

Welcome to tonight's City Council meeting!

The elected officials of the City of Bonners Ferry are appreciative of an involved constituency. Testimony from the public is encouraged concerning issues when addressed under the Public Hearing portion of the agenda. Any individual who wishes may address the council on any issue, whether on the agenda or not, during the Public Comments period. Normal business will preclude public participation during the business portion of the meeting with the discretion left to the Mayor and Council.

Vision Statement

Bonners Ferry, "The Friendliest City", strives to achieve balanced growth, builds on community strengths, respects natural resources, promotes excellence in Government, and values quality of life.

AGENDA
CITY COUNCIL MEETING
Bonners Ferry City Hall
7232 Main Street
267-3105
January 7, 2014
7:00 p.m.

PLEDGE OF ALLEGIANCE

PUBLIC HEARING

PUBLIC COMMENTS

Each speaker will be allowed a maximum of five minutes, unless repeat testimony is requested by the Mayor/Council

GUESTS

REPORTS

Police/Fire/City Administrator/Economic Development Coordinator/Urban Renewal District

CONSENT AGENDA

1. Call to Order/Roll Call
2. Approval of Bills and Payroll
3. Treasurer's Report
4. Approve December 17, 2013 Council Meeting Minutes

SWEAR IN TOM MAYO AND RON SMITH AS COUNCILMEN AND PRESENT CERTIFICATES OF ELECTION

OLD BUSINESS

5. Police/Fire – Discuss Kootenai Tribe Fire/Law Enforcement Contract

NEW BUSINESS

6. P&Z – Consider Special Use Permit for a Mental Health and Addictions Counseling Center at 6807 Cody Street by Applicant Rawlings Community Counseling (attachment)
7. Electric – Authorize Mayor to Sign Change Order #2 on Moyie Power Plant Unit 3 Repair Project (attachment)
8. Electric – Authorize Mayor to Sign Bonneville Power Administration Conservation Agreement Amendment #01 (attachment)

9. City – Consider Reappointment of Dean Satchwell, Don Lindsay, and John Marquette to Traffic Safety Committee
10. City – Authorize Mayor to Sign Cafeteria Plan Documents (attachment)
11. City – Discuss Light Duty Policy (attachment)
12. Electric – Discuss Moyie Substation Purchase (attachment)
13. City – Elect Council President

EXECUTIVE SESSION PURSUANT TO IDAHO CODE 67-2345, SUBSECTION 1

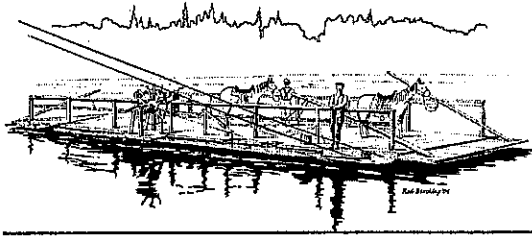
- (a) Consider hiring a public officer, employee, staff member or individual agent.
- (b) Consider the evaluation, dismissal or disciplining of, or to hear complaints or charges brought against, a public officer, employee, staff member or individual agent, or public school student.
- (c) Conduct deliberations concerning labor negotiations or to acquire an interest in real property which is not owned by a public agency.
- (d) Consider records that are exempt from disclosure as provided in chapter 3, title 9, Idaho Code.
- (e) Consider preliminary negotiations involving matters of trade or commerce in which the governing body is in competition with governing bodies in other states or nations.
- (f) Communicate with legal counsel for the public agency to discuss the legal ramifications of and legal options for pending litigation, or controversies not yet being litigated but imminently likely to be litigated.
- (g) Engage in communications with a representative of the public agency's risk manager or insurance provider to discuss the adjustment of a pending claim or prevention of a claim imminently likely to be filed.

ADJOURNMENT

NEXT MEETING DATE

INFORMATION

14. Street – Traffic and Speed Volume Graph for Cow Creek (attachment)



CITY OF BONNERS FERRY

7232 Main Street
P.O. Box 149
Bonners Ferry, Idaho 83805
Phone: 208-267-3105 Fax: 208-267-4375

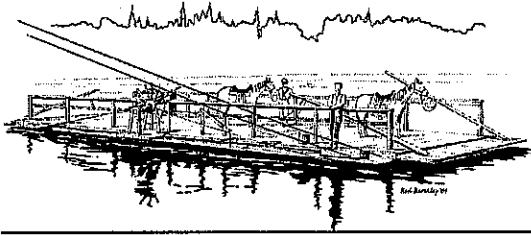
OATH OF OFFICE

I, **Tom Mayo**, do solemnly swear (or affirm) that I will support the Constitution of the United States, and the Constitution of the State of Idaho, and that I will faithfully discharge the duties of Councilman of the City of Bonners Ferry according to the best of my ability.

Tom Mayo

Subscribed and sworn to before me this 7th day of January, 2014.

Kris Larson, City Clerk



CITY OF BONNERS FERRY

7232 Main Street
P.O. Box 149
Bonners Ferry, Idaho 83805
Phone: 208-267-3105 Fax: 208-267-4375

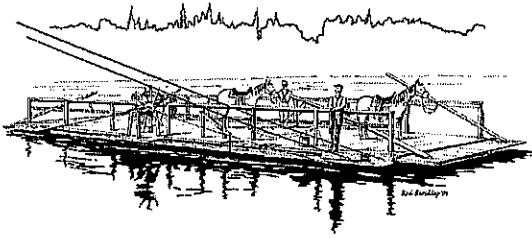
OATH OF OFFICE

I, **Ron Smith**, do solemnly swear (or affirm) that I will support the Constitution of the United States, and the Constitution of the State of Idaho, and that I will faithfully discharge the duties of Councilman of the City of Bonners Ferry according to the best of my ability.

Ron Smith

Subscribed and sworn to before me this 7th day of January, 2014.

Kris Larson, City Clerk



P & Z – COUNCIL RECOMENDATION

CITY OF BONNERS FERRY

3 February 2012

Subject: Special Use Permit for a Mental Health and Addictions Counseling Center

Applicant: Rawlings Community Counseling

Location: 6807 Cody Street

At the Planning and Zoning hearing of 19 December 2013 a request was heard for the Subject a Special Use Permit (SUP) request to consider a allowing for an existing structure to be used as a Counseling Center in a Residential AA Zone. The legal description of the property is Lot 6, Block 2, Bruce Acre Tracts, Tax 3 in Section 34, Township 62N Range 1E.

The Planning and Zoning Commission recommended approval of the SUP with the following contingencies:

1. A minimum of 23 parking spaces are to be provided
2. Maximum sign size is 4' x 5' and must be located within 2' of the building
3. Outdoor lighting to be non-obtrusive and the building to have motion lights installed around the perimeter
4. Hours of operation are to be 8 a.m. – 8 p.m. Monday through Friday and 8 a.m. – 3 p.m. Saturday and Sunday

As stated in Section 5.9 of the City's Zoning Ordinance, the Council has the following options regarding their decision for this SUP request:

1. Prior to granting a special use permit, the Council may require a public hearing. They may request studies from the applicant that more clearly determine the effects of the special use.
2. The Council may approve the special use permit as recommended by P & Z.
3. The Council may approve the special use permit with additional conditions.
4. The Council may disapprove the special use permit.

The Council may wish to schedule another public hearing if there is additional information that the Council would like to obtain from the applicant, or if you have additional concerns that would warrant another hearing. Please let me know if you have any questions regarding this issue.

Notice of Public Hearing

Notice is hereby given that the Bonners Ferry Planning and Zoning Commission will hold a Public Hearing at City Hall, 7232 Main, on Thursday, 19 December 2013, at 5:15 p.m., to consider an application from Rawlings Community Counseling for a **Special Use Permit** to operate a Mental Health and Addictions Counseling Center at 6807 Cody Street.

The legal description of the property is Lot 6, Block 2, Bruce Acre Tracts, Tax 3 in Section 34, Township 62N Range 1E. according to the records on file with the Boundary County Idaho Recorder.

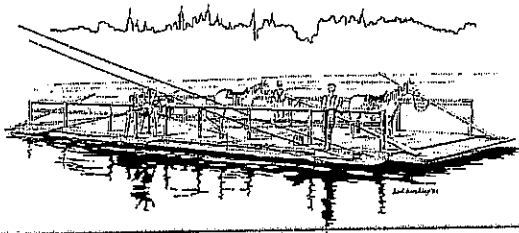
The deadline for submitting written comment and/or material is 5 p.m. 13 December 2013. Written comment can be mailed to City of Bonners Ferry, Planning and Zoning, P.O.Box 149, Bonners Ferry, ID 83805, or faxed to (208) 267-4375. Written comment of two pages or less will be accepted at the hearing provided the person submitting the material reads it into the record.

Further information on this application is on file in the Planning and Zoning Department at City Hall, 7232 Main, and is available for public review. Anyone requiring special accommodation due to disability should contact the City Clerk at (208) 267-3105 at least two days prior to the meeting.

City of Bonners Ferry Planning and Zoning

ATTEST: _____

PUBL: 5 December 2013



CITY OF BONNERS FERRY

7232 Main Street
P.O. Box 149
Bonners Ferry, Idaho 83805
Phone: 208-267-3105 Fax: 208-267-4375

28 December 2011

Subject: Special Use Permit for Rawlings Community Counseling

Dear Property Owner:

Notice is hereby given that the Bonners Ferry Planning and Zoning Commission will hold a Public Hearing at City Hall, 7232 Main, on Thursday, 19 December 2013, at 5:15 p.m., to consider an application from Rawlings Community Counseling for a Special Use Permit to operate a Mental Health and Addictions Counseling Center at 6807 Cody Street.

The legal description of the property is Lot 6, Block 2, Bruce Acre Tracts, Tax 3 in Section 34, Township 62N Range 1E. according to the records on file with the Boundary County Idaho Recorder.

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Further information on this application is on file in the Planning and Zoning Department at City Hall, 7232 Main, and is available for public review. Anyone requiring special accommodation due to disability should contact the City Clerk at (208) 267-3105 at least two days prior to the meeting.

Attached is a form that can be used to provide public comment regarding the proposal. You will also have the opportunity to speak on the night of the hearing. You will also see an attachment that lists the steps of public hearing. Please call me if you have any questions.

Sincerely,

SJB

Stephen Boorman, PE
City Administrator

Attachment

BONNERS REMNANT CHURCH
PO BOX 3157
BONNERS FERRY, ID 83805
WEBSITE: BONNERSREMNANTCHURCH.ORG

November 20, 2013

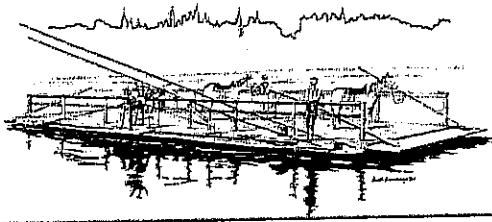
Mr. Steve Boorman
City Administrator
Bonners Ferry, Idaho

Dear Mr. Boorman,

The purpose of this letter is to voice support as the owner for the issuance of a special use permit for the benefit of Christopher and Treva Rawlings in their pending purchase of our church property and building located at 6807 Cody Street, Bonners Ferry, Idaho, 83805.

If you have any questions for me I can be reached at the ministry office - (406) 295-5104.
Thank you for your consideration in this matter.

Pastor Dennis C. Crystal
Bonners Remnant Church



CITY OF BONNERS FERRY

7232 Main Street
P.O. Box 149
Bonners Ferry, Idaho 83805
Phone: 208-267-3105 Fax: 208-267-4375

APPLICATION FOR SPECIAL USE PERMIT

APPLICANT NAME: Rawlings Community Counseling PHONE: 267-0900
946-8843-Barb
MAILING ADDRESS: 6658 Comanche Street
Bonnors Ferry, ID 83805

LEGAL DESCRIPTION:(attach if necessary) TOWNSHIP: 62N RANGE 1E Sec 34

ADDITION: Bruce Ave BLOCK: 2 LOTS: 6

STREET ADDRESS OF PROJECT: 6807 Cody

SIZE OF PROPERTY: .79 acre (ft x ft) CURRENT ZONING: Res. AA

WHAT ZONE BORDERS THE PROJECT SITE:

NORTH: Res. AA
SOUTH: Commercial
EAST: Commercial
WEST: Res. AA

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NOV 14 2013

SITE PLAN ATTACHEMENT:

- show location of structures on property with dimensions
- show location of signs and outdoor lighting if applicable
- show entrances onto City streets and names of streets
- indicate property lines

CITY OF BONNERS FERRY

BUSINESS INFORMATION:

- proposed business name Rawlings Community Counseling
- description of business Mental Health Agency
-

LETTERS OF COMMENT: please attach to application

STATEMENTS ATTACHEMENT: (address the following)

- a. Full description of proposed use (be specific)
- b. How does the requested use conform with the area's land use?
- c. Would the requested use adversely affect the public interest? And why.

THE DATE OF THE PLANNING AND ZONING COMMISSION HEARING WILL BE ESTABLISHED UPON ACCEPTANCE OF A **COMPLETE** APPLICATION. AN APPLICATION WILL BE CONSIDERED COMPLETE WHEN ALL OF THE REQUESTED INFORMATION HAS BEEN SUBMITTED. I ALSO UNDERSTAND THAT THE DECISION MADE BY THE CITY PLANNING AND ZONING COMMISSION IS ONLY A RECOMMENDATION TO THE CITY COUNCIL, WHICH HAS THE FINAL DECISION CONCERNING MY REQUEST.

I UNDERSTAND THAT ALL LOCAL, STATE, AND FEDERAL PERMITS WILL BE APPLIED FOR SEPERATELY. (I.E. BUILDING, ELECTRICAL, PLUMBING, ETC..)

ALL THE INFORMATION, STATEMENTS, ATTACHMENTS, AND EXHIBITS TRANSMITTED HERE WITHARE TRUE TO THE BEST OF MY KNOWLEDGE.

Treva Rawlings
SIGNATURE

Treva Rawlings
PRINTED NAME

11/13/13
DATE

208.267.0900
PHONE NUMBER

Special Use Permit Application for 6807 Cody from Rawlings Community Counseling

STATEMENT:

A: Full description of proposed use

Rawlings Community Counseling is an established Mental Health Agency in Bonners Ferry offering comprehensive counseling services through an interdisciplinary team of 4 therapists to children, adolescents, families, couples and adults via individual, family and group sessions. We provide Case Management, Community Based Rehabilitation Services (CBRS), Veterans Assistance and transportation for clients when needed.

We accept payment through Idaho Medicare and Medicaid, Montana Medicaid, VA, Private insurance, private pay and offer a sliding fee scale. We do not turn anyone away for an inability to pay.

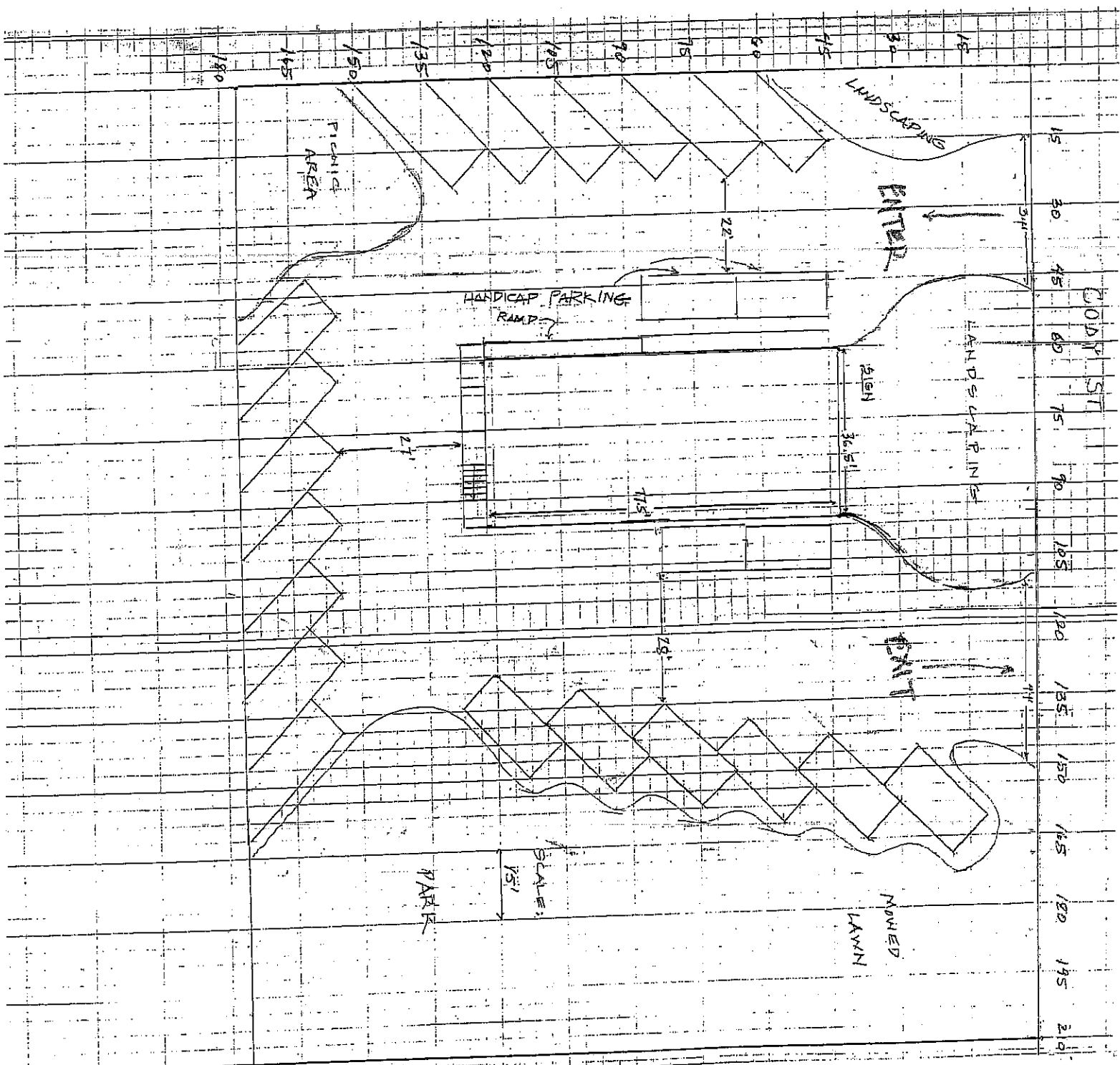
B: How does the requested use conform with the area's land use?

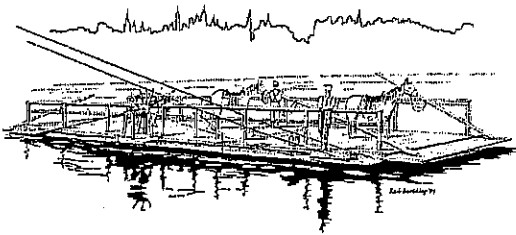
The property is contiguous on 2 sides with commercially zoned lots. The size and geography of the property provides a considerable buffer for the residential lot to the north. The residence to the west does not face Cody Street. Cody St. already serves as a very public thoroughfare. The impact of the relatively light traffic flow generated by RCC will be managed via the planned one-way drive, allowing for entrance on the south and exit on the north side of the building.

C. Would the requested use adversely affect the public interest? Why?

RCC would not adversely affect the public interest. To the contrary, in the past 2 years we have operated successfully and peacefully in a much more residential setting on Comanche St. RCC is offering much needed mental health services to our community as evidenced by our growth. We will be making visible improvements to the property through landscaping and year round grounds keeping as well as upgrades to the building.

Currently the building has been empty for quite some time. Prior to that it was used as a church for the past 10 years. RCC will revitalize this property and positively affect the public interest.





P & Z
STAFF
REVIEW
CITY OF BONNERS FERRY

16 December 2013

Subject: Special Use Permit for a Mental Health and Addictions Counseling Center

Applicant: Rawlings Community Counseling

Location: 6807 Cody

Proposal Background:

1. The proposal is a request to consider a Special Use Permit to allow for an existing structure to be used as a Counseling Center in a Residential AA Zone.
2. The parcel is currently zoned Residential A and the parcels to the north and west are zoned Residential AA. The parcels to the east and south are zoned commercial.

The parcel has frontage on Cody Street.

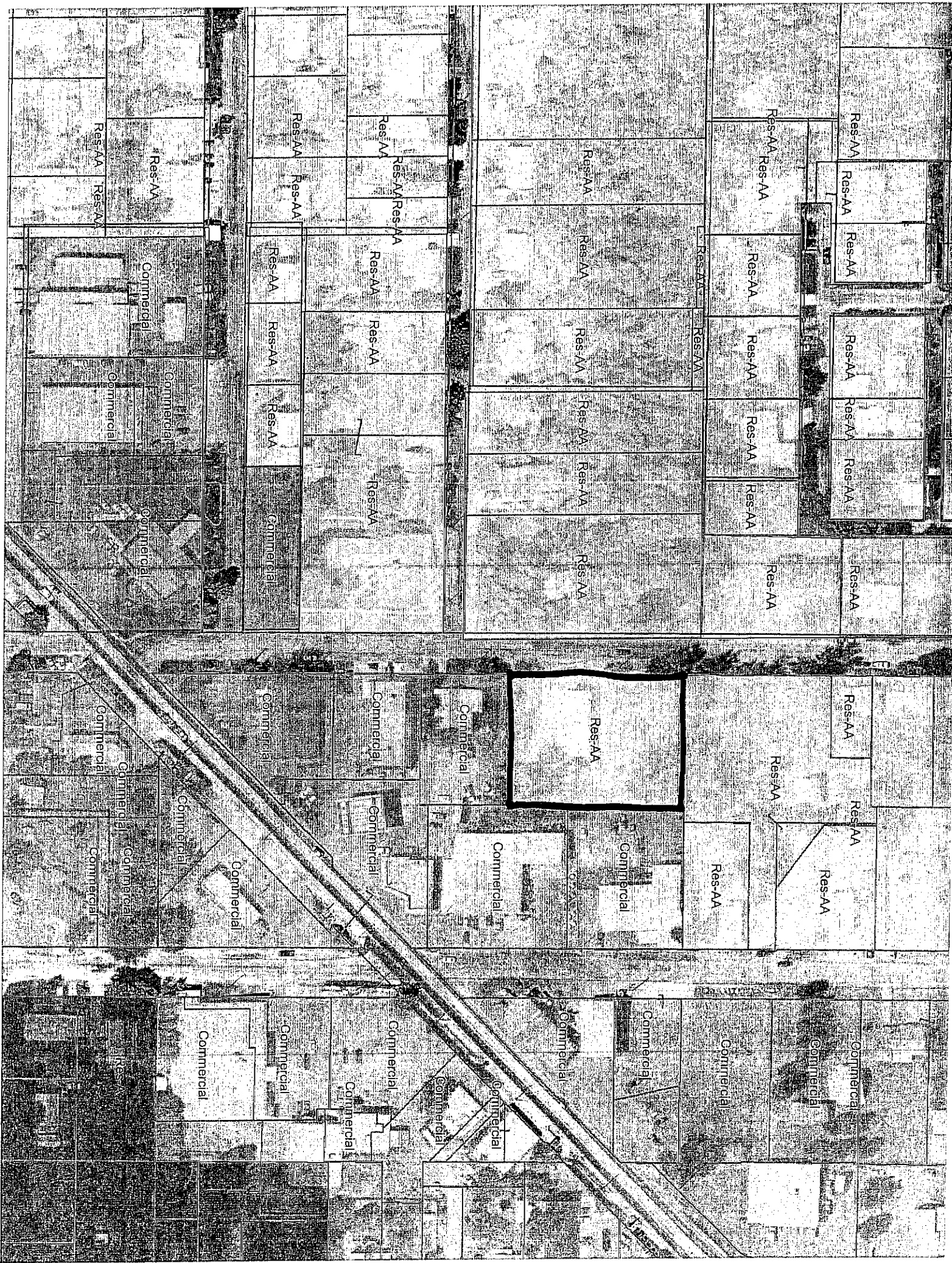
3. The legal description of the property is Lot 6, Block 2, Bruce Acre Tracts, Tax 3 in Section 34, Township 62N Range 1E.
4. The immediate past use of the property was for a church.
5. Public notice was provided to all residences within 300 feet of the proposed special use, as well as in the Bonners Ferry Herald. (see attached notices)
6. In accordance with the new Zoning Ordinance No. 504, Section 5.3:
"Special uses shall be issued to an individual or corporation specifically to a parcel or property. Subsequent owners of the parcel shall be required to apply for a Special Use Permit if they desire to continue the Special Use. If a use is moved to different parcel it will require a new special use."

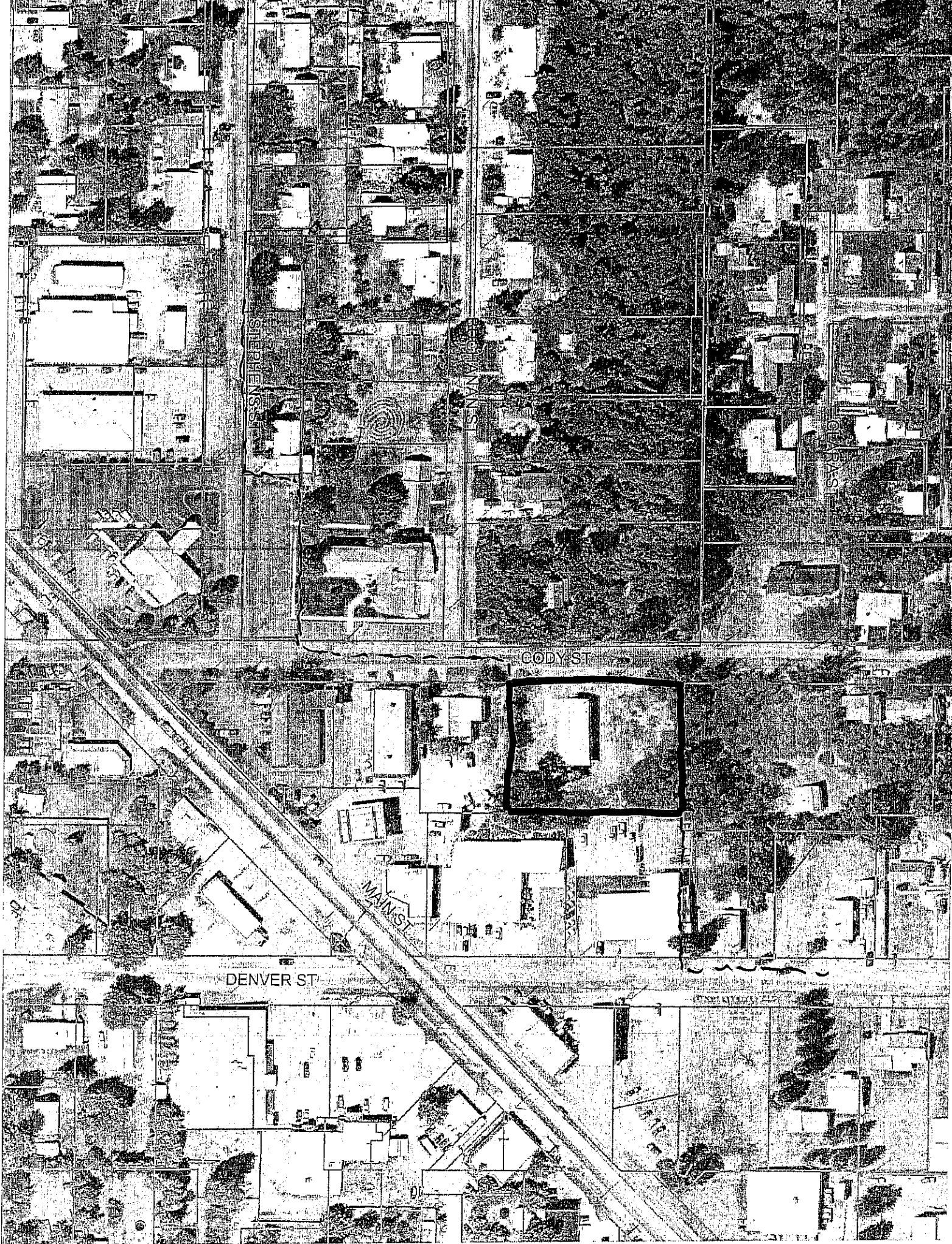
Staff Comments:

1. The proposal shows 23 off-street parking spaces which appears to meet the parking ordinance requirement.
2. Street – During construction of the parking lot the drainage needs to be reviewed. This is due to the amount of storm water that drains through this area from the east.
3. City Attorney – The local judicial system does use Rawlings Community Counseling as they are the only local counseling service that provide some of the services desired by the judicial system.
4. Traffic Safety Meeting will be held on the 17th and their comments will provide at the Public Hearing.

Staff Recommendations:

1. The Commission should forward a recommendation to the City Council that is in the best interest of the City, based on information provided by the applicant.
2. If the Commission recommends that City Council approve this request, they should determine if special requirements or conditions should be put on the request in order to protect public welfare. Appropriate conditions could include the following areas.
 - a. Parking requirements
 - b. Maximum signage size
 - c. Hours of operation
 - d.
 - e.
 - f.





STEPHENSON ST

BECHANAN ST

CODY ST

DENVER ST

MAIN ST

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City of Bonners Ferry

Public Hearing Comment Form

Meeting Date: December 19, 2013

Name Randy Krogseth

Address 9021 17th Ave SW.
Rochester, WA 98579

Hearing: Special Use Permit Rawlings Community Counseling 6807 Cody St.

Please indicate one of the following:

I Support the proposal

I wish to speak

I am Neutral

I do not wish to speak

I am Opposed to the proposal

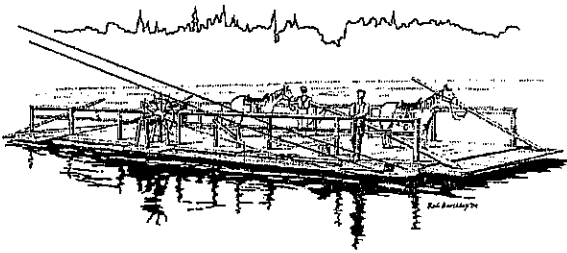
Please provide any comments below:

I believe that growth is good for any
community. Since I don't live in the community
anymore I think the Neighborhood should
decide if they want that type of business
near them

As noted on the comment form I am opposed Rawlings Community Counseling opening a mental health and addiction counseling center on 6807 Cody Street in Bonners Ferry. The reasons I am opposed to this facility being at this location is it introduces hazards to a residential area in two ways. Individuals with mental health and addiction challenges not only pose a danger to themselves but also to other people due to their unstable state of mind. Secondly, I believe opening this facility on Cody Street will increase vehicle traffic to an already very busy street. This area around Cody Street has many residents with children. It is also close to Valley View Elementary school. Putting this facility on Cody Street can pose a danger to residents in that vicinity.

I do believe the mental health and counseling facility Rawlings Community Counseling would like to open is a much needed service to our community. However, I feel strongly that a non residential or less populated residential location would be better for public safety.

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DEC 12 2013
CITY OF BONNERS FERRY



City of Bonners Ferry

Public Hearing Comment Form

Meeting Date: December 19, 2013

Name JONATHAN A. KYRIACO, MARISSA J. KYRIACO

Address 6617 BUCHANAN ST. BONNERS FERRY

Hearing: Special Use Permit Rawlings Community Counseling 6807 Cody St.

Please indicate one of the following:

I Support the proposal

I wish to speak

I am Neutral

I do not wish to speak

I am Opposed to the proposal

RECEIVED

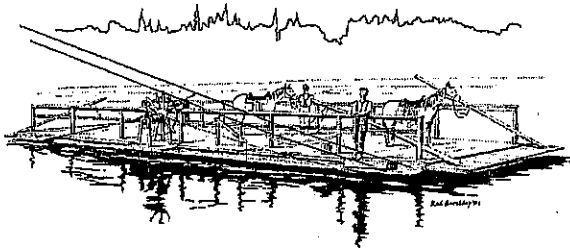
DEC 12 2013

CITY OF BONNERS FERRY

Please provide any comments below:

AS A PROPERTY OWNER AND RESIDENT, I
STRONGLY OPPOSE THIS PROPOSED CENTER. I
FEEL IT WILL HAVE A NEGATIVE IMPACT ON THE
NEIGHBORHOOD IN MANY WAYS. WE BOUGHT OUR HOME
HERE BECAUSE IT WAS QUIET, SAFE, CLEAN, AND
ANICE ENVIRONMENT TO RAISE OUR YOUNG CHILDREN.
THE PROPOSED CENTER IS NOT ONLY CLOSE TO OUR HOME,
BUT CLOSE TO A PRE-SCHOOL, CHURCHES, ELEMENTARY
SCHOOL, MANY HOMES WITH CHILDREN, AND RESPECTABLE
BUSINESSES. PLEASE CONSIDER THE IMPACTS THIS PROJECT
WILL HAVE ON US AND THIS NEIGHBORHOOD. THERE ARE OTHER
PLACES THIS PROJECT WOULD FIT BETTER IN. I FEEL THERE
IS A NEED IN TOWN FOR THESE SERVICES, BUT I DO NOT
BELIEVE THIS IS THE RIGHT LOCATION. PLEASE DON'T
FORCE THIS UN-WELCOME ELEMENT INTO OUR DAILY LIVES.

THANK YOU



City of Bonners Ferry

Public Hearing Comment Form

Meeting Date: December 19, 2013

Name WAYNE A. YOUNG

Address 6605 Buchanan (PO Box 807)
Bonners Ferry, Idaho 83805

Hearing: Special Use Permit Rawlings Community Counseling 6807 Cody St.

Please indicate one of the following:

I Support the proposal

I wish to speak

I am Neutral

I do not wish to speak

I am Opposed to the proposal

Please provide any comments below:

SEE ATTACHED WRITTEN RESPONSE AND SUPPORTING DOCUMENTS
CONSISTING OF FOUR (4) pages.

Multiple horizontal lines provided for writing comments.

RECEIVED

DEC 12 2013

CITY OF BONNERS FERRY

December 12, 2013

City of Bonners Ferry
7232 Main Street
Bonners Ferry, Idaho 83805

SUBJECT: Opposition to Special Use Permit for
Rawlings Community Counseling to operate a
Mental Health and Addictions Center at
6807 Cody Street, Lot 6, Block 2, Bruce Acre Tracts

In 1975 I moved to Boundary County and have been a resident/
summer resident for 30 years. One of my past employment
positions was with the county assessor's office as a certified
tax appraiser. Due to a career change decision, my wife and
I accepted employment in Alaska. Prior to moving to Alaska,
we purchased the residence located on Lot 1, Block 1, Schlener's
Subdivision as a permanent summer residence and future retirement
home. Since 1989 we have invested considerable resources
developing the property. This includes construction of a
custom designed home, extensive landscaping, and paying the full
tax levied on the property since we were not year round residents.
The property, previously used as a summer home, is now our
permanent retirement residence.

I was a school administrator during my tenure in Alaska. Among
my administrative duties was the task of coordinating mental
health/addiction counseling services for students in rural
Alaskan, native communities. Key to the successful implementation
of counseling services was the ability to build trust and rapport
across multi-cultural, social, and economic obstacles; with and
among clients and clinicians representing public, private, and
corporate counseling groups.

In 2001 I accepted a position in Seward, Alaska as administrator/
liason between the school district and Alaska Department of
Corrections to oversee the development of an alternative high
school providing academic, vocational, mental health and
addiction counseling services to youthful offenders ages 14 to 21
housed inside the Spring Creek Maximum Security Correctional
Facility. I initiated the development and management of an
intra/inter agency intervention team to coordinate a variety of
counseling services for youth assigned to the Youthful Offender
Program. Counseling services were provided by private, federal,
and state organizations. In 2011 my wife and I retired and moved
back to Bonners Ferry to live on property we have owned for the
past 26 years.

Information outlined above is provided to commission members to
establish that my opposition to the Special Use Permit is based
on professional knowledge and experience needed to address the
mental health and addiction counseling of individuals and
subsequent impact on both community needs and private, residential
property rights.

My opposition is predicated by misinformation conveyed to me weeks prior to the submission of the application. Additionally, there is misleading and erroneous information contained in the application document.

In the fall, 2013, while standing at the entrance gate to my property facing Cody Street, a gentleman approached me. He introduced himself as a person affiliated with the group of people inspecting the Bonners Remnant Church property. During the conversation he stated that they were considering making an offer for the property; however, purchase of the property would require submission of a request to change the property from residential to commercial usage. He stated that the group wanted to convert the building into a midwifery facility. Since my property lies directly across from the church property, He wanted to know in advance if I objected to the midwifery facility being located across the street. Our conversation was cordial conveying to me that he was being forthright and transparent in his effort to establish a trusting, positive rapport.

That was the only contact between myself and the prospective buyers. The current owner of the property has made no effort to contact me regarding the sale and the need for a Special Use Permit.

On Saturday, December 7, 2013, I received written notice of the pending public hearing to consider the Special Use Permit. After reviewing the application at City Hall on December 9, 2013, and reviewing public documents at the Boundary County Courthouse on December 10, 2013, I have a number of questions/concerns that have led me to decide to oppose the application for a Special Use Permit:

1. The application is for a Mental Health and Addiction Counseling Center--NOT a Midwifery Facility. A midwifery facility is very different from a Mental Health and Addiction Center. Had the conversation earlier in the Fall included some mention of a Mental Health and Addiction Counseling Center, I would have raised concerns but been willing to postpone making any decision pending a review of specific details pertaining to the intended use of the property.
2. Part B of the application, which states: "The residence to the west does not face Cody Street." is erroneous and misleading. The residence to the west is Lot 1, Block 1, Schlener's Subdivision, the legal location of my retirement home and property. This is a .9 acre, corner lot facing Buchanan Street on the south and Cody Street on the east. The primary entrance to the property is midway in the eastern boundary line or facing the Cody Street location directly west of the existing Bonners Remnant Church building and property.

3. The P&Z Staff Review Page, Proposal Background section of the application is also erroneous and misleading. Sub point 2 states: "The parcel immediately to the west is currently the Lutheran church." This statement does not accurately reflect the geographic location of land parcel locations in the impacted area. The Lutheran Church property is located 2 parcels south of the Bonners Remnant Church property. The Lutheran Church is due west of the Thrift Store and Wells Fargo Bank properties. Please understand that the property immediately to the west of the Bonners Remnant Church property is my retirement home, Lot 1, Block 1, Schlener's Subdivision. The Lutheran Church property is located immediately south of my property fronting Buchanan Street. Reference the attached 2009 Aerial Photograph obtained from the Boundary County Assessor's Office on December 10, 2013.

4. Aside from the sketch of the proposed Mental Health and Addiction Counseling Center, the Special Use Permit lacks specific details on two significant points:

a. Proposed hours of operation: Will they be 8 to 5, on regular work days; 24/7 seven days a week; or some other configuration in order to accommodate clientele?

b. Will the Center be limited to out patient counseling only or is there the option now or in the future to expand services to include emergency, temporary, or permanent residential counseling depending on the needs of clients?

5. Currently there is both a high volume of foot and motorized traffic on Cody Street that contributes to an increased risk of public safety including the intersection of Buchanan Street with Cody Street. During the day regular activities at the Lutheran Church as well as randomly scheduled events i.e. funerals, weddings, the Day Care operation and Second Harvest food distribution all combine to create traffic gridlock on both Cody and Buchanan Streets. This gridlock is impacted by the daily operations of the Wells Fargo Bank's drive up facilities and the customer use of the Thrift Store and indirectly customer use of Yoder's store.

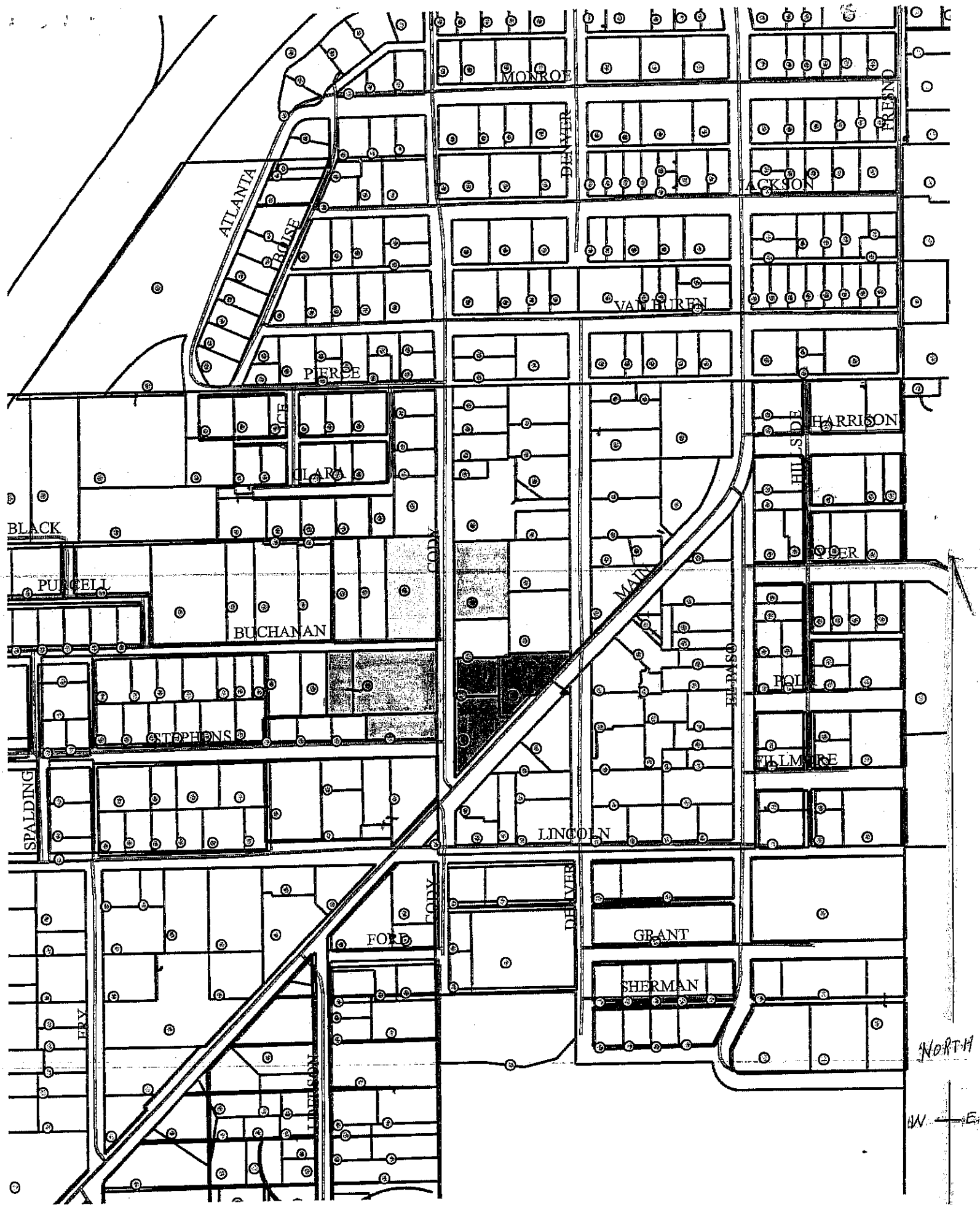
The development of a counseling center would contribute an additional flow of foot and motorized traffic on Cody Street, the primary route of travel for residents and non-residents making use of the existing services.

SUMMARY:


The erroneous and misleading information noted in the special use application coupled with the misleading conversation in Fall 2013 and limited conversations with other residents living in the impact area (all of whom are opposed to development of a counseling center) support one conclusion: Opposition to the Proposal

Sincerely,

Wayne A. Young
WAYNE A. YOUNG







Map Legend:

 Lot 1, BLOCK 1
Schlener's Sub.

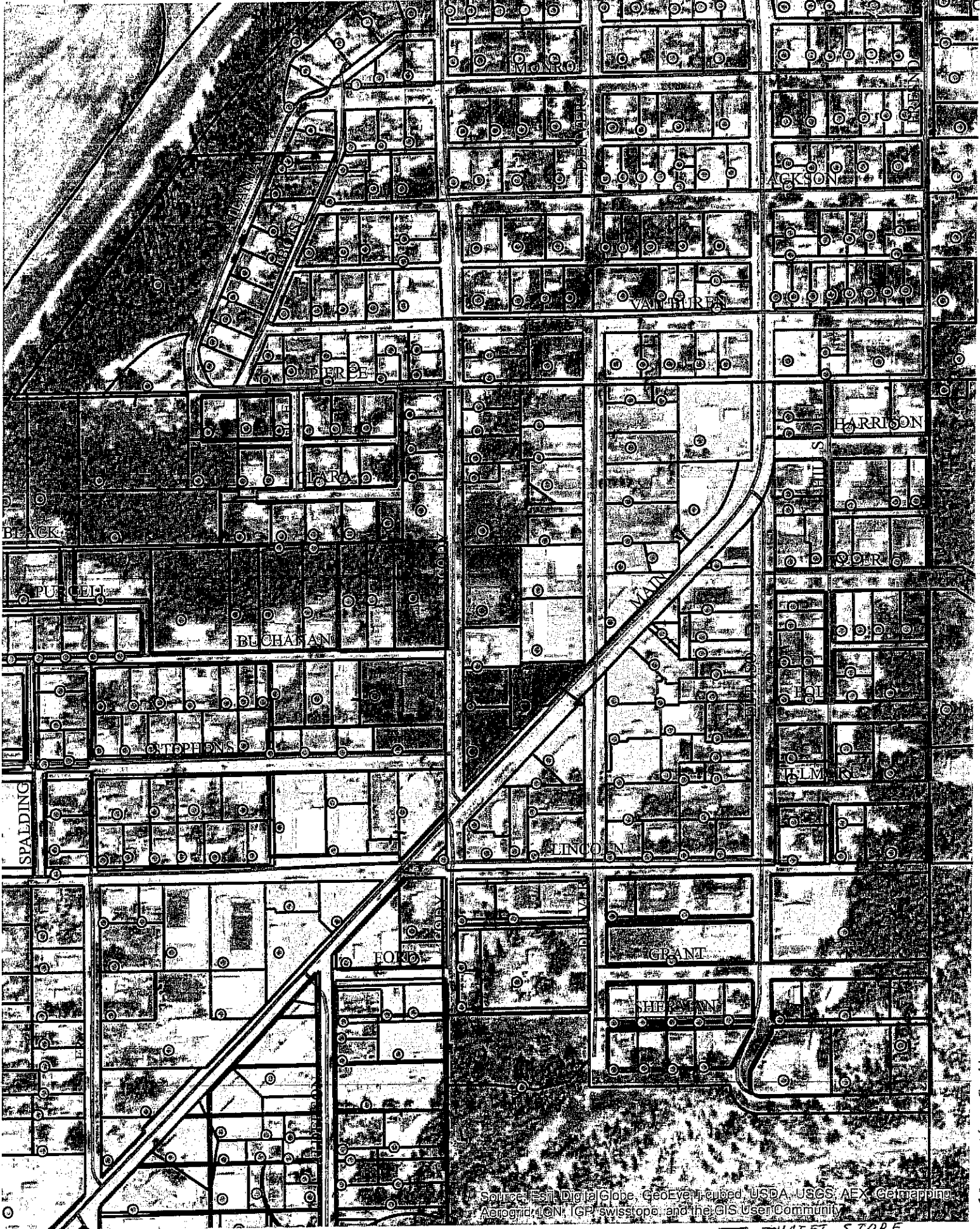


Lot 6, BLOCK 2
Bruce Here Tracts
TAX 3

 LUTHERAN
Church
Property

 THEFT STORE
 WELLS FARGO BANK
 YDDER'S STORE

NORTH
W — E



Source: Esri, DigitalGlobe, GeoEye, Earthstar (USA), USGS, AeroGRID, IGN, IGP, Swisstopo, and the GIS User Community

Map Legend:

Lot 1, Block 1
Schlener's Sub.

Lot 6, Block 2
Bruce Ave Tracts
Tax 3

Lutheran
Church Property

THREFT STORE
WELLS FARGO BANK
YODEK'S STORE



City of Bonners Ferry

Public Hearing Comment Form

Received this yesterday 12/10
which is too late during the
holiday season to make
travel plans to attend.

Please note letter sent to me
was m755 dated 28 December 201

Meeting Date: December 19, 2013

Name DONALD A. HARTMAN

Address 1406 Baron Grove Dr.; Kingwood Tx 77345

Property owner of 6836 Denver St. with ~300' of

Hearing: Special Use Permit Rawlings Community Counseling 6807 Cody St.

frontage on Cody Street's adjacent property owner

Please indicate one of the following:

I Support the proposal

I wish to speak

I am Neutral

I do not wish to speak

I am Opposed to the proposal

Please provide any comments below:

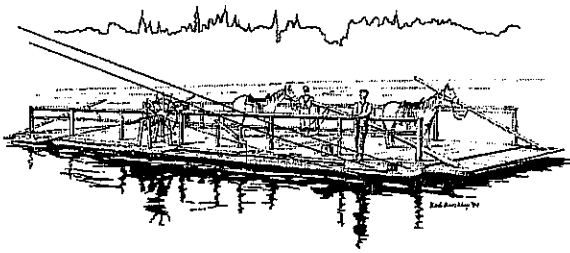
1) the proposed site too close to Valley View School.

2) the proposed site is on A street frequently
used by children walking to and from
Valley View School and neighboring churches

3) this use of the property would further deteriorate
the quality and property values of this
area which is primarily residential.

4) I own adjacent property to the north and within
the next 5 years plan to sell. The frontage on Cody
street could be 2 residential lots. This proposed
use of 6807 Cody Street would substantially reduce
the value of my property

DA Hartman 12/11/2013



City of Bonners Ferry

Public Hearing Comment Form

Meeting Date: December 19, 2013 5:15 PM PST
Name Gregory Lamberty & Colleen Lamberty
Address 6628 Clara St.
Bonnors Ferry ID 83805

Hearing: Special Use Permit Rawlings Community Counseling 6807 Cody St.

Please indicate one of the following:

I Support the proposal

I wish to speak

I am Neutral

I do not wish to speak

I am Opposed to the proposal

Please provide any comments below:

① A facility of this type should not be located
in a residential area.

ⓐ increased crime

ⓑ children put in danger + residents

ⓒ Destroy property values = less city / county
revenue

② A better place would be

ⓐ near a police facility or hospital

ⓑ an area on the outskirts of town

The traffic safety committee meeting of December 17, 2013 convened at noon at City Hall. Present for the meeting were Dick Hollenbeck, Kirk Dixon, Dean Satchwell, Don Lindsay, John Marquette, Silas Thompson, Dave Kramer, Stephen Boorman, John Youngwirth, and Clerk Kris Larson.

Dave Kramer asked if Don, Dean, and John would like to be reappointed to the traffic safety committee. They all agreed.

Dick Hollenbeck moved to approve the traffic safety committee meeting minutes from May 21, 2013. John Marquette seconded the motion. The motion passed, all in favor.

Dave Kramer asked about the conversations of closing off a portion of Augusta Street in front of Valley View School. John Youngwirth said he is against it due to the access that may be needed for police and fire services and also street maintenance. John Marquette asked what the legalities are. Stephen said City Council can manage any city street so they could legally close it if they so desired. Dave Kramer looked at the area last week and monitored traffic, and he does not see a big benefit to closing the street. Dean said the traffic counter gets a lot of traffic volume but many of the vehicles are turning off before they reach Valley View. Dick Hollenbeck asked if it is the accident or if it is a speed issue. Dean said it is not a speed issue according to the traffic counter data. Dick said to put up larger or more signs. John Youngwirth said most people do abide by the slow speed limits but there are younger drivers that sometimes drive too fast. John Youngwirth said he puts pylons out to slow the traffic but someone moves them so the street gets wider than what he would like. Stephen said David Sims is applying for a grant for sidewalks on Augusta Street and this will narrow the street and it should slow traffic down some. Stephen said Main Street is narrower than it used to be and there is also a higher rise in the mid-block crossing that helps slow people down. Silas asked about speed bumps being installed. The group briefly discussed speed bumps. There was also conversation about the buses having to use Spalding Street and that would be too narrow and not a good option for the bus traffic. The group was not in favor of closing the street in front of Valley View. Dean moved not to close the street in front of Valley View. Dick Hollenbeck seconded the motion. The motion passed, all in favor.

The group reviewed the planning and zoning request for 6807 Cody Street for a special use permit for Rawlings Counseling Center. John Marquette asked if Rawlings would be moving from their current location on the Northside. Stephen said they are looking to purchase the building on Cody Street. Silas said Rawlings' business may be increasing a bit. Dean suggested that they be required to use off street parking. The loading expected will be two to 15 individuals per day according to the application. John Marquette thinks it would be an improvement to have someone in the building on Cody Street. Dave Kramer said they will do updates to the landscaping and building according to the application. Silas said there are people that will be dropped off by a van sometimes. John Youngwirth said the driveway goes completely around the building and he thinks it is a good location. Don Lindsay said it is not a hindrance to traffic. John Marquette said he does not see any problems and thinks it should be approved as is. Dick Hollenbeck seconded the motion. The motion passed, all in favor.

The regularly scheduled Planning and Zoning meeting of December 19, 2013 was called to order at 5:15pm by Chairwoman Glenda Poston. Present for the meeting were: Chairwoman Glenda Poston, Planning and Zoning Members Brad Hanson, Marcia Morman, Andy Howe, Dave Gray by phone, City Administrator Stephen Boorman, Office Clerk Christine McNair, City Attorney Andrakay Pluid, Treva Rawlings, Chris Rawlings, Barbara Rawlings, Paul Rawlings, Wayne Young, David Herzog, Cherie Herzog, Ginny Kirsch, Carolyn Testa, Robert Hanover, Brad Buerge, Emmie Dua, Patrick Bennett, Heather Bennett, Gregory Lamberty, Robert Kent, Sean McCoy, Tom Shirley and Erik Friederich.

Glenda opened the hearing for the Special Use Permit for Rawlings Community Counseling at 6807 Cody Street. She also explained how the meeting will proceed.

Stephen gave the staff presentation. He stated that public notice was published in the Herald and sent to all residences within 300 feet. The property already has 23 parking spaces which meets the parking ordinance. Drainage is a consideration for future development of the property. City Attorney stated that the local judicial system uses Rawlings Community Counseling since it is the only local counseling that provides some of the services that the judicial system uses. Traffic Safety Committee met and did not have any issues with this parcel.

Treva Rawlings gave her presentation. Rawlings Community Counseling(RCC) started two years ago with two part time and two full time therapists and a part time receptionist. Outpatient mental health counseling is offer to; children, adolescences, adults, couples, families and veterans. RCC now employs four full time therapists, a full time office manager, a part time receptionist, a part time operations officer and three community based rehabilitation service providers. They are state approved to provide veteran services, Medicaid, Medicare, they also accept insurance and offer a sliding fee scale to those who qualify. Services are not denied due to inability to pay. They **do not** and **will not** offer a sex offender program and **will not** be a residential program. They will improve the Cody Street property by beautification of grounds by landscaping and constant upkeep, facility renovation, all off street parking, one way ingress and egress and establish office hours thus having oversight on the property.

Chris Rawlings spoke about the clients of Rawlings Community Counseling. He said they are our co-workers, friends, family, neighbors, kids, veterans. Fifty percent of RCC's mental health clients and Ninety percent of the community based rehabilitation clients are children. Currently twenty families are receiving services.

Dave Gray asked about lighting for the area. Chris said the plan is to have motion lights in the back, the possibility of a closed circuit tv and lighting in the front for access to the

building. Dave asked if the lighting will be soft or glaring. Paul said the lighting need not be harsh.

Andy asked what the hours of operation will be. Treva said the hours will be Monday-Friday 8am – 8pm and 8am-3pm Saturday and Sunday. The current schedule is 8am-8pm Monday – Saturday.

Marcia stated that there were concerns in the written correspondence regarding unreputable people. She asked what the risks are. Chris said that four percent of their clients have felonies. Treva stated that those individuals are seeking counseling to become productive members of society. Paul stated that in the two years RCC has been in the current location there hasn't been a rise in criminal activity in that area.

Written correspondence was received from Randy Krogseth in support, Robert Kent, Jonathan & Marissa Kyriaco, Wayne Young, Donald Hartman, Gregory & Colleen Lamberty in opposition.

Barb Rawlings read two letters from Debbie Higgins and Jennifer Rucker in support of the Special Use Permit.

Debbie Higgins' letter:

To Whom It May Concern:

I am in full support of Rawlings Community Counseling providing services to our community at the location in question. RCC is providing several services to the community that no one else is. It is vital to the entire community and everyone benefits. It is a quiet, friendly setting with no negative impact on the current neighborhood.

The children and veterans in our community benefit greatly from our services. Common everyday people just like you utilize the services they provide. It would be a tragedy to deny this special use permit.

Please allow the special use permit for the benefit of our children, veterans, senior citizens and neighbors in our community.

Sincerely, Debbie Higgins

Jennifer Rucker's letter:

To Whom It May Concern,

Rawlings Community and the entire staff has been amazing. Even when I haven't been reliable, or down on myself, all I ever had to do is reach out and accept, help advice, care, empathy and the list goes on. When it feels like there's no where to turn, they are all welcoming. You are treated with respect no matter the situation. When I don't feel like I really can open up, it only takes a few encouraging words and smiles from each and everyone of them. Counseling here is still a major work in progress with myself, but with all the help offered. I thank everyone whole heartedly!

Truly, Jennifer Rucker

Chris Rawlings read two letters of support from David & Cherie Herzog and Boundary County Community Justice

David & Cherie Herzog's letter:

We both have used there facility in the past. We have never seen any routy or sespecous activities there. It has always been a friendly and pleasant place to go and to be helped by. The property was always clean from inside to outside. We feel they could make the area look nicer with the building been empty people park cars there and kids are playing around it.

Boundary County Community Justice's letter:

Rawlings Community Counseling is one of the very few sources here in Boundary County, for substance abuse and mental health counseling, and is the only source available in our community, that allows funding through the Access to Recovery grant(ATR), and Substance Use Disorder System(SUDS), funding streams.

Quite often the only thing keeping someone from going to jail is the ability to obtain this state funding to access the counseling that is required. And often, the population of people ordered to obtain counseling, do not have the ability to pay for this counseling and do not have health insurance coverage that will cover all or even part of the cost.

As a probation office we try very hard to limit the amount of recidivism that occurs, and a large majority of our clientele, are as a result of alcohol abuse and or drug use. As a community resource, Rawlings Community Counseling is absolutely essential.

Respectfully, Stacy Brown, Chief Probation Officer.

Brad Buerge spoke in support: He stated for the first time in 50years he'd found help. Without RCC he doesn't think he'd be here.

Treva stated that Brad is able to receive services since he is a veteran and RCC receives funding for veterans.

Emmie Dua spoke is support: She is from Belgium and the mental health facilities there are always in residential areas. She thinks it is a good move for RCC to be closer to the community.

Ron Pell spoke in support: He works for the Idaho State Department of Corrections. He handles all the felonies for Boundary County. Without RCC most of them wouldn't be able to make it. The state requires and pays for counseling. There has been a very good success rate for people getting back into the community and being successful at getting off probation or parole. He said RCC is very needed in this community.

Sean McCoy spoke in support: He said the new location will be easier for people to access. He said the current location didn't look so good until RCC moved in and now it looks beautiful. The new location is currently an eyesore. He knows RCC will make it a really pretty place that is safe for everyone.

Paul Rawlings spoke in support: He is designing a rehabilitation plan for the building and grounds. He has rehabbed at least six properties in the county and is very excited to be involved in making this property a nicer place.

Barb Rawlings spoke in support: She stated that RCC has significantly outgrown their current location. They feel this property is ideal. RCC will be able to vastly improve the property it will also improve the working environment for the employees since there will be more room.

Carolyn Testa spoke in support: She is concerned if the special use permit isn't granted that the building will continue to deteriorate and the weeds will grow and the property will continue to be an eyesore that it has been for many years.

No uncommitted testimony

Gregory Lamberty asked what will happen to property values of the surrounding homes when one of these facilities is in a neighborhood. Glenda explained that the property values for a home is driven by what the homeowner does to their own property not what the neighboring properties do. Stephen stated that no one at the hearing was qualified to answer that question.

Wayne Young stated that his initial opposition was based on erroneous facts and misinformation. He can see this as a positive if it is developed as it has been proposed. He believes that RCC will follow through.

Treva clarified what community based rehabilitation services are: The providers go to the clients. The new location will be within walking distance for the kids that use their services. That way the kids can have earlier appointments.

Glenda closed the public hearing at 6:08pm.

Glenda called the regular meeting to order at 6:08pm.

Andy moved to accept the minutes of the November 15, 2012 meeting. Brad seconded the motion. Motion passed with all in favor.

Andy asked if Residential AA supports a counseling center. Stephen said the city attorney said this is a professional office, so it is allowed in Residential AA.

Brad thinks this is a very good use of a special use permit. The organization is committed to improve the basic character of our community and have a demonstrated skill at it. They are supplying employment within the city limits which is a big positive and they have a proven track record. He is strongly in favor of this.

Brad moved to approve the Special Use Permit for Rawlings Community Counseling at 6807 Cody with the following conditions: Parking as specified by their site map and approved by the parking committee/traffic safety committee with a minimum of 23 sites, 4x5 sign maximum within two feet of the building, no obtrusive lights, motion sensors around the perimeter of the building, hours of operation Monday-Friday 8am-8pm, Saturday & Sunday 8am-3pm. Andy seconded the motion. Motion passed with all in favor.

Dave moved to adjourn. Brad seconded the motion. Motion passed with all in favor.

Glenda Poston, Chairwoman

Attest: _____
Christine McNair, City Office Clerk

WRITTEN DECISION OF THE BONNERS FERRY PLANNING AND ZONING
REGARDING:

The Special Use Permit application of Rawlings Community Counseling for a Counseling Center, in a Residential AA Zone, to be located at 6807 Cody. The legal description of the property is Lot 6, Block 2, Bruce Acre Tracts, Tax 3 in Section 34, Township 62N Range 1E.

The hearing was advertised in the Bonners Ferry Herald and property owners within 300 feet were notified by mail.

CONCLUSIONS:

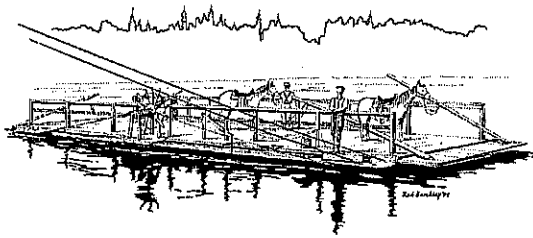
Based upon the factual record compiled and upon testimony received at the public hearing conducted to receive such testimony, the Bonners Ferry Planning and Zoning Commission voted 5 to 0 in favor of the Special Use Application, therefore P & Z does make a recommendation to the Bonners Ferry City Council to approve. The motion did include recommended restrictions as was follows:

- A minimum of 23 parking spaces are to be provided
- Maximum sign size is 4' x 5' and must be located within 2' of the building
- Outdoor lighting to be non-obtrusive and the building to have motion lights installed around the perimeter
- Hours of operation are to be 8 a.m. – 8 p.m. Monday through Friday and 8 a.m. – 3 p.m. Saturday and Sunday

Findings and Conclusions approved on the 19 day of December, 2013.

Bonnors Ferry Planning and Zoning Commission

Glenda Poston, Chairman



MEMO

CITY OF BONNERS FERRY
CITY ADMINISTRATOR

Date: 2 January 2014
To: City Council
From: Stephen Boorman, City Administrator
Subject: Change Order 2 for the Rebuild on Unit 3 at the Power Plant.

This memo is to recommend that the Council approve the attached change order for the amount of \$7,080. This is for the repair of the Intermediate and Lower Guide bearings. Which are identified in the original bid as Alternates B and D.

SJB

CHANGE ORDER

No. 2

DATE OF ISSUANCE 7 January 2014

EFFECTIVE DATE 7 January 2014

OWNER: City of Bonners Ferry

CONTRACTOR: Riverside Inc.

Project: CITY OF BONNERS FERRY MOYIE POWERPLANT UNIT 3 REPAIR

You are directed to make the following changes in the Contract Documents:

Qty	Description	Unit Price	Sub-total
1	Alternate B (Intermediate bearing)		3,740.00
1	Alternate D (Lower Guide bearing)		3,340.00
Total			\$7,080

CHANGE IN CONTRACT PRICE:
Original Contract Price \$ <u>58,800.00</u>
Net Increase (Decrease) from previous Change Orders No. <u> </u> to <u> </u> : \$ <u>11,845.00</u>
Contract Price prior to this Change Order: \$ <u>70,645</u>
Net increase (decrease) of this Change Order: \$ <u>\$7,080</u>
Contract Price with all approved Change Orders: \$ <u>77,725</u>

APPROVED:

By: _____
OWNER (Authorized Signature)

Date: _____

CHANGE IN CONTRACT TIMES:
Original Contract Times: Substantial Completion: <u>60</u> Ready for final payment: _____ (days or dates)
Net change from previous Change Orders No. <u>1</u> to No. <u>1</u> : Substantial Completion: <u>30</u> Ready for final payment: _____ (days)
Contract Times prior to this Change Order: Substantial Completion: <u>90</u> Ready for final payment: _____ (days or dates)
Net increase (decrease) this Change Order: Substantial Completion: <u>0</u> Ready for final payment: _____ (days)
Contract Times with all approved Change Orders: Substantial Completion: <u>90</u> Ready for final payment: _____ (days or dates)

ACCEPTED:

CONTRACTOR(Authorized Signature)

Date: _____

Riverside Inc.



P.O. Box 720 Parma, Idaho 83660
Office 208.722.6731 Fax 208.722.6736
Email riverside@rsicorp.net

12/30/2013

RE: Moyie Power Plant Unit 3 Repair

Dear Stephen

As per our conversation, we are recommending the repairs of:

1. Alternate B- Refurbish intermediate bearing (This bearing is .014" out of round)
2. Alternate D- Refurbish lower guide bearing (This bearing is +.018" to .023" over shaft dimension)

The industry standard is .008" to .010" total clearance.

Rotor test results: shaft is straight, drop test passed, megger one minute = 500v 2206 megohms @9.7 c and the PI test -500v index 0.952. This puts the insulation condition at dangerous with a 10/1-minute ratio (polarization index). We will do another PI test after we clean and bake.

Please contact me if you have any questions.

Sincerely,

Jonathan Kauer
Machine Shop Manager
Riverside Inc.
Office 208.722.6731
Fax 208.722.6736
Cell 208.577.7087
jon@rsicorp.net
www.rsicorp.net



Department of Energy

Bonneville Power Administration
P.O. Box 640
Ronan, MT 59864

POWER SERVICES

December 17, 2013

In reply refer to: PSE-Ronan

Mr Stephen Boorman
City Administrator
City of Bonners Ferry
P.O. Box 149
Bonners Ferry, ID 83805-0149

Dear ^{STEPHEN} Mr Boorman,

Enclosed are two originals of Amendment No. 01 to the City of Bonners Ferry's (Bonners Ferry) Energy Conservation Agreement (Agreement), Contract No. 09ES-11107. This Amendment No. 01 extends the expiration date of the Agreement by one year to September 30, 2015.

If Bonners Ferry finds this Amendment No. 01 offer acceptable, sign and date both originals, and return them to me as soon as practicable but no later than February 28, 2014. I will sign and return a fully executed original for your records.

Please feel free to contact me at (406) 676-2669 if you have any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael R. Normandeau".

Michael R. Normandeau
Account Executive

Enclosures (2)

Amendment No. 01
Contract No. 09ES-11107

AMENDMENT
executed by the
BONNEVILLE POWER ADMINISTRATION
and
CITY OF BONNERS FERRY ELECTRIC DEPARTMENT

This AMENDMENT to Energy Conservation Agreement Contract No. 09ES-11107 (Agreement) is executed by the UNITED STATES OF AMERICA, Department of Energy, acting by and through the BONNEVILLE POWER ADMINISTRATION (BPA) and CITY OF BONNERS FERRY ELECTRIC DEPARTMENT (Bonners Ferry).

This Amendment No. 01 (Amendment) between BPA and Bonners Ferry extends the expiration date of the Agreement by one year.

BPA and Bonners Ferry agree:

1. EFFECTIVE DATE

This Amendment shall take effect on the date executed by the Parties.

2. AMENDMENT OF AGREEMENT

BPA and Bonners Ferry amend the Agreement as follows:

(a) Section 1(a) of the Agreement shall be deleted and replaced by the following:

“(a) This Agreement takes effect on the date signed by both Parties (Effective Date), and expires on September 30, 2015, unless terminated earlier as provided in section 6, Termination. Except as provided for in section 3(c), all liabilities shall remain until satisfied.”

(b) Section 2(h) shall be deleted and replaced by the following:

“(h) “Implementation Period” means the period of time from the Effective Date through September 30, 2015.”

3. SIGNATURES

The Parties have executed this Amendment as of the last date indicated below.

CITY OF BONNERS FERRY
ELECTRIC DEPARTMENT

UNITED STATES OF AMERICA
Department of Energy
Bonneville Power Administration

By: _____

By: _____

Name: _____
(Print/Type)

Name: Michael R. Normandeau
(Print/Type)

Title: _____

Title: Account Executive

Date: _____

Date: _____

December 19, 2013

Christine McNair
City of Bonners Ferry
PO Box 149
Bonners Ferry, ID 83805

RE: Cafeteria Plan Documents

Dear Christine,

As your third party administrator we take pride in making sure the plan documents associated with your Cafeteria Plan are amended as required by law changes enacted by the Internal Revenue Service (IRS), Health and Human Services (HHS) and the Department of Labor (DOL). This past year has seen numerous amendments and enactments to Code Section 125 requiring your Plan document to be completely restated.

The restated Plan document includes changes to eligibility requirements, medical maximum limits, benefit package options, and the carryover option (not currently offered).

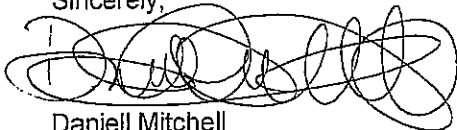
Enclosed are the following documents for your Cafeteria Plan:

1. A bound report containing the following:
 - o Plan Document
 - o Summary Plan Description
 - o Summary of Privacy Practices
 - o Certificate of Corporate Resolution
 - o TPA Service Agreement
 - o Fee Schedule
2. An unbound copy of the Plan Document, Certificate of Corporate Resolution, TPA Service Agreement and the Fee Schedule
3. A copy of the enclosed Summary Plan Description and Certificate of Privacy Practices should be made available to each plan participant.

Please sign the pages marked in the bound report and retain for your files. Please sign the pages indicated on the unbound copies and return to us in the enclosed envelope.

If you have any questions, please do not hesitate to call me.

Sincerely,



Daniell Mitchell
Health Benefit Services
Magnuson, McHugh & Co.

dm
Enclosures

City of Bonners Ferry
Summary Plan Description

INTRODUCTION

We have restated the Cafeteria Plan-Flexible Spending Account employee benefit that is available to our benefited employees. Under this program, you will be able to choose from pre-tax and after-tax benefits. The available benefits and other important information concerning the Plan are outlined in this summary plan description (SPD). The SPD explains your rights under this Plan, many of the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the Plan will control. Also, if there is a conflict between an insurance contract and either the plan document or this summary plan description, the insurance contract will control.

ELIGIBILITY

When Can I Become a Participant in the Plan?

You are eligible to become a Participant in the Plan when you are eligible for our group medical plan.

When does Participation Begin and End in the Cafeteria Plan?

Your participation begins after you complete an Individual Election Form/Salary Reduction Agreement during your open enrollment period and return it to the Human Resource Office within the time period specified in the enrollment materials.

Participation ends if you (a) cease to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) or (b) you don't complete the Election Form during the open enrollment period each year.

The Open Enrollment Period is generally thirty days immediately prior to the start of new Plan Year.

How Do I Enroll to Pay for Benefits on a Pre-Tax Basis?

By completing the Election Form/Salary Reduction Agreement you elect to pay for benefits on a pre-tax basis by designating a salary reduction amount to pay for your share of the cost of coverage (also known as contributions). That contribution amount pays for your coverage by having that portion deducted from each paycheck on a pre-tax basis, generally an equal portion from each paycheck throughout the year.

OPERATION

How Does This Plan Operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts which must be set up for you in order to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket,

taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

CONTRIBUTIONS

How Much of My Pay May the Employer Redirect?

Each year, you may elect to have us contribute on your behalf a certain amount of your compensation based on your annual election. These amounts will be deducted from your pay over the course of the year. The amounts which may be redirected have certain limitations as follows:

Health Care Reimbursement Fund	\$ 2,500
Dependent Care Assistance Program	\$ 5,000

What Tax Savings are Possible Under the Salary Reduction Plan?

You may save federal income tax, state income tax (if applicable) and FICA (Social Security) taxes by participating in the Cafeteria Plan.

What Happens to Contributions Made to the Plan?

Before each Plan Year begins, you will select the non-insured benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year. Your employer may also contribute to the plan on your behalf. If so, the employer will determine prior to the beginning of each plan year how much it will contribute and communicate this to the employees.

When Is the "Election Period" for Our Plan?

Your election period will start on the date you first meet the "eligibility requirements" and end 30 days after your "entry date." (You should review Section I on Eligibility to better understand the terms "eligibility requirements" and "entry date.") Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period.

May I Change My Elections During the Plan Year?

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. For all benefits except health benefits, you are permitted to change if there is a change in your family status. Currently, Federal law considers the following events to be examples of a change in family status:

- You get married or divorced.
- You have a child or adopt one.
- Your spouse and/or child(ren) die(s).
- Your spouse commences or terminates employment.
- Your or your spouse's employment status changes from full-time to part-time or from part-time to full-time.
- You or your spouse takes an unpaid leave of absence.

There may be other events which are considered to be a change in family status. Also, any election change must be consistent with the reason that such change was permitted.

For health benefits, there are also certain limited situations when you can change your elections. You are permitted to change elections if you have a change in status which results in you, your spouse or dependent gaining or losing eligibility for coverage under our health plan or your spouse's or dependent's health plan, and the change you make is consistent with that gain or loss of coverage. Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Termination or commencement of employment by you, your spouse, or dependent;
- A reduction or increase in hours of employment by you, your spouse or dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence or worksite of you, your spouse or dependent.

If you have a change in family status or a change in status, you should contact the Administrator, who will provide you with the required forms for changing your benefit elections.

In addition, for health insurance premiums being contributed to the Plan, we will adjust the salary redirection election you have made for the remainder of the Plan Year if there is a change in the premium expense. If the increase in premium expense is significant, we will let you either change the salary redirection election or revoke your election entirely and, in lieu thereof, elect to receive on a prospective basis, coverage under another health plan with similar coverage.

May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the "election period" before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

BENEFITS

What Benefits Are Available?

Health Care Reimbursement Plan:

The Health Care Reimbursement Plan enables you to pay for expenses which are not covered by our insured medical plan or privately held insurance policies and save taxes at the same time. The account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and vision expenses incurred by you and your dependents. Effective March 30, 2010, the definition of "Dependent" was amended to include any child of the Participant who as of the end of the taxable year has not attained age 27, and any child of the Participant who is a child(ren) of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year; or may be covered by the requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

The expenses which qualify are those permitted by Section 213 of the Internal Revenue Code. A list of covered expenses is available from the Administrator. As of January 1, 2011, a doctor's prescription is required for reimbursement of over-the-counter medicines or drugs purchased after December 31, 2010 except Insulin. Over-the-counter items that are not a medicine or drug do not require a prescription. The Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied.

You may not, however, be reimbursed for the cost of long-term care expenses.

The most that you can contribute to your Health Care Reimbursement Plan each Plan Year is \$2,500.00 (indexed for inflation after 2013). In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month.

Limited Health Care Reimbursement Plan (if applicable):

The Limited Health Care Reimbursement Plan enables you to pay for expenses which are not covered by our insured medical plan or privately held insurance policies and save taxes at the same time. The account is limited to allow reimbursement by the Employer for out-of-pocket dental, vision and preventative care expenses only. The expenses may be for you and your dependents.

In order to be reimbursed for a Limited FSA expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month.

Health Savings Account (if applicable):

The HSA is not an employer-sponsored employee benefit plan – it is an individual account that the employee opens with an HSA trustee, typically a bank to be used primarily for reimbursement of "eligible medical expenses". The HSA trustee is chosen by you and will establish and maintain your HSA. All Code §223 expenses qualify for reimbursement from this account.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA option is selected. To be an HSA-Eligible Individual you must meet certain requirements under Code §223 and have elected High Deductible Health Plan coverage. Please be aware that coverage under a Spouse's plan could make you ineligible.

In addition, the total of employee and employer annual contributions is limited by IRS Code and may be pro-rated by the number of months in which you are an HSA-Eligible Individual. For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what is a qualifying High Deductible Health Plan, contributions to and distributions from the HSA) please refer to your HSA agreement provided to you by your HSA trustee. You may also review IRS Publication 969.

Dependent Care Assistance Account:

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws.
- An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An "Individual" who provides care inside or outside your home. The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$200 for one dependent or \$400 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this

Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you.

Premium Expense Account (if applicable):

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan, if deducted from your payroll.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

BENEFIT PAYMENTS

When Will I Receive Payments From My Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not when it is paid for or billed. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the expense qualifies you will receive a reimbursement payment soon thereafter. If available, you may use a Flex debit card (if applicable) to pay for eligible medical expenses for yourself, your spouse and your dependents. Use of the card certifies any expense paid with the card has not been and will not be reimbursed under any other health benefit plan. Most card swipes are automatically substantiated but on occasion you may be asked to submit copies of the receipt or an explanation of benefits. Always keep your receipts as this is an IRS requirement. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Assistance Account to the extent that there are sufficient funds in the Account to cover your request.

What Happens If I Don't Spend All Plan Contributions?

Any funds left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Care Reimbursement Plan. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. However, for the Health Care Reimbursement Plan, the expenses you incur during that lapse in coverage are not reimbursable and your maximum amount will be reduced proportionately for the time that you were gone.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Care Reimbursement Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

What Happens If I Terminate Employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate.
- You may submit claims with a date of service between the plan start date and your termination date, you have 90 days to submit the claims. If eligible, you may also elect to continue participation in the Health Care Reimbursement Plan for the remainder of the Plan Year if you are unable to provide claims with a date of service prior to your termination date. However, to do so, you must continue to pay the required contribution even though you are no longer employed. However, these contributions will be made with your after-tax funds. You will be entitled to reimbursements as long as you contribute to the plan.

What is "Continuation Coverage" and How Does it Work?

"Continuation Coverage" means your right, or your spouse and dependents' right, to continue to be covered under the Health Care reimbursement Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours.
- Your death.
- Divorce or legal separation from your spouse.
- You're becoming entitled to receive Medicare benefits.
- When a dependent of yours ceases to be a dependent.

For a Qualifying Event, other than a change in your employment status, it will be your obligation to inform the appropriate Plan Administrator of each medical benefit plan you have elected of its occurrence within 60 days of the occurrence. You as a Participant in the Health Care Reimbursement Plan will be eligible for COBRA Continuation Coverage if you have a positive Medical Care Expense Reimbursement Account balance at the time of a Qualifying Event (taking into account all claims submitted before the date of the qualifying event). You will be notified if you are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the qualifying event occurs, COBRA coverage for the Medical Care Expense Reimbursement Account will cease at the end of the year and cannot be continued for the next Plan Year. You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage costs.

Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

HIGHLY COMPENSATED AND KEY EMPLOYEES

Do Limitations Apply to Highly Compensated Employees?

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a "highly compensated employee" or a "key employee."

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

PLAN ACCOUNTING

Periodic Statements

Account information including account balance is available through the web site at www.mmcccpa.com. It is important to periodically review your account so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

General Plan Information

City of Bonners Ferry Cafeteria Plan is the name of the Plan.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on November 1 and ends on October 31.

Employer Information

Your Employer's name, address, and identification number are:

City of Bonners Ferry
PO Box 149
Bonners Ferry, ID 83805

Plan Administrator Information

Your employer is the Plan Administrator who has engaged the following subcontractor to perform administrative services for the Plan:

Magnuson, McHugh & Company, P.A.
P.O. Box 2260
Coeur d'Alene, Idaho 83816-2260
(208) 765-9500

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

City of Bonners Ferry
PO Box 149
Bonners Ferry, ID 83805

Type of Administration

The type of Administration is Employer Administration.

ADDITIONAL PLAN INFORMATION

Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- (a) examine, without charge, at the Administrator's office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and
- (b) obtain copies of all Plan documents and other Plan information upon request to the Administrator. The Administrator may charge a reasonable fee for the copies.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit 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 your claim reviewed and 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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$100 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's funds, 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.

Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than 90 days after the end of a Plan Year. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be reviewed in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan

on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If we fail to respond within 90 days, your claim is treated as denied. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our Cafeteria Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Summary of Privacy Practices

This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by your Employer's Health Flexible Spending Account and/or Health Reimbursement Arrangement (the "Plan") or others in the administration of your claims, and certain rights that you have. For a complete detailed description of all privacy practices, as well as your legal rights, please request a full Privacy Practices Notice from your employer.

Our Pledge Regarding Medical Information

We are committed to protecting your personal health information.

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- make available to you a copy of the Privacy Practice Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Medical Information About You

We may use and disclose your personal health information without your permission to facilitate your medical treatment, for payment for any medical treatments, and for any other health care operation. We will disclose your medical information to your employer's representative for plan administration functions; but that representative may not share your information without your permission as allowed or required by law. Otherwise, we must obtain your written authorization for any other use and disclosure of your medical information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given.

Your Rights Regarding Your Medical Information

You have the right to inspect and copy your medical information, to request corrections of your medical information and to obtain an accounting of certain disclosures of your medical information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your medical information, or that communications about your medical information be made in different ways or at different locations.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to:

- your past, present, or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present, or future payment for the provision of health care to you

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact your employer's privacy officer. All complaints must be submitted in writing. We will not retaliate against you for making a complaint.

If you have any questions about this Notice or about our privacy practices, please request a paper copy of the complete Privacy Practice Notice from your employer.

This Notice is effective January 1, 2014

**City of Bonners Ferry
Cafeteria Plan**

**ARTICLE I
INTRODUCTION**

1.1 Establishment of Plan

City of Bonners Ferry (the Employer) originally established the City of Bonners Ferry Cafeteria Plan (the Plan) effective November 1, 2004, and hereby restates the Plan as of January 1, 2014.

Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions under the Medical Insurance Plan, a separate Dental Insurance Plan or a separate Vision Insurance Plan on a pre-tax Salary Reduction basis and to contribute on a pre-tax Salary Reduction basis to an Employee's health savings account (HSA) if applicable, to an account for reimbursement of certain Medical Care Expenses (Health FSA Account), and/or to an account for reimbursement of certain Dependent Care Expenses (DCAP Account).

1.2 Legal Status

This Plan is intended to qualify as a cafeteria plan under Code § 125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a self-insured medical reimbursement plan under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b). The DCAP Component is intended to qualify as a dependent care assistance program under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a).

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of ERISA, HIPAA, and COBRA. If applicable, the HSA funding feature described in the HSA Component is not intended to establish an ERISA plan or to otherwise be part of an ERISA benefit plan. In the event that the Health FSA Component is determined not to be a separate plan, the Plan shall be designated as a hybrid entity for purposes of HIPAA, such that it shall be a covered entity only with respect to the Health FSA Component.

**ARTICLE II
DEFINITIONS**

2.1 Account(s) means the Health FSA Accounts and the DCAP Accounts described in Section 7.5 for Health FSAs, and Section 9.5 for DCAPs. In some contexts, the term Account(s) may also include the record of HSA Contributions described in Section 8.3, if applicable.

2.2 Benefits means the Premium Payment Benefits, the Health FSA Benefits, the HSA Benefits (if applicable), and the DCAP Benefits offered under the Plan.

2.3 Benefit Package Option means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

2.4 Change in Status means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- (a) *Legal Marital Status*. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;
- (b) *Number of Dependents*. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;
- (c) *Employment Status*. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;
- (d) *Dependent Eligibility Requirements*. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and
- (e) *Change in Residence*. A change in the place of residence of the Participant or his or her Spouse or Dependents.

2.5 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.6 **Code** means the Internal Revenue Code of 1986, as amended.

2.7 **Contributions** means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, Section 8.2 for HSA Benefits, and Section 9.2 for DCAP Benefits.

2.8 **Committee** means the Benefits Committee appointed by the Board of Directors of the employer.

2.9 **Compensation** means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

2.10 **DCAP** means dependent care assistance program.

2.11 **DCAP Account** means the account described in Section 9.5.

2.12 **DCAP Benefits** has the meaning described in Section 9.1.

2.13 **DCAP Component** means the component of this Plan described in Article IX.

2.14 **Dental Insurance Benefits** means the Employee's Dental Insurance Plan coverage for purposes of this Plan.

2.15 **Dental Insurance Plan** means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing dental type benefits through a group insurance policy or policies, if separate from the Medical Insurance Plan. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

2.16 **Dependent** means: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent as defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Component, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

- 2.17 Dependent Care Expenses** has the meaning described in Section 9.3.
- 2.18 Earned Income** shall have the meaning given such term in Code § 129(e)(2).
- 2.19 Effective Date** of this Plan means November 1, 2004.
- 2.20 Election Form/Salary Reduction Agreement** means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following (if applicable): Premium Payment Benefits, Health FSA Benefits, HSA Benefits, and DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.
- 2.21 Eligible Employee** means an Employee eligible to participate in this Plan, as provided in Section 3.1.
- 2.22 Employee** means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.
- 2.23 Employee-Only Health FSA Option** has the meaning described in Section 7.3(b).
- 2.24 Employer** means City of Bonners Ferry, and any Related Employer that adopts this Plan with the approval of City of Bonners Ferry Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Articles IX and XIV and Section 15.3, "Employer" means only City of Bonners Ferry.
- 2.25 Employment Commencement Date** means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.
- 2.26 ERISA** means the Employee Retirement Income Security Act of 1974, as amended.
- 2.27 FMLA** means the Family and Medical Leave Act of 1993, as amended.
- 2.28 General-Purpose Health FSA Option** has the meaning described in Section 7.3(b).
- 2.29 Grace Period** means the period that begins immediately following the close of a Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year.
- 2.30 Health FSA** means health flexible spending arrangement, which consists of three options: the General-Purpose Health FSA Option; the Limited (Vision/Dental/Preventive Care) Health FSA Option; and the Employee-Only Health FSA Option.
- 2.31 Health FSA Account** means the account described in Section 7.5.
- 2.32 Health FSA Benefits** has the meaning described in Section 7.1.
- 2.33 Health FSA Component** means the component of this Plan described in Article VII.
- 2.34 High Deductible Health Plan** means the high deductible health plan offered by the Employer as a Benefit Package Option under the Medical Insurance Plan that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials provided separately by the Employer.
- 2.35 HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.
- 2.36 HMO** means the health maintenance organization Benefit Package Option under the Medical Insurance Plan.
- 2.37 HSA** means a health savings account established under Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian. Even though funded by Salary Reduction under this Plan, the HSA is not part of or intended to be part of an ERISA-covered benefit plan.
- 2.38 HSA Benefits** has the meaning described in Section 8.1.

- 2.39 HSA-Eligible Individual** means an individual who is eligible to contribute to an HSA under Code § 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.
- 2.40 Limited (Vision/Dental/Preventive Care) Health FSA Option** has the meaning described in Section 7.3(b).
- 2.41 Medical Care Expenses** has the meaning described in Section 7.3.
- 2.42 Medical Insurance Benefits** means the Employee's Medical Insurance Plan coverage for purposes of this Plan.
- 2.43 Medical Insurance Plan** means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies (with HMO, PPO, and High Deductible Health Plan options). The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.
- 2.44 Open Enrollment Period** with respect to a Plan Year means one month immediately preceding the new Plan Year, or such other period as may be prescribed by the Administrator.
- 2.45 Participant** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect the Premium Payment Benefit, Health FSA Benefits, HSA Benefits, DCAP Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Medical, Dental and Vision Insurance Plans (if any) with after-tax dollars outside of this Plan and who have not elected any Health FSA Benefits, HSA Benefits, or DCAP Benefits.
- 2.46 Period of Coverage** means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.
- 2.47 Plan** means the City of Bonners Ferry Salary Reduction Plan as set forth herein and as amended from time to time.
- 2.48 Plan Administrator** means City of Bonners Ferry The contact person is the Human Resources Manager or other designated person for City of Bonners Ferry who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 13.1.
- 2.49 Plan Year** means the fiscal year (i.e., the 12-month period commencing November 1 and ending on October 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.
- 2.50 PPO** means the preferred provider organization Benefit Package Option under the Medical Insurance Plan.
- 2.51 Premium Payment Benefits** means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.
- 2.52 Premium Payment Component** means the component of this Plan described in Article VI.
- 2.53 Prior Plan Year Health FSA Amounts** has the meaning described in Section 7.4(f).
- 2.54 QMCSO** means a qualified medical child support order, as defined in ERISA § 609(a).
- 2.55 Qualifying Dependent Care Services** has the meaning described in Section 9.3.
- 2.56 Qualifying Individual** means (a) a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1); (b) a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

2.57 Related Employer means any employer affiliated with City of Bonners Ferry that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with City of Bonners Ferry for purposes of Code § 125(g)(4).

2.58 Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

2.59 Spouse means an individual who is legally married to a Participant as determined under applicable state law and who is treated as a spouse under the Code. Notwithstanding the above, for purposes of the DCAP Component the term Spouse shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

2.60 Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

2.61 Vision Insurance Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing vision type benefits through a group insurance policy or policies, if separate from the Medical Insurance Plan. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

ARTICLE III ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan (including, if applicable, the Premium Payment Component, the Health FSA Component, the HSA Component, and the DCAP Component) as of the date he satisfies the eligibility conditions for the employer's group medical plan. Eligibility for Premium Payment Benefits shall also be subject to the additional requirements, if any, specified in the Medical, Dental and Vision Insurance Plans. To participate in the HSA Component (if applicable), the individual must be an HSA-Eligible Individual and shall also be subject to the additional requirements, if any, specified in the High Deductible Health Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the following month, not to exceed 90 calendar days, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- (a) the termination of this Plan; or
- (b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits, Section 7.8 for Health FSA Benefits and Section 9.8 for DCAP Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical, Dental and Vision Insurance Benefits will terminate as of the date(s) specified in the Medical, Dental and Vision Insurance Plans. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 9.8 for DCAP Benefits.

Distributions from a Participant's HSA (whether before or after termination of employment) and all other matters relating to a Participant's HSA are outside of this Plan and are to be handled by the Participant and his or her trustee/custodian in accordance with the agreement between them— see Article VIII.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical Insurance Plan, the separate Dental Insurance Plan or the separate Vision insurance Plan (if applicable) is reinstated. Likewise, an HSA Benefit, if applicable, election will only be reinstated if an individual is an HSA-Eligible Individual. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) *Health Benefits.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical, Dental and Vision Insurance Benefits, HSA Benefits (if applicable), and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require participants to continue all Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits and Health FSA Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, and Health FSA Benefits (if applicable) during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, and Health FSA Benefits (if applicable) during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be

withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, or Health FSA Benefits (if applicable), as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

- (b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 12.3(d) will apply.

ARTICLE IV METHOD AND TIMING OF ELECTIONS

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan midyear may elect to commence participation in one or more Benefits on the first day of the month after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 12.3. Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The

Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 12.3.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a midyear election change, as described under Section 12.3 or 12.4. If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Medical Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a midyear election change as described under Section 12.3), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article XII), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

- (a) Premium Payment Benefits (if applicable), as described in Article VI;
- (b) Health FSA Benefits, as described in Article VII. The Health FSA election may be for any one of the following (if applicable):
 - General-Purpose Health FSA Option;
 - Limited (Vision/Dental/Preventive Care) Health FSA Option;
 - Employee-Only Health FSA Option; or
- (c) HSA Benefits (if applicable) as described in Article VIII; and
- (d) DCAP Benefits, as described in Article IX.

HSA Benefits (if applicable) cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who has an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA Account is \$0 as of the last day of that Plan Year. For this purpose, a Participant's Health FSA Account balance is determined on a cash basis—that is, without regard to any-claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

In no event shall Benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during the Grace Period (if applicable), as provided in Article VII or amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be applied to the Carryover (if applicable), up to the maximum eligible amount of \$500, as provided in Article VII. In addition, a Participant's Salary Reductions during a Plan Year under the

Premium Payment Component may be applied by the Employer to pay the Participant's share of the Contributions for Medical Insurance Benefits that are provided to the Participant during the Grace Period immediately following the close of that Plan Year. No Grace Period is currently available for DCAP Benefits.

5.2 Employer and Participant Contributions

- (a) *Employer Contributions.* For Participants who elect Medical Insurance Benefits described in Article VI, the Employer may contribute a portion of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement.
- (b) *Participant Contributions.* Participants who elect any of the Medical Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after tax deductions, by completing an Election Form/Salary Reduction Agreement. Participants who elect Health FSA Benefits, HSA Benefits (if applicable), or DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

- (a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits (if applicable), Section 7.2 for Health FSA Benefits, Section 8.2 for HSA Benefits (if applicable), and Section 9.2 for DCAP Benefits, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component, HSA Component (if applicable), or DCAP Component to the extent permitted under Section 12.3, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 12.3, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).
- (b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits (if applicable), Health FSA Benefits, HSA Benefits (if applicable), and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits (if applicable), as described in Section 6.2; and (b) as described under Section 7.4(b) for Health FSA Benefits, Section 8.2 for HSA Benefits (if applicable), and Section 9.4(b) for DCAP Benefits.

ARTICLE VI PREMIUM PAYMENT COMPONENT

6.1 Benefits

The Premium Payment Component offers benefits under the Medical Insurance Plan, providing major medical benefits (with PPO, HMO, and High Deductible Health Plan options), and the Dental and/or Vision Insurance Plan. Notwithstanding any other provision in this Plan, the Medical, Dental and Vision Insurance Benefits are subject to the terms and conditions of the Medical, Dental and Vision Insurance Plans, and no changes can be made with respect to such Medical, Dental and Vision Insurance Benefits under this Plan (such as midyear changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Medical, and/or Dental and/or Vision Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and pay for his or her share of the Contributions, if any, for Medical, Dental and Vision Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates. A Participant's Salary Reductions during a Plan Year under the Premium Payment Component may be applied by the Employer to pay the Participant's share of the Contributions for Medical and/or Dental and/or Vision Insurance Benefits that are provided to the Participant during the period that begins immediately following the close of that Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Benefits Provided Under the Medical, Dental and/or Vision Insurance Plans

Medical, Dental and/or Vision Insurance Benefits will be provided by the Medical, Dental and/or Vision Insurance Plans, not this Plan. The types and amounts of Medical, Dental and/or Vision Insurance Benefits, the requirements for participating in the Medical, Dental and/or Vision Insurance Plans, and the other terms and conditions of coverage and benefits of the Medical, Dental and/or Vision Insurance Plans are set forth in the Medical, Dental and/or Vision Insurance Plans. All claims to receive benefits under the Medical, Dental and/or Vision Insurance Plans shall be subject to and governed by the terms and conditions of the Medical, Dental and/or Vision Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical, Dental and/or Vision Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical, Dental and/or Vision Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical, Dental and/or Vision Insurance Plans the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage for Medical, Dental and/or Vision Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical, Dental and/or Vision Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

- Limited (Vision/Dental/Preventive Care) Health FSA Option (if applicable). For purposes of this Option, Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care as defined in Code § 213(d) and as further described under the General Purpose Health FSA Option— provided, however, that such expenses are for vision care and dental care (as defined in Code § 223(c)) only.
- Employee-Only Health FSA Option (if applicable). For purposes of this Option, Medical Care Expenses means expenses incurred by a Participant (but not by his or her Dependent or Spouse) for medical care as defined in Code § 213(d) and as further described under the General Purpose Health FSA Option.

7.4 Maximum and Minimum Benefits for Health FSA

- (a) *Maximum Reimbursement Available*; Uniform Coverage. The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8 or is entitled to submit expenses incurred during a Grace Period, if applicable, as provided in Section 7.4(f) or is entitled to the Carryover option, if applicable, as provided in Section 7.4(g).
- (b) *Maximum Dollar Limit*. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be \$2,500 (as adjusted for inflation pursuant to Code § 125(i)), subject to Section 7.5(c). Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.
- (c) *Changes*; No Proration. For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document, provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code § 125(i). If a Participant enters the Health FSA Component midyear or wishes to increase his or her election midyear as permitted under Section 12.3, then there will be no proration rule— i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable. Notwithstanding the foregoing, the Plan Administrator may limit the elections of a Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the requirements of Code § 125(i).
- (d) *Effect on Maximum Benefits If Election Change Permitted*. Any change in an election under Article XII (other than under Section 12.3(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 12.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.
- (e) *Monthly Limits on Reimbursing OTC Drugs*. Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's Health FSA Account in a single calendar month (even assuming that the drug otherwise meets the requirements of this Article VII, including that it has been prescribed (unless it is insulin) and is for medical care under Code § 213(d)); stockpiling is not permitted.

(f) *Grace Periods (if applicable)*; Special Rules for Claims Incurred During a Grace Period. Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 7.4(b), an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Health FSA Amounts") if he or she is either: (1) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

- Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.
- Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 7.7 will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Medical Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Health FSA Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year Health FSA Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.
- Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than 90 days following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.6(b).

(g) *Carryover (if applicable)*; Special Rules apply for remaining amounts in his or her Health FSA Account at the end of the Plan year. The Plan shall provide for a carryover of up to \$500 of any amount unused in a Health FSA as of the end of the Plan year. Such carryover amount may be used to pay or reimburse medical expenses under the Health FSA incurred during the entire Plan year to which it is carried over. Notwithstanding the foregoing, any Plan participant shall have the right to change to a Limited Health FSA if such participant has already enrolled in a health care savings account for the following Plan year. Remaining unused amounts (up to \$500) that are carried over will be added to the amount elected (\$2,500 maximum (as adjusted for inflation pursuant to Code § 125(i)), subject to Section 7.5(c)) for the following plan year.

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

- (a) *Crediting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.
- (b) *Debiting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period (or for reimbursement of Medical Care Expenses incurred during any Grace Period (if applicable) or carryover (if applicable) to which he or she is entitled as provided in Section 7.4(f)).
- (c) *Available Amount Not Based on Credited Amount*. As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of

Coverage (or during the Grace Period if applicable); it is not based on the amount credited to the Health FSA Account at a particular point in time except as provided in Section 7.4(f). Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan (with the exception of the carryover option, if applicable).

7.6 Forfeiture of Health FSA Accounts

- (a) **Use-or-Lose Rule** (applies only to Grace Periods (if applicable)). Except as otherwise provided in Section 7.4(f) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.
- (b) **Carryover Option** (if applicable). Except as otherwise provided in Section 7.4(g) (regarding certain individuals who may carryover up to \$500 from the Prior Plan Year Health FSA), if any balance over \$500 remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.
- (c) **Use of Forfeitures.** All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA

- (a) **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.
- (b) **Claims Substantiation.** A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 90 days following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 7.8) setting forth:
- the person(s) on whose behalf Medical Care Expenses have been incurred;
 - the nature and date of the Expenses so incurred;
 - the amount of the requested reimbursement;
 - a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and

- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Participant's Health FSA Account for a Plan Year or other Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least \$10. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.

(d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise re-characterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA (if applicable)

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in Section 7.4(f) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period, if applicable), the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (or during any Grace Period, if applicable, to which he or she is entitled as provided in Section 7.4(f)), provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Notwithstanding the foregoing, a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of a Plan Year may be entitled to reimbursement of Medical Care Expenses incurred during the Grace Period, if applicable, following that Plan Year in accordance with the provisions of Section 7.4(f).

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and

consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

7.9 Named Fiduciary for Health FSA

City of Bonners Ferry is the named fiduciary for the Health FSA Component for purposes of ERISA § 402(a).

7.10 Coordination of Benefits With HSA (if applicable)

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan. Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health FSA and the HSA (if applicable), the Participant may choose to seek reimbursement from either the health FSA or the HSA, but not both.

ARTICLE VIII HSA COMPONENT (if applicable)

8.1 HSA Benefits

An Eligible Employee can elect to participate in the HSA Component by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Plan). As described in Article XII, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who has an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA Account is \$0 as of the last day of that Plan Year.

8.2 Contributions for Cost of Coverage for HSA; Maximum Limits

The annual Contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant, but in no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the Contribution is made (\$3,250 for single and \$6,450 for family are the statutory maximum amounts for 2013).

An additional catch-up Contribution of \$1,000 may be made for Participants who are age 55 or older. In addition, the maximum annual Contribution shall be:

- (a) reduced by any matching (or other) Employer Contribution made on the Participant's behalf (there are currently no such Employer Contributions (other than pre-tax Salary Reductions) made under the Plan); and
- (b) prorated for the number of months in which the Participant is an HSA-Eligible Individual.

8.3 Recording Contributions for HSA

As described in Section 8.5, the HSA is not an employer-sponsored employee benefit plan— it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Participant, not by the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax Salary Reductions— such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Reductions, but it

will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in a HSA.

8.4 Tax Treatment of HSA Contributions and Distributions

The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.

8.5 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan

HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

ARTICLE IX DCAP COMPONENT

9.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XII), such election of DCAP Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

9.2 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 9.4(b). (For example, if the maximum \$5,000 annual benefit amount is elected, then the annual Contribution amount is also \$5,000.)

9.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- (a) *Incurred.* A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).
- (b) *Dependent Care Expenses.* "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services— provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article IX.
- (c) *Qualifying Dependent Care Services.* "Qualifying Dependent Care Services" means services that: (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to

remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(d) *Exclusion.* Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;
- a Participant's child (as defined in Code § 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant's under age 13 qualifying child as defined in Code § 152(a)(1) (e.g., a former spouse who is the child's noncustodial parent).

9.4 Maximum and Minimum Benefits for DCAP

(a) *Maximum Reimbursement Available.* The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 9.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements).) Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article IX have been satisfied.

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

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse who is not employed during a month in which the Participant incurs a Dependent Care Expense and is either (1) physically or mentally incapable of self-care, or (2) a Student shall be deemed to have Earned Income in the amount specified in Code § 21(d)(2)); or
- either \$5,000 or \$2,500 for the calendar year, as applicable:

(1) \$5,000 for the calendar year if one of the following applies:

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

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

- (c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 12.3, then there will be no proration rule— i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.
- (d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 9.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

9.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 9.6.

- (a) *Crediting of Accounts.* A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.
- (b) *Debiting of Accounts.* A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
- (c) *Available Amount Is Based on Credited Amount.* As described in Section 9.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

9.6 Forfeiture of DCAP Accounts; Use-or-Lose Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing DCAP Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

9.7 Reimbursement Claims Procedure for DCAP

- (a) *Timing.* Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional

15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims.* A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than 90 days following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 90 days after the date that eligibility ceases, as described in Section 9.8), setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 9.4(b); and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least \$10.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.

9.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible, with one exception: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred in the month following termination of employment or other cessation of eligibility if such month is in the current Plan Year, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible.

ARTICLE X HIPAA PROVISIONS FOR HEALTH FSA

10.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article X:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to

a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer shall have access to PHI from the Health FSA only as permitted under this Article X or as otherwise required or permitted by HIPAA. HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), the statutory provisions of which are incorporated herein by reference.

10.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

10.3 Permitted Uses and Disclosure of Summary Health Information

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

10.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 10.5 and obtaining written certification pursuant to Section 10.7, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

10.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer shall:

- not use or further disclose the PHI other than as permitted or required by the Health FSA or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Health FSA and the Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

10.6 Adequate Separation Between Plan and Employer

The Employer shall allow access to PHI: only to certain designated persons; and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 10.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

10.7 Certification of Plan Sponsor

The Health FSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Health FSA incorporates the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5.

10.8 Privacy Official

The Privacy Official shall be responsible for compliance with the Employer's and the Health FSA's obligations under this Article and HIPAA. Specific rules regarding the Privacy Official follow:

- Appointment, Resignation and Removal of Privacy Official.* The Employer shall appoint one or more individuals to act as Privacy Official on matters regarding the Health FSA. The individual appointed as Privacy Official may resign by giving 30 days notice in writing to the Employer. The Employer shall have the power to remove that individual for any or no reason.
- Policies and Procedures.* The Privacy Official shall from time to time formulate and issue to Participants and the Employer such policies and procedures as he or she deems necessary for compliance with this Article and HIPAA. No policy or procedures, however, shall amend any substantive provision of the Health FSA. Additionally, such policies and procedures must be accepted by the Plan Administrator.
- Privacy Notice.* The Privacy Official shall be responsible for arranging with the Employer, the Plan Administrator and any third-party administrator for the issuance of, and any changes to, the Privacy Notice under the Health FSA.
- Complaint Contact Person.* The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this Article and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any.

ARTICLE XI (Reserved)

ARTICLE XII IRREVOCABILITY OF ELECTIONS

12.1 Irrevocability of Elections

Except as described in this Article XII, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- (a) participation in this Plan;
- (b) Salary Reduction amounts; or
- (c) election of particular Benefit Package Options (including the various Health FSA Options).

However, as described further in Section 12.4, an election to make a Contribution to an HSA can be changed at any time on a prospective basis (if applicable).

12.2 Procedure for Making New Election If Exception to Irrevocability Applies

- (a) **Timeframe for Making New Election.** A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 12.3 (or within 60 days of the occurrence of an event described in Section 12.3(e)(3) or (4)), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical, Dental and/or Vision Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30- day period.
- (b) **Effective Date of New Election.** Elections made pursuant to this Section 12.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 12.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).
- (c) **Effect of New Election Upon Amount of Benefits.** For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 9.4 respectively.

12.3 Events Permitting Exception to Irrevocability Rule for All Benefits Other than HSA Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable component of this Plan:

- (a) **Open Enrollment Period (Applies to Premium Payment, Health FSA, and DCAP Benefits).** A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.
- (b) **Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits).** A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.
- (c) **Leaves of Absence (Applies to Premium Payment, Health FSA, and DCAP Benefits).** A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non- FMLA leave in accordance with Section 3.5.
- (d) **Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits as Limited Below, and DCAP Benefits as Limited Below).** A Participant may change his or her actual or deemed election

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

- (e) HIPAA Special Enrollment Rights (Applies to Medical Insurance Benefits, but Not to Dental Insurance, Vision Insurance, Health FSA, or DCAP Benefits). If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:
- (1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because:
 - (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or
 - (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;
 - (2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption;
 - (3) the Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or
 - (4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days). For purposes of Section 12.3(e)(1), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
- (f) Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits). If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.
- (g) Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits). If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or

cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

- (h) Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits). For purposes of this Section 12.3(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.
- (1) Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.
 - (2) Significant Cost Increases. If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.
 - (3) Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.
 - (4) Limitation on Change in Cost Provisions for DCAP Benefits. The above "Change in Cost" provisions (Sections 12.3(h)(1) through 12.3(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).

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

The definition of "similar coverage" under Section 12.3(h) applies also to this Section 12.3(i).

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

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

(b) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) Definition of Loss of Coverage. For purposes of this Section 12.3(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

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

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

(2) Addition or Significant Improvement of a Benefit Package Option. If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit

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

- (3) **Loss of Coverage Under Other Group Health Coverage.** A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).
- (4) **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance. Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:
- (1) **Loss of Spouse or Dependent Eligibility; Special COBRA Rules.** For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for

coverage (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage.

- (2) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.
- (3) **Special Consistency Rule for DCAP Benefits.** With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

A Participant entitled to change an election as described in this Section 12.3 must do so in accordance with the procedures described in Section 12.2.

12.4 Election Modifications for HSA Benefits (if applicable)

As set forth in Section 8.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Package Option election changes can occur as a result of a change in HSA election except as otherwise described in this Article XII. For example, a Participant generally would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described in Section 12.3 for Health FSAs otherwise applied.

A Participant entitled to change an election as described in this Section 12.4 must do so in accordance with the procedures described in Section 12.2.

12.5 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions (including Salary Reductions for HSA Benefits) for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XIII APPEALS PROCEDURE

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. The Committee acts on behalf of the Plan Administrator with respect to appeals.

13.2 Claims Procedures for Medical, Dental and/or Vision Insurance Benefits

Claims and reimbursement for Medical, Dental and/or Vision Insurance Benefits shall be administered in accordance with the claims procedures for the Medical, Dental and/or Vision Insurance Benefits, as set forth in the plan documents and/or summary plan description for the Medical, Dental and/or Vision Insurance Plans.

ARTICLE XIV RECORD KEEPING AND ADMINISTRATION

14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- (f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- (g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- (h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- (j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

14.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

14.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

14.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

14.7 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

14.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.9 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

14.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV GENERAL PROVISIONS

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 9.6 with respect to DCAP Benefits, and then by the Employer. For HSA Benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian. Any such fees shall be the responsibility of the Participant; they will not be paid by the Employer.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Idaho to the extent not superseded by the Code, ERISA, or any other federal law.

15.5 Compliance With Code, ERISA, and Other Applicable Laws

It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. (ERISA applies to the Medical Insurance Plan, the Dental Insurance Plan, the Vision Insurance Plan and the Health FSA Component but not to the HSA Component or the DCAP Component.) This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

15.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

15.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, this Plan document is hereby executed this ____ day of _____, 2013

City of Bonners Ferry

By: _____
Employer

Title

Witness as to Employer



CERTIFICATE OF CORPORATE RESOLUTION

The undersigned representative of City of Bonners Ferry (the Employer) hereby certifies that the following restatement of the Plan is duly adopted by the Employer.

RESOLVED, that the form of the Cafeteria Plan restatement effective January 1, 2014, presented to this meeting is hereby approved and adopted, and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan, one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, as restated, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

RESOLVED, that the Administrator shall act as soon as possible to notify the employees of the adoption of the Cafeteria Plan as restated by making available to each employee a copy of the summary description of the Plan in the form of the Summary Plan Description presented to this meeting, which form is hereby approved.

The undersigned further certifies that attached hereto are true copies of the Cafeteria Plan Document, the Summary Plan Description, and the TPA Agreement approved and adopted in the foregoing resolutions.

Signed this _____ day of _____ 201_____

By:

Secretary/Principal of City of Bonners Ferry



TPA SERVICES AGREEMENT

RECITALS

City of Bonners Ferry has established certain employee benefit programs, including the following: A health flexible spending arrangement ("Health FSA") under Code § 105, and a dependent care assistance program ("DCAP") under Code § 129. The Health FSA and the DCAP are each offered under a Code § 125 cafeteria plan.

Some or all of the arrangements under the Program may be "welfare benefit plans" within the meaning of ERISA § 3(1); some or all may be subject to requirements under the Code; and some or all may be subject to requirements under Health Care Reform.

Employer operates in multiple roles with respect to the Program. Magnuson, McHugh & Company P.A. ("TPA") is in the business of assisting with the performance of various services related to employee benefit programs.

Employer has requested TPA to assist it with respect to a variety of services, including making payment of certain benefits, and providing recordkeeping and other administrative services as described in this Agreement.

In consideration of the mutual promises contained in this Agreement, Employer and TPA agree as follows.

ARTICLE I INTRODUCTION

1.1 EFFECTIVE DATE AND TERM

The effective date of this Agreement is January 1, 2014 ("Effective Date"). The initial term shall be the initial twelve (12) month period commencing on the Effective Date; thereafter, this Agreement will renew automatically for successive periods of twelve (12) months unless this Agreement is terminated in accordance with the provisions of Section 7.8.

1.2 SCOPE OF UNDERTAKING

Employer has sole and final authority to establish, maintain, control and manage the operation of the Program. TPA is and shall remain an independent contractor with respect to the services being performed hereunder and shall not for any purpose be deemed an employee of Employer. Nor shall TPA and Employer be deemed partners, engaged in a joint venture or governed by any legal relationship other than that of independent contractor. TPA does not assume any responsibility for the general policy design of the Program, the adequacy of its funding, or any act or omission or breach of duty by Employer. Nor is TPA in any way to be deemed an insurer, underwriter or guarantor with respect to any benefits payable under the Program. With respect to payment of the benefits, TPA generally provides reimbursement services only and does not assume any financial risk or obligation with respect to claims for benefits payable by Employer in the Program. TPA does not intend to be the "named fiduciary," "plan sponsor," or "plan administrator" (as a party to such terms are described in ERISA, other applicable law or the Program documentation) or assume any of the administrative duties or responsibilities commensurate with those designations. Unless required by applicable law, nothing in the this Agreement shall be deemed to (a) render the TPA a party to the Program; (b) confer upon TPA any authority or control respecting management of the Program, authority or responsibility in connection with administration of the Program. Or responsibility for the terms or validity of the Program; or (c) impose upon TPA any obligation to any employee of Employer or any person who is participation in the Program ("Participant") or otherwise entitled to benefits through the Program.

1.3 DEFINITIONS

"Agreement" means this TPA Services Agreement, including all Appendices hereto.

"Appendix" or **"Appendices"** means one or more appendices to this Agreement, which are incorporated by reference into and form part of this Agreement.

"Business Associate Contract" means any separate agreement entered into between one or more employee benefit plans or arrangements under the Program and the TPA (as business associate) to document compliance with HIPAA's privacy, security, and electronic data interchange (EDI) requirements.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, including regulation thereunder.

"Code" mean the Internal Revenue Code of 1986, as amended.

"DCAP" has the meaning given in the Recitals.

"Eligibility Reports" have the meaning described in Section 2.3.

"Employer" has the meaning given in the Recitals and refers to the Employer in its various roles, including Named Fiduciary, Plan Administrator, and Plan Sponsor.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, including regulations thereunder.

"Effective Date" has the meaning given in Section 1.1.

"Electronic PHI" is a type of PHI and has the meaning assigned to such term under HIPAA.

"Health Care Reform" means the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), and as further amended from time to time, including regulations thereunder.

"Health FSA" has the meaning given in the Recitals.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, including regulation thereunder.

"Named Fiduciary" means the named fiduciary as defined in ERISA § 402(a)(1).

"Participant" has the meaning given in Section 1.2.

"Plan" means each portion of the Program through which benefits are provided, including the Health FSA or DCAP, as applicable.

"Plan Administrator" means the administrator as defined in ERISA § 3(16)(A).

"Plan Sponsor" means the Employer.

"Program" has the meaning given in the Recitals and refers to the Plans collectively.

"Protected Health Information" or **"PHI"** has the meaning assigned to such term under HIPAA.

"TPA" has the meaning given in the Recitals.

ARTICLE II EMPLOYER RESPONSIBILITIES

2.1 SOLE RESPONSIBILITIES

- (a) General. Employer has the sole authority and responsibility for the Program and its operation, including the authority and responsibility for establishing, administering, construing and interpreting the provisions of the Program and making all determinations thereunder. Employer gives the TPA the authority to act on behalf of Employer in connection with the Program, but only as expressly stated in this Agreement or as mutually agreed in writing by Employer and TPA. All final determinations as to a Participant's entitlement to Program benefits are to be made by Employer, including any determination upon appeal of a denied claim for Program benefits. Employer is considered the Plan Administrator and Named Fiduciary of the Program benefits for purposes of ERISA.
- (b) Responsibilities. Without limiting Employer's responsibilities described herein, it shall be Employer's sole responsibility (as Plan Administrator) and duty to: ensure compliance with COBRA; perform required nondiscrimination testing; amend the Plans as necessary to ensure ongoing compliance with applicable law; file any required tax or governmental returns (including Form 5500 returns) relating to the Plans; collect and forward any fees related to the Programs; determine if and when a valid election change has occurred; handle Participant claim appeals; execute and retain required Plan and claims documentation; and take all other steps necessary to maintain and operate the Plans in compliance with applicable provisions of the Plans, ERISA, HIPAA, the Code, Health Care Reform, and other applicable federal and state laws.

2.2 SERVICE CHARGES; FUNDING

Employer shall pay TPA the service charges set forth in the Appendices hereto, as described in Article V. Employer shall promptly make funds available for the payment of Program benefits as described in Article IV. It is the Employer's intent that the Program be operated to fall within an exception or non-enforcement policy with respect to ERISA's trust requirement for plan assets. To the extent TPA administers the remittance of fees or expenses for which Employer is responsible (e.g., certain fees under Health Care Reform), Employer shall promptly make funds available to the TPA for such remittance.

2.3 INFORMATION TO TPA

Employer must furnish the information requested by TPA as determined necessary to perform TPA's functions hereunder, including information concerning the Program and the eligibility of individuals to participate in and receive Program benefits. Such information shall be provided to TPA in the time and in the manner agreed to by Employer and TPA. TPA shall have no responsibility with regard to benefits paid (or not paid) in error, or with regard to failure to timely provide required notices or other communications, due to Employer's failure to timely update such information. From time to time thereafter, at least as frequently as necessary to enable employer and TPA to discharge their respective responsibilities under applicable law, TPA shall provide Employer with updated reports summarizing the eligibility data provided by Employer ("Eligibility Reports") by electronic medium unless otherwise agreed by the parties. The Eligibility Reports shall specify the effective date for each Participant who is added to or terminated from participation in the Program. Employer shall be responsible for ensuring the accuracy of its Eligibility Reports, and bears the burden of proof in any dispute with TPA relating to the accuracy to any Eligibility Report. TPA shall have no liability to Employer or any Participant as a consequence of an inaccurate Eligibility Report, and TPA shall not have any obligation to credit Employer for any claims expenses or administrative fees incurred or paid to TPA as a consequence for Employer failing to review Eligibility Reports for accuracy. TPA shall assume that all such information is complete and accurate and is under no duty to question the completeness or accuracy of such information. With respect to any Plan subject to the HIPAA privacy rule, such Eligibility Reports shall be considered

PHI and, when transmitted by or maintained in electronic media shall be considered ePHI, subject to the privacy and security rules under HIPAA, as provided in Section 3.13 of this Agreement.

2.4 PLAN DOCUMENTS

Employer is responsible for the Program's compliance with all applicable federal and state laws and regulations, including amending Plan documents as necessary to comply with applicable law changes and reflect changes to the benefit arrangements. Employer shall provide TPA with all relevant documentation, including but not limited to, the Program documents (attached hereto as Appendices) and any Program amendments. To the best of its ability, Employer will notify TPA of any changes to the Program at least thirty (30) days before the effective date of such changes. Employer acknowledges that TPA is not providing tax or legal advice and that Employer shall be solely responsible for determining the legal and tax status of the Program.

2.5 FINANCIAL RESPONSIBILITY FOR CLAIMS

Employer is responsible for payment of claims made pursuant to, and the benefits to be provided by, the Program. TPA does not insure or underwrite the liability of Employer under the Program. Except for (a) expenses required for TPA to be in the business of providing services under this Agreement; and (b) expenses specifically assumed by TPA in this Agreement, Employer is responsible for all expenses incident to the Program.

2.6 MEDICAL RECORDS

Employer shall, if required by law or regulation, (a) notify each Participant and provide each Participant with an opportunity to opt out (if required); or (b) obtain from each Participant such written authorization for release of any personal financial records and medical records in accordance with applicable state and federal law (including HIPAA and the Gramm-Leach-Bliley Act) to permit Employer and/or TPA to perform their obligations under this Agreement.

2.7 HIPAA PRIVACY AND SECURITY

With respect to any arrangement under the Program that is subject to the HIPAA privacy rule, Employer shall provide TPA with certification that the applicable Plan document has been amended as required by the privacy rule to permit disclosures of PHI to Employer for plan administration purposes and that Employer agrees to the conditions set forth in applicable Plan documentation. Upon request, Employer will provide a copy of any applicable Plan amendments to TPA. Other aspects of the HIPAA privacy rule are reflected in Section 3.13 of this Agreement.

ARTICLE III TPA RESPONSIBILITIES

3.1 LIMITED RESPONSIBILITIES

TPA's sole responsibilities shall be as described in this Agreement, including the obligations listed in any Appendix to this Agreement. TPA generally provides certain reimbursement, recordkeeping and other administrative services, as described further below. The TPA will carry out its duties in accordance with the Plan documents and applicable law.

3.2 CUSTOMER SERVICE

TPA shall provide customer service personnel during normal business hours as determined by TPA (and consented to by Employer, which consent shall not be unreasonably withheld) by telephone and shall provide electronic administrative services twenty-four (24) hours per day, seven (7) days per week. TPA shall not be deemed in default of this Agreement, nor held responsible for, any cessation, interruption or delay in the performance of its obligations hereunder due to causes

beyond its reasonable control, including, but not limited to, natural disaster, act of God, labor controversy, civil disturbance, disruption of the public markets, war or armed conflict, or the inability to obtain sufficient materials or services required in the conduct of its business, including Internet access, or any change in or the adoption of any law, judgment or decree.

3.3 BENEFIT PROCESSING AND PAYMENT

TPA shall, on behalf of the Employer, operate under the express terms of this Agreement and the Program. TPA shall accept and process claims of Participants received by TPA for benefits under the Program in accordance with the terms and conditions, including timeframes, of the applicable Plan (as set forth in the Plan document) and applicable law. TPA shall initially determine if persons covered by the Program (as described in the Eligibility Reports) are entitled to benefits under the Program and shall adjudicate and pay Program benefits to Participants, as set forth in this Article III and Article IV, in accordance with Plan terms and in its usual and customary manner. Where a claim is not paid in full, TPA shall provide written denial notices in accordance with the terms and conditions, including timeframes, of the applicable Plan (as set forth in the Plan document) and applicable law. TPA shall have no duty or obligation with respect to claims incurred prior to the Effective Date ("Prior Reimbursement Requests"), if any, or Program administration (or other) services arising prior to the Effective Date ("Prior Administration"), in any, regardless of whether such services were/are to be performed prior to or after the Effective Date. Employer agrees that: (a) TPA has no responsibility or obligation with respect to Prior Reimbursement Requests and/or Prior Administration; (b) Employer will be responsible for processing Prior Reimbursement Requests (including any run-out claims submitted after the Effective Date) and maintaining legally required records of all Prior Reimbursement Requests and Prior Administration sufficient to comply with applicable legal (e.g., IRS substantiation) requirements; and (c) Employer shall indemnify and hold TPA harmless for any liability relating to Prior Reimbursement Requests and/or Prior Administration.

3.4 BONDING AND INSURANCE COVERAGE

TPA has, and will maintain, a fidelity bond for all persons involved in collecting money or making claim payments, and all officers of TPA. This bond covers the handling of Employers' and Participants' money and must protect such money from losses by dishonesty, theft, forgery or alteration, and unexplained disappearance. Such bond shall be in an amount sufficient to at least satisfy the fidelity bonding requirement under ERISA § 412 and any other applicable bonding requirement(s). TPA shall also maintain business liability coverage in the amount of at least \$1 million. TPA shall provide proof of such bonding and business liability coverage upon Employer's request and shall notify Employer of any material changes, including change of carrier, change in amount of coverage, etc.

3.5 REPORTING

TPA shall make available to Employer at least monthly via electronic medium (unless otherwise agreed by the parties) a master report showing the payment history and status of Participant claims and the amounts and transactions of Participant accounts during the preceding month. TPA shall also make available to Participants at least monthly via electronic medium a report showing individual payment history, status of claims, and the amounts and transactions of the individual accounts during the preceding month.

3.6 CLAIMS APPEALS

TPA shall refer to Employer or its designee, for final determination, any claim for benefits or coverage that is appealed after initial denial by TPA or any class of claims that Employer may specify, including: (a) any question of eligibility or entitlement of the claimant for coverage under the Program; (b) any question with respect to the amount due; or (c) any other appeal.

3.7 ADDITIONAL DOCUMENTS

If Employer requests, and Employer and TPA mutually agree upon payment of applicable fees, then TPA shall furnish Employer: (a) sample documents to be reviewed by Employer with its legal counsel, for creation of customized documentation for the Program to be approved and executed by Employer, including board resolutions, summary plan descriptions (SPDs), plan documents and plan amendments (if any); and (b) sample administrative forms needed for TPA to perform under this Agreement. Employer acknowledges that Employer is solely responsible for determining the legal and tax status of the Program.

3.8 RECORDKEEPING

TPA shall maintain, for the duration of this Agreement, the usual and customary books, records and documents, including electronic records, that relate to the Program and its Participants that TPA has prepared or that have otherwise come within its possession. These books, records and documents, including electronic records, are the property of Employer, and Employer has the right of continuing access to them during normal business hours at TPA's offices with reasonable prior notice. No documentation shall be destroyed by TPA. If this Agreement terminates, TPA shall deliver all such books, records, and documents to Employer, subject to TPA's right to retain copies of any records it deems appropriate. Employer shall be required to pay TPA reasonable charges for transportation of such records.

3.9 STANDARD OF CARE; ERRONEOUS PAYMENTS

TPA shall use reasonable care and due diligence in the exercise of its powers and the performance of its duties under this Agreement, provided that a higher standard of care will be exercised where required by applicable law. If TPA makes any payment under this Agreement to an ineligible person, or if more than the correct amount is paid, TPA shall promptly notify Employer and make diligent efforts to recover any payment made to or on behalf of an ineligible person or any overpayment. To the extent electronic payment cards are used, TPA shall follow the Plan language and applicable legal requirements regarding the efforts to be made. TPA will not be financially responsible for such erroneous payment, unless TPA would otherwise be financially responsible under another provision of the Agreement.

3.10 NOTICES TO EMPLOYER

TPA shall provide to Employer all notices (including any required opt-out notice) reflecting its privacy policies and practices as required by state and/or federal law (including HIPAA and the Gramm-Leach-Bliley Act).

3.11 NON-DISCRETIONARY DUTIES; ADDITIONAL DUTIES

TPA and Employer agree that, to the fullest extent permitted by applicable law, the duties to be performed under this Agreement by TPA are non-discretionary duties. TPA and Employer may agree to additional duties in writing as may be specified in an amendment to this Agreement, including amendment to any of the Appendices from time to time. With respect to any such additional duties, TPA and Employer agree that, to the fullest extent permitted by applicable law, any such additional duties shall be non-discretionary duties.

3.12 SUBCONTRACTORS

TPA may engage subcontractors to assist TPA in the performance of its obligations under this Agreement. Subcontractors may include, among others, vendors of debit card services. The Employer must be promptly notified of the initial engagement of a subcontractor and any subsequent material modifications to the subcontractor relationship, including changing subcontractors, discontinuing use of a subcontractor, and change in scope of subcontractor

responsibilities. TPA guarantees the subcontractor's performance to the same degree as if the TPA provided the services directly, as provided in Section 3.13 of this Agreement.

3.13 BUSINESS ASSOCIATE CONTRACT PROVISIONS

I. Definitions.

Examples of specific definitions:

- (a) Breach. "Breach" shall have the same meaning as the term "breach" in 45 CFR § 164.402.
- (b) Breach Notification Rule. "Breach Notification Rule" shall mean the Standards and Implementation Specification for Notification of Breaches on Unsecured Protected Health Information under 45 CFR Parts 16 and 164, subparts A and D.
- (c) Business Associate. "Business Associate" shall mean Magnuson, McHugh & Company, P.A.
- (d) Covered Entity. "Covered Entity" shall mean City of Bonners Ferry.
- (e) Electronic Protected Health Information. "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103.
- (f) Electronic Transactions Rule. "Electronic Transactions Rule" shall mean the final regulations issued by HHS concerning standard transactions and code sets under 45 CFR Part 160 and 162.
- (g) Enforcement Rule. "Enforcement Rule" shall mean the Enforcement Provisions set forth in 45 CFR Part 160.
- (h) Genetic Information. "Genetic Information" shall have the same meaning as the term "genetic information" in 45 CFR § 160.103.
- (i) HHS. "HHS" shall mean the Department of Health and Human Services.
- (j) HIPAA Rules. "HIPAA Rules" shall mean the Privacy Rule, Security Rule, Breach Notification Rule, and Enforcement Rule.
- (k) HITECH Act. "HITECH Act" shall mean the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009.
- (l) Privacy Rule. "Privacy Rule" shall mean the Privacy Standards and Implementation Specifications at 45 CFR parts 160 and 164, subparts A and E.
- (m) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity pursuant to this Agreement.
- (n) Required by Law. "Required by Law" shall have the same meaning as the term "required by Law" in 45 CFR § 164.103.
- (o) Security Incident. "Security Incident" shall have the same meaning as the term "securing incident" in 45 CFR § 164.304.
- (p) Security Rule. "Security Rule" shall mean the Security Standards and Implementation Specifications at 45 CFR Parts 160 and 164, subparts A and C.
- (q) Subcontractor. "Subcontractor" shall have the same meaning as the term "subcontractor" in 45 CFR § 160.103.
- (r) Transaction. "Transaction" shall have the meaning given the term "transaction" in 45 CFR § 160.103.
- (s) Unsecured Protected Health Information. "Unsecured Protected Health Information" shall have the meaning given the term "unsecured protected health information" in 45 CFR § 164.402.

II. Privacy and Security of Protected Health Information

- (a) **Permitted Uses and Disclosures.** Business Associate is permitted to use and disclose Protected Health Information that it creates or received on Covered Entity's behalf or receives from Covered Entity (or another business associate of Covered Entity) and to request Protected Health Information on Covered Entity's behalf (collectively, "Covered Entity's Protected Health Information") only:
 - (i) **To Perform Its Assigned Duties in Accordance with this Agreement.**
 - (ii) **Business Associate's Operations.** Business Associate's may use Protected Health Information for the proper management and administration of the Business Associate

or to carry out the legal responsibilities of the Business Associate. Business Associates may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out Business Associate's legal responsibilities provided that,

(A) The disclosure is Required by Law; or

(B) Business Associate obtains reasonable assurance from any person or entity to which Business Associate will disclose Protected Health Information that the person or entity will:

(1) Hold the Protected Health Information in confidence and use or further disclose the Protected Health Information only for the purpose for which Business Associate disclosed the Protected Health Information to the person or entity or as Required by Law; and

(2) Promptly notify Business Associate of any instance of which the person or entity becomes aware, in which the confidentiality of Protected Health Information was breached.

(iii) **Minimum Necessary.** Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request; except that Business Associate will not be obligated to comply with this minimum-necessary limitation if neither Business Associate nor Covered Entity is required to limit its use, disclosure or request to the minimum necessary under the HIPAA Rules. Business Associate and Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and the HIPAA Rules.

(b) **Prohibition on Unauthorized Use or Disclosure.** Business Associate will neither use nor disclose Covered Entity's Protected Health Information, except as permitted or required by this Agreement or in writing by Covered Entity or as Required by Law. This Agreement does not authorize Business Associate to use or disclose Covered Entity's Protected Health Information in a manner that would violate the HIPAA Rules if done by Covered Entity, except as permitted for Business Associate's proper management and administration, as described above.

(c) **Information Safeguards.**

(i) **Privacy of Covered Entity's Protected Health Information.** Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of Covered Entity's Protected Health Information. The safeguards must reasonably protect Covered Entity's Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement.

(ii) **Security of Covered Entity's Electronic Protected Health Information.** Business Associate will comply with the Security Rule and will use appropriate administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that Business Associate creates, receives, maintains, or transmits on Covered Entity's behalf.

(iii) **No Transfer of PHI Outside the United States.** Business Associate will not transfer Protected Health Information outside the United States without the prior written consent of the Covered Entity. In this context, a "transfer" outside the United States occurs if Business Associate's workforce members, agent, or subcontractors physically located outside the United States are able to access, use, or disclose Protected Health Information.

(d) **Subcontractors.** Business Associate will require each of its Subcontractors to agree, in written agreement with Business Associate, to comply with the provisions of the Security

Rule; to appropriately safeguard Protected Health Information created, received, maintained, or transmitted on behalf of the Business Associate; and to apply the same restrictions and conditions that apply to the Business Associate with respect to such Protected Health Information.

- (e) **Prohibition on Sale of Protected Health Information.** As of the effective date of the Business Associate Agreement, the Business Associate shall not engage in any sale (as defined in the HIPAA rules) of Protected Health Information.
- (f) **Prohibition on Use or Disclosure of Genetic Information.** As of the effective date of the Business Associate Agreement, the Business Associate shall not use or disclose Genetic Information for underwriting purposes in violation of the HIPAA rules.
- (g) **Penalties for Noncompliance.** Business Associate acknowledges that it is subject to civil and criminal enforcement for failure to comply with the HIPAA Rules, to the extent provided by the HITECH Act and the HIPAA Rules.

III. **Compliance with Electronic Transactions Rule.** If Business Associate conducts in whole or part electronic Transactions on behalf of Covered Entity for which HHS has established standards, Business Associate will comply, and will require any subcontractor it involves with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule and of any operating rules adopted by HHS with respect to Transactions.

IV. **Individual Rights.**

- (a) **Access.** Business Associate will, within 29 calendar days following Covered Entity's request, make available to Covered Entity (or, at Covered Entity's written direction, to an individual or the individual's designee) for inspection and copying Protected Health Information about the individual that is in a Designated Record Set in Business Associate's custody or control, so that Covered Entity may meet its access obligations under 45 CFR § 164.524. Effective as of the date specified by HHS, if Covered Entity requests an electronic copy of Protected Health Information that is maintained electronically in a Designated Record Set in the Business Associate's custody or control, Business Associate will provide an electronic copy in the form and format specified by the Covered Entity if it is readily producible in such format; if it is not readily producible in such format, Business Associate will work with Covered Entity to determine an alternative form and format that enable Covered Entity to meet its electronic access obligations under 45 CFR § 164.524.
- (b) **Amendment.** Business Associate will, upon receipt of written notice from Covered Entity, promptly amend or permit Covered Entity access to amend any portion of an Individual's Protected Health Information that is in a Designated Record Set in the custody or control of the Business Associate, so that Covered Entity may meet its amendment obligations under 45 CFR § 164.526.
- (c) **Disclosure Accounting.** To allow Covered Entity to meet its obligations to account for disclosure of Protected Health Information under 45 CFR § 164.528:
 - (i) **Disclosures Subject to Accounting.** Business Associate will record the information specified below ("Disclosure Information") for each disclosure of Covered Entity's Protected Health Information, not excepted from disclosure accounting as specified below, that Business Associate makes to Covered Entity or to a third party.
 - (ii) **Disclosure Not Subject to Accounting.** Business Associate will not be obligated to record Disclosure Information or otherwise account for disclosures of Covered Entity's Protected Health Information if Covered Entity need not account for such disclosures under the HIPAA Rules.
 - (iii) **Disclosure Information.** With respect to any disclosure by Business Associate of Covered Entity's Protected Health Information that is not excepted from disclosure accounting under the HIPAA Rules, Business Associate will record the following Disclosure Information as applicable to the type of accountable disclosure made:
 - (A) **Disclosure Information Generally.** Except for repetitive disclosures of Covered Entity's Protected Health Information as specified below, the Disclosure Information that Business Associate must record for each accountable disclosure is (i) the disclosure date, (ii) the name and (if known) address of the entity to which

Business Associate made the disclosure, (iii) a brief description of Covered Entity's Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure.

(B) Disclosure Information for Repetitive Disclosures. For repetitive disclosures of Covered Entity's Protected Health Information that Business Associate makes for a single purpose to the same person or entity (including Covered Entity), the Disclosure Information that Business Associate must record is either the Disclosure Information specified above for each accountable disclosure, or (i) the Disclosure Information specified above for the first of the repetitive accountable disclosures; (ii) the frequency, periodicity, or number of the repetitive accountable disclosures; and (iii) the date of the last of the repetitive accountable disclosures.

(iv) Availability of Disclosure Information. Business Associate will maintain the Disclosure Information for at least 6 years following the date of the accountable disclosure to which the Disclosure Information relates (3 years for disclosures related to an Electronic Health Record, starting with the date specified by HHS). Business Associate will make the Disclosure Information available to Covered Entity within 59 calendar days following Covered Entity's request for such Disclosure Information to comply with an individual's request for disclosure accounting. Effective as of the date specified by HHS, with respect to disclosure related to an Electronic Health Record, Business Associate shall provide the accounting directly to an individual making such a disclosure request, if a direct response is requested by the individual.

(d) Restriction Agreements and Confidential Communications. Covered Entity shall notify Business Associate of any limitations in the notice of privacy practices of Covered Entity under 45 CFR § 164.520, to the extent that such limitations may affect Business Associate's use or disclosure of Protected Health Information. Business Associate will comply with any notice from Covered Entity to (i) restricts use or disclosure of Covered Entity's Protected Health Information pursuant to 45 CFR § 164.522(a), or (ii) provide for confidential communications of Covered Entity's Protected Health Information pursuant to 45 CFR § 164.522(b), provided that Covered Entity notifies Business Associate in writing of the restriction or confidential communication obligations that Business Associate must follow. Covered Entity will promptly notify Business Associate in writing of the termination of any such restriction agreement or confidential communication requirement and, with respect to termination of any such restriction, instruct Business Associate whether any of Covered Entity's Protected Health Information will remain subject to the terms of the restriction agreement.

V. Breaches and Security Incidents.

(a) Reporting.

(i) Impermissible Use or Disclosure. Business Associate will report to Covered Entity any use or disclosure of Protected Health Information not permitted by this Agreement not more than 30 calendar days after Business Associate discovers such non-permitted use or disclosure.

(ii) Breach of Unsecured Protected Health Information. Business Associate will report to Covered Entity any potential breach of Unsecured Protected Health Information not more than 30 calendar days after discovery of such potential Breach. Business Associate will treat the potential Breach as being discovered in accordance with 45 CFR § 164.410. Business Associate will make the report to Covered Entity's Privacy Officer. If a delay is requested by a law-enforcement official in accordance with 45 CFR § 164.412, Business Associate may delay notifying Covered Entity for the applicable time period. Business Associate's report will include the following, provided that absence of any information will not be cause for Business Associate to delay the report:

(A) Identify the nature of the Breach, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;

(B) Identify the types of Covered Entity's Protected Health Information that were involved in the Breach (such as whether full name, social security number, date

of birth, home address, account number, diagnosis, or other information were involved);

- (C) Identify who made the non-permitted use of disclosure and who received the non-permitted disclosure.
 - (D) Identify what corrective or investigational action Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;
 - (E) Identify what steps the individuals who were subject to a Breach should take to protect themselves;
 - (F) Provide such other information, including a written report and risk assessment under 45 CFR § 164.402, as Covered Entity may reasonably request.
- (iii) **Security Incidents.** Business Associate will report to Covered Entity any Security Incident of which Business Associate becomes aware. Business Associate will make this report once per month, except if any such Security Incident resulted in a disclosure not permitted by this Agreement or Breach of Covered Entity's Unsecured Protected Health Information, Business Associate will make the report in accordance with the provisions set forth above.
 - (iv) **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect known to the Business Associate resulting from a use or disclosure in violation of this Agreement.

VI. Term and Termination

- (a) **Term.** This Agreement shall be effective immediately and shall terminate when all Protected Health Information provided by Covered Entity to Business Associate, or created, received or maintained by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section.
- (b) **Right to Terminate for Cause.** Covered Entity may terminate this Agreement if it determines, in its sole discretion, that Business Associate has breached any provision of this Agreement, and after written notice to Business Associate of the breach, Business Associate fails to cure the breach within 60 calendar days after receipt of the notice. Any such termination will be effective immediately or at such other date specified in Covered Entity's notice of termination.
- (c) **Treatment of Protected Health Information on Termination.**
 - (i) **Return or Destruction of Covered Entity's Protected Health Information as Feasible.** Upon termination of this Agreement, Business Associate will, if feasible, return to Covered Entity or destroy all of Covered Entity's Protected Health Information in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of Covered Entity's Protected Health Information. This provision shall apply to Protected Health Information that is in the possession of subcontractors of the Business Associate. Further, Business Associate shall require any such subcontractors to certify to Business Associate that it returned to Business Associate (so that Business Associate may return it to the Covered Entity) or destroyed all such information, which could be returned or destroyed all such information, which could be returned or destroyed. Business Associate will complete these obligations as promptly as possible, but not later than 60 calendar days following the effective date of the termination of this Agreement.
 - (ii) **Procedure When Return or Destruction Is Not Feasible.** Business Associate will identify any of Covered Entity's Protected Health Information, including any Protected Health Information that Business Associate has disclosed to subcontractors, that cannot feasibly be returned to Covered Entity or destroyed and explain why return or destruction is infeasible. Business Associate will limit its further use or disclosure of such information to those purposes that make return or destruction of such information infeasible. Business Associate will complete these obligations as

promptly as possible, but not later than 120 calendar days following the effective date of the termination or other conclusion of Agreement.

- (iii) **Continuing Privacy and Security Obligation.** Business Associate's obligation to protect the privacy and safeguard the security of Covered Entity's Protected Health Information as specified in this Agreement will be continuous and survive termination or other conclusion of this Agreement.

VII. General Provisions.

- (a) **Definitions.** All terms that are used but not otherwise defined in this Agreement shall have the meaning specified under HIPAA, including its statute, regulations and other official government guidance.
- (b) **Inspection of Internal Practices, Books and Records.** Business Associate will make its internal practices, books and records relating to its use and disclosure of Protected Health Information available to Covered Entity and to HHS to determine compliance with the HIPAA Rules.
- (c) **Amendment to Agreement.** This Agreement may be amended only by a written instrument signed by the parties. In case of a change in applicable law, the parties agree to negotiate in good faith to adopt such amendments as are necessary to comply with the change in the law.
- (d) **No Third-Party Beneficiaries.** Nothing in this Agreement shall be construed as creating any rights or benefits to any third parties.
- (e) **Interpretation.** Any ambiguity in the Agreement shall be resolved to permit Covered Entity and Business Associate to comply with the applicable requirements under the HIPAA Rule.
- (f) **Governing Law, Jurisdiction, and Venue.** This Agreement shall be governed by the law of Idaho, except to the extent preempted by federal law.
- (g) **Severability.** The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, which shall remain in full force and effect.
- (h) **Construction and Interpretation.** The section headings contained in this Agreement are for reference purposes only and shall not in any way affect the meaning or interpretation of this Agreement. This Agreement has been negotiated by the parties at arm's-length and each of them has had an opportunity to modify the language of the Agreement. Accordingly, the Agreement shall be treated as having been drafted equally by the parties, and the language shall be construed as a whole and according to its fair meaning. Any presumption or principle that the language is to be construed against any part shall not apply. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.
- (i) **Notices.** All notices and communications required by this Agreement shall be in writing. Such notices and communications shall be given in one of the following forms: (i) by delivery in person, (ii) by a nationally-recognized, next-day courier service, (iii) by first-class, registered or certified mail, postage prepaid; or (iv) by electronic mail to the address that each party specifies in writing.

ARTICLE IV

BENEFIT PROGRAM PAYMENT; EMPLOYER'S FUNDING RESPONSIBILITY

4.1 PAYMENT OF BENEFITS

Employer authorizes TPA to pay Program benefits by checks written (or other draft payment or debit) on one or more bank accounts established and maintained in the name of Employer for the payment of Program benefits. Employer shall enter into such agreements and provide instructions to its bank as are necessary to implement this Section 4.1. TPA shall have authority to provide whatever notifications, instructions, or directions as may be necessary to accomplish the disbursement of such Program funds to or on behalf of Participants in payment of approved claims.

4.2 FUNDING OF BENEFITS

Funding for any payment to (or on behalf of) the Participants under the Program, including but not limited to, all benefits to Participants in accordance with the Program, is the sole responsibility of Employer, and Employer agrees to accept liability for, and provide sufficient funds to satisfy, all payments to Participants under the Program, including claims for reimbursement for covered expenses, as described in the applicable Plan documents, if such expenses are incurred and the claim is presented for payment during the term of this Agreement.

ARTICLE V TPA COMPENSATION

5.1 SERVICE CHARGES

The monthly service charges of TPA are described in the Appendices. TPA may change the amount of service charges by providing at least thirty (30) days written or electronic notice to Employer. TPA may also change the monthly service charges as of the date of any Program change.

5.2 BILLING OF CHARGES

All service charges of TPA, whether provided for in this or any other Section, shall be billed separately from statements for payment of claims so that proper accounting can be made by Employer of the respective amounts paid for claims and for administrative expenses.

5.3 PAYMENT OF CHARGES

All charges under this Article V shall be determined by TPA and billed to Employer monthly. Employer shall make payment to TPA within ten (10) business days of receipt of notice of the amount due, or such amount will automatically be deducted from the bank account maintained by Employer as described in Article IV.

5.4 COMPENSATION DISCLOSURES

TPA shall disclose direct and indirect sources of compensation received by TPA, other than the items discussed above, attributable to this Agreement. Total compensation received by TPA for the performance of services under this Agreement, including direct and indirect sources of compensation, may not exceed what is considered to be "reasonable" for purposes of ERISA's prohibited transaction exemption for services provided to a plan.

ARTICLE VI INDEMNIFICATION AND HOLD HARMLESS

6.1 INDEMNIFICATION BY EMPLOYER

Employer shall indemnify TPA and hold it harmless from and against all loss, liability, damage, expense, attorney's fees, or other obligations resulting from, or arising out of, any act or omission of Employer in connection with the Program, or claim, demand, or lawsuit by Program Participants and beneficiaries against TPA in connection with benefit payments or services performed (or not performed) hereunder. In addition, Employer shall indemnify TPA and hold it harmless from and against any liability, expense, demand, or other obligation resulting from or arising out of any premium charge, tax, or similar assessment (federal or state), for which the Program or Employer is liable. Employer shall also have the indemnification obligation described in Section 3.3.

6.2 INDEMNIFICATION BY TPA

TPA shall indemnify Employer and hold it harmless from and against all loss, liability, damage, expense, attorney's fees, or other obligations resulting from, or arising out of, any act or omission of TPA in connection with the Program, or claim, demand, or lawsuit by Program Participants and beneficiaries against Employer in connection with benefit payments or services performed (or not performed) by TPA hereunder. In addition, TPA shall indemnify Employer and hold it harmless from and against any liability, expense, demand, or other obligation resulting from or arising out of any premium charge, tax, or similar assessment (federal or state), for which the TPA liable.

ARTICLE VII GENERAL PROVISIONS

7.1 SEVERABILITY; HEADINGS

If any term of this Agreement is declared invalid by a court, the same will not affect the validity of any other provision, provided that the basic purposes of this Agreement are achieved through the remaining valid provisions. The headings of Sections and subsections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

7.2 COMPLIANCE; NON-WAIVER

Failure by Employer or TPA to insist upon strict performance of any provision of this Agreement will not modify such provision, render it unenforceable, or waive any subsequent breach. No waiver or modification of any of the terms or provisions of this Agreement shall be valid unless in each instance the waiver or modification is accomplished pursuant to the amendment provisions of Section 7.3.

7.3 ASSIGNMENT; AMENDMENT

Neither Employer nor TPA can assign this Agreement without the other party's written consent, in which consent will not be unreasonably withheld. This Agreement may be amended only by written agreement of duly authorized officers of Employer and TPA.

7.4 AUDITS

Each party shall be authorized to perform audits of the records of payment of all Participants and other data specifically related to performance of the parties under this Agreement upon reasonable prior written notice to the other. Audits shall be performed during normal working hours. Audits may be performed by an agent of either party provided such agent signs an acceptable confidentiality agreement. Each party agrees to provide reasonable assistance and information to the auditors. Employer acknowledges and agrees that if it requests an audit, it shall reimburse TPA for TPA's reasonable expenses, including copying and labor costs, in assisting Employer to perform the audit. Each party also agrees to provide such additional information and reports as the other party shall reasonably request.

7.5 NON-DISCLOSURE OF PROPRIETARY INFORMATION

- (a) General. Employer and TPA each acknowledge that a contemplation of entering into this Agreement (and as a result of the contractual relationship created hereby), each party has revealed and disclosed, and shall continue to reveal and disclose to the other, information which is proprietary and/or confidential information of such party. Employer and TPA agree that each party shall; (1) keep such proprietary and/or confidential information of the other party in strict confidence; (2) not disclose confidential information of the other party to any third parties or to any of its employees not having a legitimate need to know such information; and (3) shall not use confidential information of the other party for any

purpose not directly related to and necessary for the performance of its obligations under this Agreement (unless required to do so by court of competent jurisdiction or a regulatory body having authority to require such disclosure).

- (b) Confidential Information Defined. Information revealed or disclosed by a party for any purpose not directly related to and necessary for the performance of such party's obligations under this Agreement shall not be considered confidential information for purposes hereof; (1) if, when, and to the extent such information is or becomes generally available to the public without the fault or negligence of the party receiving or disclosing the information; or (2) if the unrestricted use of such information by the party receiving or disclosing the information has been expressly authorized in writing and in advance by an authorized representative of the other party; or (3) if required by applicable law. For purposes of this Section, confidential information is any information in written, human-readable, machine-readable, or electronically recorded form (and legended as confidential and/or proprietary or words of similar import) and information disclosed orally in connection with this Agreement and identified as confidential and/or proprietary (or words of similar import); and programs, policies, practices, procedures, files, records and correspondence concerning the parties' respective business or finances. The terms and conditions of this Section 7.5 shall survive the termination of this Agreement.

7.6 ARBITRATION

Any controversy or claim arising out of or relating to this Agreement between Employer and TPA, or the breach thereof, shall be subject to non-binding arbitration prior to the filing of a complaint in a court of law; provided, however, that such arbitration shall be final and binding and may be enforced in any court with the requisite jurisdiction if the parties in advance, in writing, that such arbitration shall have final, binding effect. All arbitration, whether binding or non-binding, shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place in Coeur d'Alene, Idaho. Nothing precludes the parties from waiving, in writing, the requirement to first pursue arbitration.

7.7 NOTICES AND COMMUNICATIONS

- (a) Notices. All notices provided for herein shall be sent by confirmed facsimile, or guaranteed overnight mail, with tracing capability, or by first class United States mail, with postage prepaid, addressed to the other party at their respective addresses set forth below or such other addresses as either party may designate in writing to the other from time to time for such purposes. All notices provided for herein shall be deemed given or made when received.
- (b) Addresses. Employer's address for notices as described above is: 1836 Northwest Blvd, Coeur d'Alene, ID 83814. TPA's address for notices as described above is: PO Box 2260, Coeur d'Alene, ID 83816-2260
- (c) Communications. Employer agrees that TPA may communicate confidential, protected, privileged or otherwise sensitive information to Employer through a named contact designated by Employer and specifically agrees to indemnify TPA and hold it harmless: (1) for any such communications directed to Employer through the Named Contact attempted via telefax, mail, telephone, e-mail or any other media, acknowledging the possibility that such communications may be inadvertently misrouted or intercepted; and (2) from any claim for the improper use or disclosure of any PHI by TPA if such information is used or disclosed in a manner consistent with responsibilities hereunder.

7.8 TERMINATION OF AGREEMENT

- (a) Automatic. Unless specifically agreed to otherwise in a written amendment to this Agreement, this Agreement shall automatically terminate as of the earliest of the following: (1) the effective date of any legislation which makes the Program and/or this Agreement illegal; (2) the date either party becomes insolvent, or bankrupt, or subject to liquidation, receivership, or conservatorship; or (3) the termination date of the Program, subject to any

agreement between Employer and TPA regarding payment of benefits after the Program is terminated.

- (b) Optional. This Agreement may be terminated as of the earliest of the following: (1) by TPA upon the failure of Employer to pay any charges within ten (10) business days after they are due and payable as provided in Article V; (2) by TPA upon the failure of Employer to perform its obligations in accordance with this Agreement; (3) by Employer upon the failure of TPA to perform its obligations in accordance with this Agreement, including the provisions of Section 3.13; or (4) by either Employer or TPA, as of the end of the term of this Agreement, by giving the other party thirty (30) days written notice.
- (c) Limited Continuation After Termination. If the Program is terminated, Employer and TPA may mutually agree in writing as an amendment to this Agreement that this Agreement shall continue for the purpose of payment of any Program benefit, expense, or claims incurred prior to the date of Program termination. In addition, if this Agreement is terminated while the Program continues in effect, Employer and TPA may mutually agree in writing as an amendment to this Agreement that the Agreement shall continue for the purpose of payment of any claims for which requests for reimbursement have been received by TPA before the date of such termination. If this Agreement is continued in accordance with this subsection, Employer shall pay the monthly service charges incurred during the period that this Agreement is so continued plus a final termination fee equal to the final month's service charge.
- (d) Survival of Certain Provisions. Termination of this Agreement shall not terminate (1) the rights or obligations of either party arising out of a period prior to such termination; (2) the indemnity, confidentiality, privacy, and security provisions of this Agreement; or (3) any provision in this Agreement that specifically provides for survival following termination of this Agreement.

7.9 COMPLETE AGREEMENT; GOVERNING LAW

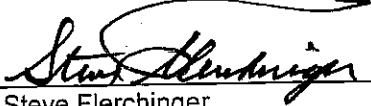
This Agreement (including the Appendices) is the full Agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements and representations between the parties. This Agreement shall be constructed, enforced, and governed by the laws of the State of Idaho.

IN WITNESS WHEREOF, Employer and TPA have caused this Agreement to be executed in their names by their undersigned officers, the same being duly authorized to do so.

City of Bonners Ferry

Magnuson, McHugh & Co., P.A. as TPA

By: _____

By: 
Steve Flerchinger

Title: _____

Title: Manager-Health Benefit Services

Date: _____

City of Bonners Ferry
Health Benefit Plan
Magnuson, McHugh & Company, P.A.

Fee Schedule

Monthly Service Charges:

All-inclusive monthly administrative fee per participant* - Cafeteria Plan \$6.00
(\$75.00 monthly minimum)

*Total monthly fees for administration will be based on the number of participants enrolled at the beginning of the plan year. The monthly fee will remain constant throughout the plan year unless there is a 10% (at least 3 participants) or greater increase in the number of participants during any one month.

Services include: recording employees contributions, review and payment of employees claims from an employer controlled bank account, notification to participants of denied claims or requests for additional documentation including substantiation of debit card swipes if necessary. Perform midyear nondiscrimination testing for the health FSA, and limited Cobra administration for the health FSA as necessary. Make changes to account when a status in election changes, as permitted by law, or termination of an employee.

Annual Service Charges:

The annual fee will be based on the actual time required and is therefore largely dependent on the volume of participants in the plan at the beginning of the plan year.

Services include: Enrollment forms (by electronic medium or paper copy) will be distributed to all benefited employees during the open enrollment period. Reimbursement and all other forms necessary for participants to file a claim will be made available both online and through the employer, Summary of Plan Description (upon request), non-discrimination testing based on data collected from the company will be performed and updated throughout the plan year. Form 5500 filing data will be provided to the employer if necessary. The annual fee will be based on the actual time required and is therefore largely dependent on the volume of participants in the plan at the beginning of the plan year.

Other Charges:

Change in status election change as permitted by law, or termination of an employee \$25.00
(per occurrence).

Plan document restatements and amendments required by law or requested by the company will be billed based on the actual time required to perform the required change.

Initial above to confirm acceptance





Bonners Ferry Police Department

David Kramer, Chief

208-267-4391 dkramer@bonnersferry.id.gov

To: Mayor and Council

From: Chief Kramer

CC:

Date: January 2, 2014

Re: Light duty for City employees

The City policy manual did not have a policy or guidance on light duty assignments for employees. On discussion with the Department Heads we felt that it would be in the best interest of the City to have a policy that would be used for all employees, if there is a request and a need.

Some of the suggestions would include developing a policy for light duty assignments on a case by case basis and if there is a need for the work, that it would be at the option of the City to allow light duty, not a benefit that an employee is entitled to.

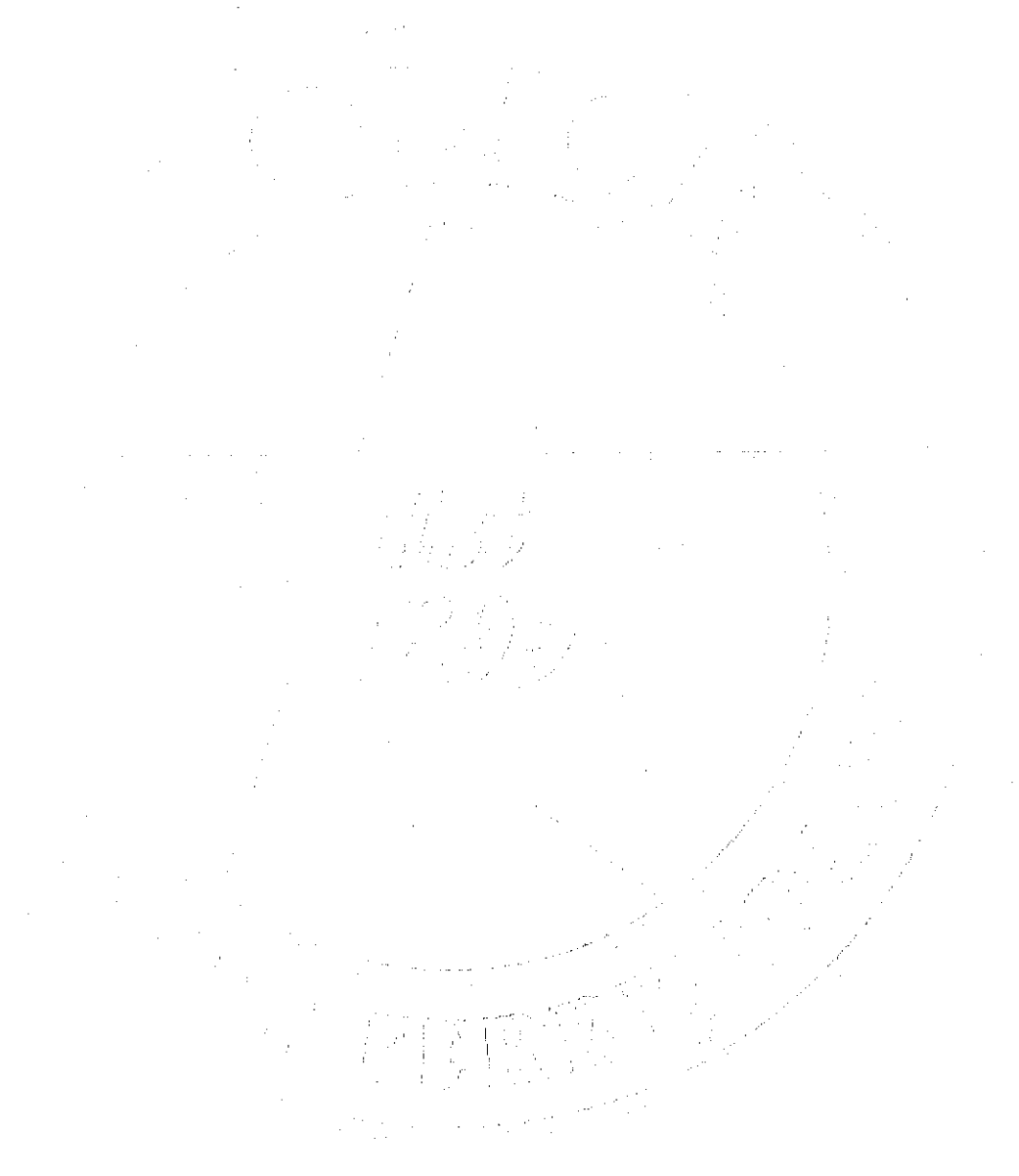
The City would set the amount of time that it could be authorized by the Dept. Head (Dept. Heads group thought 6 weeks) anything approved after that timeline would require approval of Council.

The City could establish a pay percentage while the employee is on light duty and not performing their regular job assignment, such as 75%-90% of their normal wage while on light duty. This creates the incentive to be released back to regular work, and the employee could choose if they want to accept it or not.

There would be a form to be completed by the employee requesting light duty assignment, any known job restrictions that they would have from their regular work. This request would be reviewed by the Department Head and if they had work that would be beneficial to the City they could authorize the employee to obtain authorization from a medical provider.

The form that the medical provider would complete and return to the City would list any restrictions or special accommodations that the City would need to be aware of. If the light duty involves operating a city vehicle or machinery, the Dr. would have to indicate if the employee has been prescribed any medications that would interfere with their ability to operate a motor vehicle or machinery.

The employee would also be required to provide a form back to the City when they have been released for their normal job assignments with nor restrictions.



Sample

Coeur d'Alene Police Department

Policy Manual

Modified Duty Assignments

1054.1 PURPOSE AND SCOPE

The purpose of this policy is to establish procedures for assigning members to modified duty.

Temporary modified-duty assignments may be available to members who have incurred a duty-related illness or injury and, due to restrictions or limitations, are unable to perform their regular assigned duties. Non-duty related illnesses or injuries may also be considered for eligibility in accordance with this policy. Eligibility for modified-duty assignment is subject to the approval of the Chief of Police or his designee.

Modified-duty assignments are intended to provide a member with the ability to continue working within the limits of his restrictions and limitations on a temporary basis not to exceed six months while providing the department with a productive member during the interim period. The department will engage in a good faith interactive process to consider reasonable accommodations for any member with a temporary or permanent disability.

1054.2 DEFINITIONS

Modified Duty - Means a temporary, limited-term assignment not requiring performance of the full range of duties associated with the regular job classification. Modified duty also may be termed as light-duty assignments.

1054.3 LIMITATIONS

Modified-duty assignments are a management prerogative and not an member right. Modified-duty assignments shall be subject to continuous re-assessment dependent upon department needs and the member's ability to perform in a modified-duty capacity. An injured member may be offered a modified-duty position outside of his normal assignment or duties if it becomes available for either an on or off duty injury.

- (a) If a member cannot adequately perform in a modified-duty assignment, such assignment may be modified or terminated.
- (b) The lack of department need or a change in priorities may result in the member's removal from or modification of a modified-duty assignment.
- (c) The department may place conditions as deemed appropriate upon any modified-duty assignment, to include scheduling changes.

1054.4 PROCEDURE

Members may request assignment to modified duty by providing a signed statement from their health care provider describing their restrictions, limitations and expected duration to their Division Commander or his designee. The statement must also indicate if the member requires any workplace accommodations, mobility aids or medical devices.

The Division Commander will determine what modified-duty assignments may be available based on the needs of the department, limitations of the member and suitability of the member to work a particular assignment, regardless of the number of modified duty hours.

Modified Duty Assignments - 399
Adopted: 2013/08/01 © 1995-2013 Lexipol, LLC

Coeur d'Alene Police Department

Policy Manual

Modified Duty Assignments

1054.4.1 MODIFIED-DUTY SCHEDULES

The schedules of members assigned to modified duty may be adjusted to suit medical appointments or department needs at the discretion of the Division Commander. The member and his supervisors should be informed in writing of the schedule, assignment and limitations and restrictions as determined by the member's health care provider.

1054.4.2 ACCOUNTABILITY

The member's supervisors shall coordinate efforts to ensure proper time accountability and documentation.

(a) Members on modified duty are responsible for coordinating required doctor visits and physical therapy appointments in advance with their supervisor to appropriately account for any duty time taken. Doctor visits and appointments for treatment of injuries or illnesses that are not work related shall be arranged during off-duty time or otherwise charged to the member's sick leave.

(b) Members shall promptly submit a status report for each visit to their treating health care provider and shall immediately notify their supervisor of any change in restrictions or limitations as determined by their health care provider. An member assigned to a modified-duty assignment shall provide a duty status report to his/her supervisor no less than once every 30 days while the member is on modified duty.

(c) Supervisors shall keep the Division Commander apprised of the member's status and ability to perform the modified-duty assignment. Modified-duty assignments that extend beyond 60 days will require a written status report and a request for an extension to the Division Commander with an update of the member's current status and anticipated date of return to regular duty. Extensions require approval of the Chief of Police.

(d) When it is determined that a member on modified duty will return to regular duty, the supervisor shall notify the Division Commander and complete proper documentation. All training and certification necessary for return to duty shall be reviewed and updated as necessary.

1054.4.3 MEDICAL EXAMINATIONS

Prior to returning to full-duty status, members shall be required to provide a statement signed by their health care provider indicating that they are medically cleared to perform the basic and essential job functions of their assignment without restriction or limitation.

1054.5 PREGNANCY

It is the policy of this department to reassign members who are pregnant to temporary assignments based upon medical need, medical restrictions, and/or when their medical condition presents a safety risk to the member or others.

1054.5.1 MEMBER NOTIFICATION

A member who is pregnant must submit, to her immediate supervisor, a statement from her health care provider listing any job restrictions and/or limitations she may have so the department can facilitate a reasonable accommodation like any other medical condition.

1054.5.2 SUPERVISOR'S RESPONSIBILITY

Upon receipt of the statement from the member's health care provider listing job restrictions and/or limitations, or when a pregnant member's medical condition presents a safety risk to the member or others, the member's immediate supervisor shall notify the Division Commander, who will consider assigning the member to an available temporary modified-duty assignment if it is deemed appropriate by the department.

1054.5.3 LEAVE OF ABSENCE

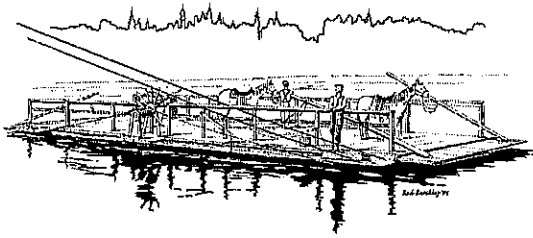
If at any point during the pregnancy it becomes necessary for the member to take a leave of absence, such leave shall be granted consistent with the City's Personnel Rules regarding family and medical care leave.

1054.6 PROBATIONARY MEMBERS

Probationary members who are assigned to a temporary modified-duty assignment shall have their probation extended by a period of time equal to the member's assignment to modified duty or long term medical leave of absence.

1054.7 MAINTENANCE OF CERTIFICATION AND TRAINING

Members assigned to modified duty shall maintain all certification, training and qualifications appropriate to both their regular and temporary duties, provided the certification, training or qualifications are not in conflict with any limitations or restrictions. Members who are assigned to modified duty shall inform their supervisor of any inability to maintain any certification, training or qualifications.



MEMO

CITY OF BONNERS FERRY
CITY ADMINISTRATOR

Date: 2 January 2014
To: City Council
From: Stephen Boorman, City Administrator
Subject: Moyie Substation Purchase.

At this time BPA has provided a price for the purchase of the BPA owned equipment in the Moyie Substation. We are not ready to make a recommendation to council at this time but are planning on doing oil test on the transformer. Following are the recommended test:

1. Furan Test - \$90
2. Dielectric Breakdown Test - \$25 (D1816)
3. Dissolved Metals - \$55
4. Interfacial Tension - \$19
5. Karl Fischer - \$14
6. Neutralization Number - \$19
7. Oxidation Inhibitor Content - \$19

It would be appropriate to discuss the proposed purchase price in executive session.

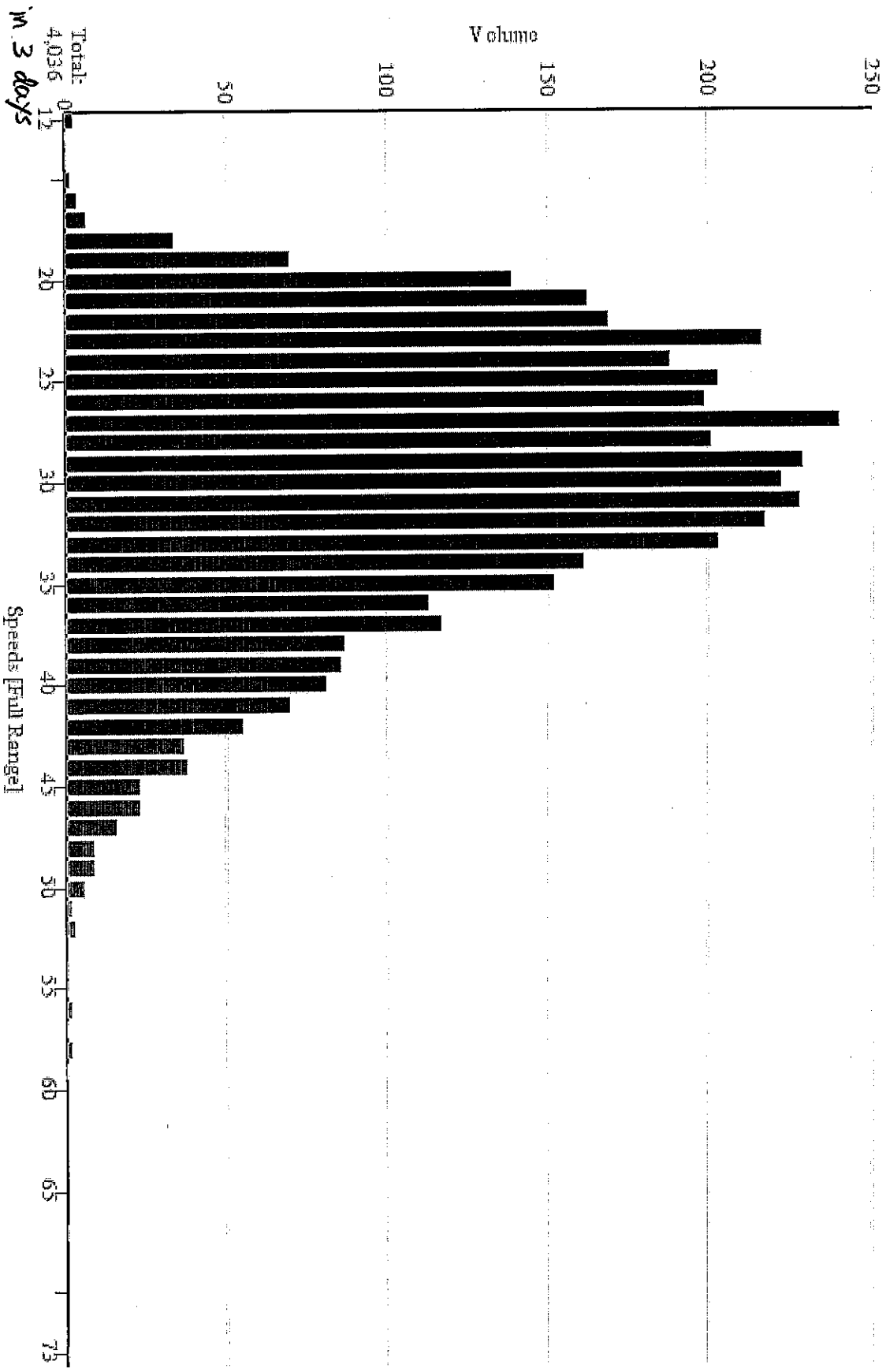
STB

Place Currently Not Set
Speed/Volume Graph

Location: Cow Creek Road
Dates: 12-16-13 to 12-19-13

Zone: Commercial
Speed Limit: 20 MPH

Travel Direction: N



12-19-2013, 16:26:45