and into our businesses.

My interests and my strengths lie in business . . . strategic business development and growth to be more specific. I know that having the right mix of businesses coupled with an interesting, easy to access, aesthetically pleasing business district is the key to a thriving community and I would love the opportunity to be involved in Ypsilanti at that level.

Please note, I think Ypsilanti is wonderfully quirky and unique – it's really one of her greatest charms. My goals, outlined below, should be read with this in mind. I would never want to turn Ypsilanti into something she's not meant to be. She has a wonderful personality . . . we just need to grow her and nurture her a little.

Some goals I would have as a board member are outlined below. This list includes aspects I think are important to a healthy business district and a healthy, happy residential community.

PROMOTION:
Selling the image and promise of the Downtown Districts to all prospects by marketing the districts' unique characteristics to shoppers, potential residents, investors, new businesses, and visitors. Employ an effective promotion strategy which forges a positive image through advertising, retail promotional activity, special events, and marketing campaigns.

ECONOMIC:
Finding a new purpose for downtown enterprises by helping existing downtown businesses expand, and recruiting new ones to respond to today's market. Help convert unused space into productive property and sharpen the competitiveness of business enterprises.

ORGANIZATION:
Getting everyone working toward the same goal—building consensus and cooperation among the groups that have an important stake in the districts.

In closing, I would just say that my heart belongs to this city . . . I recently found myself in a situation where I had to make the decision whether to leave, not only our great State, but our amazing little town . . . I'm proud and happy I decided to stay and make my home in Ypsilanti, Michigan. I promise to bring this same passion and enthusiasm, as well as my business background and skill set to the table every time. I look forward to hearing from you regarding your decision.

Sincerely,
Regan L. Parker

REGAN L. PARKER

124 W. Michigan Ave, #203 • Ypsilanti, Michigan 48197
regan.borton@gmail.com • (734) 276-1193

PROFESSIONAL PROFILE

Relationship Building • Communication • Strategy Development

An innovative business development professional with eight years' experience within various industries including insurance, healthcare, education and advertising. Proven track record in developing and launching successful business development activities on time and within budget. Exceptional at managing multiple projects from conception to completion. A team player that is highly organized and demonstrates self-motivation, creativity, and initiative to achieve corporate goals. A proven proactive team leader. Proficient in word processing, database, spreadsheet, design applications and Internet applications.

CORE COMPETENCIES

- Relationship Management
- Written/Verbal Communication
- Strategic Planning
- Problem Solving
- Media Relations
- Marketing Communications
- Visioning
- Budget Administration
- Consensus Building

PROFESSIONAL EXPERIENCE

THOMSON-SHORE, INC. – Dexter, Michigan 2009 – Present

Business Development Director

Thomson-Shore is a renowned book manufacturer and publishing services firm which has been helping publishing customers get their books to market more efficiently and with more class than anyone in the industry for 40 years..

Oversight of the research, development, and implementation of new products and services along with designing, communicating, and facilitating Thomson-Shore's annual marketing plan. General ownership of promoting the Thomson-Shore brand and responsibility for developing key corporate messages and building corporate marketing strategies.

Key Achievements:

- Conceptualized and led development of a comprehensive Retail Channel Distribution Program responsible for $250,000 in revenue annually.
- Improved marketing efforts which supported a 5% increase in new quote activity and 12% increase in requests for information.
- Conceptualized and led development of sales training program to improve sales team efforts and switch focus from tactical sales to a programmatic sales style, resulting in a 15% increase in long-term contract work.
- Led effort to implement new Global Print Network which opened up markets overseas and resulted in $100,000 in new business in its first year of implementation.

HYLANT GROUP, INC – Ann Arbor, Michigan 2007 – 2009

Client Executive

From Fortune 100 companies that span the globe, to local family-held businesses, Hylant Group provides specially tailored, cost effective, international risk management solutions for its clients' unique business for nearly 70 years.

Overall accountability for providing excellent customer service to existing accounts while growing to $250,000 book of business over 3 years. Plan and implement strategic initiatives to grow personal book of business. Manage

expectations of clients while providing services that address key business concerns. Act as risk management advisor in collaboration with other business advisors such as attorneys, consultants and accountants. Facilitate team of client support staff to achieve corporate and client goals. Participate in corporate change initiatives with senior management.

Key Achievements:

- Developed $10,000 book of business in one year.
- Contributed to change efforts for Sales Team meetings resulting in a more effective and efficient meetings that are value added to everyone.
- Worked on community engagement efforts resulting in a 50% increase in our staff community involvement.

UNIVERSITY OF MICHIGAN – Ann Arbor, Michigan 2001 – 2007

Director of Development (2004-2007)

Serve as Director of Development to U-M's Physical Medicine & Rehabilitation Center; part of one of the largest health care complexes in the world.

Plan, implement, and direct comprehensive capital and programmatic development initiatives for department with high, multi-year fundraising goals. Collaborate with top-level University administrators, faculty, and volunteers to provide direction and leadership in establishing department goals and objectives. Develop and implement strategies to identify, cultivate and solicit major donors and prospects in accordance with performance targets. Maintain donor pipeline of $2 million annually and manage team of development and support staff to achieve fundraising goals. Participate with U-M senior Development leaders regarding department policies and procedures.

Key Achievements:

- Spearheaded the first fundraising effort in the history of the U-M's PM&R department.
- Selected an advisory board of 5 faculty members and 15 community leaders to assist in strategic planning of development program activities.
- Created a database of 100 prospective donors and 50 prospective major gift donors in under a year.
- Assisted in the development and implementation of a recruitment program that produced 5 of the top 6 candidates for department's Residency Program.
- Coordinated the redesign of the website to provide up-to date, relevant department information.

Promotions Coordinator (2002-2004)

Served as Promotion Coordinator for University's Cardiovascular Center that provides outstanding cardiovascular resources across the U-M Health System.

Developed and implemented strategies for promoting University programs. Coordinated marketing programs, events, and activities in support of strategic objectives. Communicated with public, constituent groups, and media to promote U-M CVC programs and advance department's image. Performed community outreach and provided coordination of local community events including fundraisers, celebrations, and other promotional endeavors. Collaborated with university teams to execute visible public events. Solicited funding partners, vendors and sponsors for events. Contacted prospective guests, speakers and attendees; and coordinated invitations and arrangements.

Key Achievements:

- Assisted with the planning and implementation of the inaugural CVC National Advisory Board Meeting, bringing together 30 prominent members of the national community to work on strategic planning for the Center.
- Integral member of Hearts on Ice organizing committee that triggered a 300% increase in fundraising efforts to benefit U-M heart transplant patients.

- Participated in a $50 million dollar fundraising campaign to generate funds for U-M's new Cardiovascular Center.
- Managed event planning and logistics for the annual American Heart Association's Washtenaw County Heart Walk comprised of 1,200 participants, raising $195,000 for cardiovascular research.

Patient Care Coordinator (2001-2002)

Served as *Patient Care Coordinator for U-M's nationally recognized Cancer Center comprised of 335 physicians and researchers treating over 65,000 patients annually.*

Directed four outpatient clerks in collaboration with faculty doctors to coordinate all aspects of patient care including, scheduling tests, inputting treatment plans, and providing educational information to patients and family members to ensure excellence in quality care and customer satisfaction.

Early Career Progression 1998 – 2001

Successfully completed two internships during a three year period; progressed through roles as Associate Account Executive for TenneyClemmons Advertising, a premier, full-service advertising agency in Southern Utah (2000-2001), and Marketing Coordinator of the Athletic department at Southern Utah University (1998-2000).

EDUCATION AND CREDENTIALS

Master of Business Administration, Eastern Michigan University – Ypsilanti, Michigan (2008)

Bachelor of Science in Communications, Southern Utah University – Cedar City, Utah (2001)

PROFESSIONAL AFFILIATIONS

Member, Ann Arbor/Ypsilanti Chamber of Commerce (2008-present)

Founding Member and Steering Committee, Women's Exchange of Washtenaw (2008-present)

Founding Member and Events Committee, YP Underground of Washtenaw (2008-present)

Member, Detroit Economic Club (2008- present)

COMMUNITY ENGAGEMENT

Development Board, Ann Arbor Hands On Museum (2008)

100th Anniversary Events Planning Board, Ann Arbor Art Center (2008-2009)

Member, Rotary Club of Ann Arbor North (2007-present)

Fundraising Events Board, Ann Arbor Symphony Orchestra (2003-present)

Marketing Board, 826Michgian (2009-present)

Resolution No. 2012 -226
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

WHEREAS, public education is a fundamental right of every child in our community and is of the utmost importance to the health, well being, vibrancy and prosperity of our city; and

WHEREAS, students should have a quality education that prepares them to lead successful and productive lives; and

WHEREAS, Willow Run Community Schools and the School District of Ypsilanti are deficit districts and they are experiencing severe economic challenges which impacts academic programs; and

WHEREAS, each district is faced with significant achievement deficiencies with many students unprepared to succeed in college and careers; and

WHEREAS, the boards of education have voted to place the question of consolidation on the November 6, 2012 ballot; and

WHEREAS, the unification of these two districts represents a unique opportunity to create a "cradle to career" educational model that is designed to ensure a strong and successful public education system; and

WHEREAS, the two ballot proposals, if approved, will maintain the current level of taxes; now

THEREFORE, be it resolved that the Ypsilanti City Council supports the effort to consolidate the two districts; and

BE IT FURTHER RESOLVED this support includes the second proposal on the ballot which allows the new district to levy the 18 mills non-homestead property tax millage as currently levied by the independent districts in order to receive full funding on a per student basis.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE:

Arika Lycan, LLMSW

226 W. Michigan Ave. Apt 2 ♦ Ypsilanti, Michigan 48197
(614) 507-1161 ♦ arika.grace@gmail.com

Objective: To help improve mutual understanding and equality among all people in the city of Ypsilanti by serving as a Commission Member for the Human Relations Commission.

Education and Certifications

Master of Social Work- Social Administration
The Ohio State University, Columbus, Ohio

Bachelor of Science in Social Work
Eastern Michigan University, Ypsilanti, Michigan

- **Limited License Master Social Worker (LLMSW) certification**
- **American Humanics Nonprofit Management Certificate**
- **CPR/First Aid Certification**

Relevant Experience

Membership Specialist- Girl Scouts Heart of Michigan, *Ann Arbor, Michigan*
December 2008-Present

- Assisting with development and implementation of recruitment, retention, and outreach strategies for girls and adult members in all segments of the Plymouth/Canton region
- Supervising volunteers in the Plymouth/Canton region to deliver Girl Scout programs to over 2,000 girls adults
- Setting membership goals and cultivating volunteers to meet those goals
- Working with school administration, teachers, and community partners to increase girl participation within Girl Scouts, developing new ways of serving girls, especially underserved girls

Support Coordinator- Community Living Services, *Berkley, Michigan*
June 2008-December 2008

- Supporting a caseload of eighteen individuals with developmental disabilities
- Connecting persons supported by the agency to community resources and benefits
- Bringing together family, friends, and community supports to most comprehensively address needs of the persons supported by the agency, through person centered planning

Social Work Intern- United Way of Central Ohio, *Columbus, Ohio*
November 2007 – June 2008

- Developed workshop objectives for two leadership programs which equip LGBT individuals and persons of color in Columbus with the tools to serve effectively on a Nonprofit board
- Compiled a list of "Best Practices", used in the development of common program outcomes for all United Way of Central Ohio-funded agencies
- Served on a Grant Review team for the Neighborhood Partnership Grants
- Created a User's Guide for United Way's Cultural Competency Standards

Administrative Assistant- Ohio Hospice & Palliative Care Organization, *Dublin, Ohio*
June 2007- June 2008

- Compiling survey results for educational programs and reporting results to presenters
- Processing Evaluation survey data for 300 participants at a state-wide conference
- Recording and managing data for conference registrations in Microsoft Excel
- Copying, collating, faxing, and other office duties

Social Work Intern- Big Brothers Big Sisters-Washtenaw County, *Ann Arbor, Michigan*
August 2006 – April 2007

- Facilitated Volunteer/Client Orientations, student meetings, and interviews
- Served as a liaison between Big Brothers Big Sisters and Eastern Michigan University
- Collaborated with fellow employees to develop new orientation process, resulting in a stream-lined approach to informing volunteers and parents about the program

Learn more about me at: www.jobfox.com/people/arikalycan

Resident Advisor- Eastern Michigan University, *Ypsilanti, Michigan*
May 2005- May 2006

- Offered emotional and academic support and on and off campus resources to residents
- Planned and implemented educational/social programs to educate and inform residents including an LGBT Ally training, a Communication program, and a Body Image program,
- Served the needs of residents on my floor and in the Residence Hall
- Enforced Hall policies and maintained safety in the hall
- Mediated conflicts between residents/roommates

Publications & Unpublished works

Author- "Ethical Dilemmas in Social Work Practice- Role Briefings and Ethics Discussion Tool", 2008, USA, English. (Unpublished)
Contributing Editor- "Palliative Care Consultant Ed. 3", Ohio Hospice and Palliative Care Organization, 2008, USA, English.

Additional Skills

- Basic knowledge of Spanish
- Grant-writing, Budgeting and Program Planning and evaluation experience
- Skilled using Microsoft Excel, Access, PowerPoint and Word

Volunteerism & Hobbies

Grant Review Committee Member-United Way of Washtenaw County, *Ann Arbor, Michigan*
January 2009
Read, reviewed and made suggestions on "Power of the Purse" grant applications for a total sum of $23,000. "Power of the Purse" awards mini-grants to women who are working to improve their lives and moving toward self-sufficiency

Group Organizer- Meetup.com, *Ypsilanti, Michigan*
October 2008 – present
Serving as Group Organizer for the Ypsilanti/Ann Arbor Lesbian Gay Bisexual Transgender and Allies Meetup group, a group of 78 members. I have planned a variety of social activities to help foster a sense of support and community for LGBTA individuals in Washtenaw County

Member- Ypsilanti Food Cooperative, *Ypsilanti, Michigan*
June 2008-present
Member of the Ypsilanti Food Co-op, a locally owned Cooperative Food market that supports local farmers, manufactures and businesses

Big Sister- Big Brothers Big Sisters of Washtenaw County, *Ann Arbor, Michigan*
October 2004-present
Matched with Little Sister Sammy since 2004. Some of our favorite things to do together are carving pumpkins on Halloween, eating Chinese food, doing homework, and traveling around Ypsilanti

Member- Social Welfare Action (SWA), EMU, *Ypsilanti, Michigan*
January 2006
Coordinated Department Presenters for Youth College Day 2006, a college student experience for 14-17 year olds sponsored by Social Welfare Action

President- Big Brothers Big Sisters at EMU, *Ypsilanti, Michigan*
September 2006-May 2007
Founded Big Brothers Big Sisters at EMU. Served as Student Coordinator/ President. Goals of the group included recruiting new Big Brothers/Sisters and providing resources for current volunteers

References

For a list of references, please inquire: arika.grace@gmail.com or (614) 507-1161

Statement by John Shuler:
I am very much interested [in being reappointed to the HRC]. The commissioners of the HRC elected me Chair at the July meeting. I have been on the commission now for two terms, so I have a long history and understanding of the commission, it's charter, and goals.

My goals for the next term are to continue promoting public awareness of the HRC and it's mission. We intend to have a public forum in November on the topic of "homlessness in Ypsilanti." I intend to continue the development of public forums like this to continue to explore the roles discrimination play in the various aspects of people's lives in Ypsilanti.

Thank you for your continued confidence in me.

Statement by Andrew Cameron:
I graduated with a bachelor's in history from U-M in 1998, with relevant coursework in calculus, statistics, economics, and accounting.

After graduation I worked as a business systems consultant at U-M for two years, becoming a lead on a campus-wide help desk during the period U-M was replacing all of its legacy central administrative data systems and converting to Peoplesoft/Oracle enterprise systems for Financials, HR, and Student Records. The first year or so was largely focused on understanding and supporting the Financial systems and reporting. Around this time I also worked evenings part-time auditing U-M credit card statements for Accounts Payable for 2-3 years.

For the last 11 years I've worked in U-M's central Office of the Registrar as a Business Systems Analyst Senior. My small group is directly responsible or provides immediate source data for a large range of institutional, state, NCAA, and federal reporting requirements. I'm also the primary support for student data and reporting needs for 200-300 employees, and am generally considered one of a handful of institutional student data experts on campus.

My goals for my term on the YCUA board include being an effective advocate for the city's interests, and building on our current cooperation with the Township. I also think YCUA's online communications (web site), while a rich source of information, deserves some attention.

Statement by Ariel Moore:
Mayor Schreiber,

Thank you for your interest in nominating me to the Board of the Ypsilanti Housing Commission. I would be honored to accept your nomination and would look forward to introducing myself to the Ypsilanti City Council at its next meeting on October 16.

I believe I am well qualified to help the board advance its goals of providing “housing services for those who need it most.” I received a Masters in Business Administration from the University of Michigan Business School in 2004. After graduation, I joined DTE Energy and

have served in various financial management positions within the company. Before my current role, I was the Financial Controller for the Nuclear Generation business unit overseeing a combined O&M and capital budget of over $300M/ year. In 2011, I moved on to become the Manager of Nuclear Strategy with responsibility for the Nuclear Generation near-term 5-year plan through the end of the plant's operating license. In short, I have experience managing budgets and strategic plans within a regulated environment.

I am also a resident of Ypsilanti and care deeply for the health and welfare of my community. I believe we have a collective responsibility to ensure our residents have access to certain basic needs – be it clean, safe, affordable energy or clean, safe affordable housing. My goals on the Commission would be to help the board and staff create and maintain transparent, accountable financial processes that not only comply with regulations, but also build the trust of those we serve that their needs will always be supported by our funds.

Again, thank you for your nomination.

Ariel Moore

Tabitha M. Boone
951 Madison St.
Ypsilanti, MI 48197
boonetabitha@yahoo.com
(734)329-1208

Mayor Paul Schreiber
City of Ypsilanti
1 South Huron St.
Ypsilanti, MI 48197

Dear Mayor Schreiber;

I am writing to express my interest in becoming a participant on the board of commissioners as a resident representative for the Ypsilanti Housing Commission. I am confident that I can serve my community and represent the tenants of Ypsilanti Public Housing well and without bias. I am currently a resident and have been here in Ypsilanti for over 5 years.

I grew up in public housing in the city of Flint, during which time I served as a youth organizer for the housing commissioners for 3 years, that is where my interest in community involvement started. A few years later shortly after the birth of my first child I became a member of Parents Promoting Excellence in the Hampton, Virginia for about 4 years along side the Hampton School Board. Within the past 5 years I organized a group called Youthful Solutions, and served along side several groups in the community to promote interest in the community for youth as well as adults. In the past few weeks I just volunteered at the local health fair downtown Ypsilanti which was a great service for our community.

As per our conversation a few days ago; I am equally interested in being a part of the tenant council for the scattered sites for the Housing Commission. My ultimate goal is to be able to serve my community and help the residents overcome some of the challenges that we all face here in the city.

If you have any questions please do not hesitate to contact me at (734)329-1208 or by email at boonetabitha@yahoo.com . looking forward to meeting with you.

Sincerely,

Tabitha M. Boone

CITY OF YPSILANTI
BOARDS AND COMMISSIONS
CITIZEN PARTICIPATION RESUME

(Note: You must be a registered voter to be eligible to serve on a City of Ypsilanti Board or Commission)

NAME: Yabitha Boone

ADDRESS: 951 Madison St.
Ypsilanti MI 48197

NO. YEARS IN THE COMMUNITY: ____

HOME: (734) 329 1208 Call: ( ) A.M. or ( ) P.M. FAX # ( )

BUSINESS: ( ) Call: ( ) A.M. or ( ) P.M.

EMAIL ADDRESS: booneyabitha@yahoo.com

EDUCATION: High School Grad w/ some college

CURRENT OCCUPATION: N/A

CURRENT EMPLOYER: N/A

I would like to be considered and could devote sufficient time to serve on the following Board(s) or Commission(s) in order of preference:

1. Ypsilanti Housing

2. ____

Please indicate experience and/or qualifications that would help make you an effective member of each board for which you have applied.

WORK/VOLUNTEER EXPERIENCE: Flint Housing, Parents Promoting Excellence, Youthful Solutions, and various organizations throughout the community

I understand that appointment to a City of Ypsilanti Board or Commission requires regular attendance at board meetings.

SIGNATURE: Yabitha Boone DATE 9-20-12

(RETURN COMPLETED FORM TO: CITY CLERK'S DEPARTMENT, 1 SOUTH HURON ST., YPSILANTI, MI 48197)

Resolution No. 2012-227
October 16, 2012

RESOLVED BY THE COUNCIL OF THE CITY OF YPSILANTI:

That the City Council Meeting be adjourned, on call, by the Mayor or two (2) members of Council.

OFFERED BY: _____

SUPPORTED BY: _____

YES: NO: ABSENT: VOTE: