SOUTHWEST
HEALTH & HUMAN
SERVICES

Southwest Health and Human Services
Board Agenda
Wednesday, November 21, 2018
Commissioners Room
Government Center, 2nd Floor
Marshall
9:00 a.m.

HUMAN SERVICES

A. Call to order

B. Pledge of Allegiance

C. Consent Agenda
1. Amend/Approval of Agenda
2. Identification of Conflict of Interest
3. Approval of 10/17/18 board minutes

D. Introduce New Staff:

E. Employee Recognition:
- Hilary Kesteloot, 5 years, Social Worker, Marshall
- Lisa DeBoer, 20 years, Fiscal Officer, Luverne
- Tanya O'Leary, 20 years, Social Worker, Pipestone

F. Financial

HUMAN SERVICES (cont.)

G. Caseload

	10/18	*10/17*	09/18	08/18
Social Service	3,795	*3,719*	3,740	3,741
Licensing	455	*456*	450	450
Out-of-Home Placements	170	*186*	176	175
Income Maintenance	12,201	*12,024*	12,150	11,923
Child Support Cases	3,258	*3,274*	3,258	3,287
Child Support Collections	$791,329	*$801,542*	$727,124	$801,268
Non IV-D Collections	$88,192	*$52,247*	$23,118	$77,212

H. Discussion/Information
1. LAC (Local Advisory Council) Update- Jennifer Lundberg & Nathaniel Kuhnau
2. Adoption Awareness- Nicole Henrichs & Amanda Holzapfel

I. Decision Items
1. 2019 Human Services Budget

COMMUNITY HEALTH

J. Call to order

K. Consent Agenda
1. Amend/Approval of Agenda
2. Identification of Conflict of Interest
3. Approval of 10/17/18 board minutes

L. Financial

COMMUNITY HEALTH (cont.)

M. Caseload

	10/18	09/18	08/18
WIC	N/A	2115	2154
Family Home Visiting	43	48	47
PCA Assessments	23	13	29
Managed Care	356	299	348
Dental Varnishing	19	17	15
Refugee Health	1	5	1
Latent TB Medication Distribution	31	26	14
Water Tests	222	168	163
FPL Inspections	44	38	67
Immunizations	48	33	58
Car Seats	15	15	20

N. Discussion/Information
1. 2017 PPMRS- Krista Kopperud

O. Decision Items
1. Environmental Health Fees- Jason Kloss
2. Public Health Fees
3. Family Home Visiting Grant Letter of Support- Kristin Deacon
4. 2019 Public Health Budget

GOVERNING BOARD

P. Call to order

Q. Consent Agenda
1. Amend/Approval of Agenda
2. Identification of Conflict of Interest
3. Approval of 10/17/18 board minutes

R. Financial

S. Human Resources Statistics

	10/18	*10/17*	09/18	08/18
Number of Employees	237	*254*	238	238
Separations	4		1	0

T. Discussion/Information
1. SWHHS 2018 Audit- E.J. Moberg – 10:15am

U. Decision Items
1. SWHHS 2018 Audit
2. Southwest Health & Human Services Flexible Benefits Plan
3. Collective Bargaining Memorandum of Agreement
4. Holli Hoffbeck, Eligibility Worker, probationary appointment (12months), $17.83 hourly, effective 11/19/2018
5. SWHHS Personnel Committee
6. 2019 Non-union wage increases
7. Personnel Policy 3- Leave and Holidays
8. C&TC Program Purchases
9. 2019 SWHHS Budget
10. Donations:
    a. Grace Lutheran Church donated 3 children's quilts and 7 larger quilts for the use of children and adults in need within Pipestone County.
    b. Avera Marshall donated Christmas gifts for 44 families in need throughout the six counties.
11. Contracts

V. Adjournment

Next Meeting Dates:

- **Wednesday, December 19, 2018 – Marshall**
- **Wednesday, January 16, 2019 – Marshall**
- **Wednesday, February 20, 2019 – Marshall**

SOUTHWEST HEALTH & HUMAN SERVICES

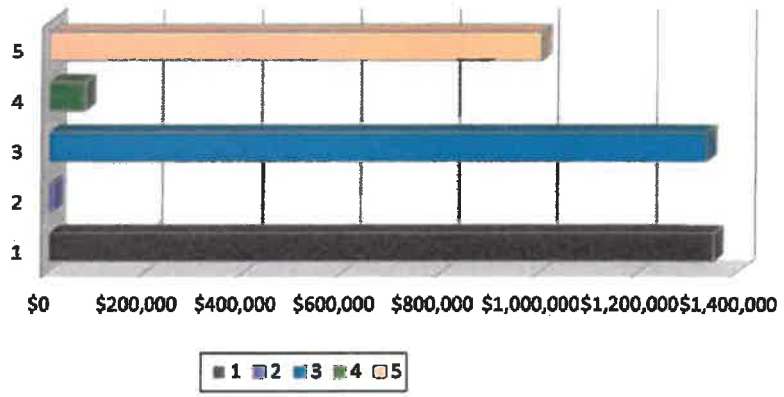
Ivanhoe, Marshall, Slayton, Pipestone, Redwood and Luverne Offices

SUMMARY OF FINANCIAL ACCOUNTS REPORT For the Month Ending: **October 31, 2018**

* Income Maintenance * Social Services * Information Technology * Health *

Description	Month	Running Balance	
BEGINNING BALANCE		**$982,988**	
RECEIPTS			
Monthly Receipts	2,539,321		
County Contribution	507,932		
Interest on Savings	5,415		
TOTAL MONTHLY RECEIPTS		3,052,668	
DISBURSEMENTS			
Monthly Disbursements	2,684,401		
TOTAL MONTHLY DISBURSEMENTS		2,684,401	
ENDING BALANCE		**$1,351,255**	
REVENUE			
Checking/Money Market	***$1,351,255***		
SS Benefits Checking	***$10,000***		
Bremer Savings	***$1,336,534***		
Great Western Bank Savings	***$75,827***		
Investments - MAGIC Fund	***$1,001,584***		**October 2017 Ending Balance**
ENDING BALANCE		**$3,775,200**	**$2,417,547**
DESIGNATED/RESTRICTED FUNDS			
Agency Health Insurance		**$690,066**	
LCTS Lyon Murray Collaborative		**$113,006**	
LCTS Rock Pipestone Collaborative		**$75,906**	
LCTS Redwood Collaborative		**$31,730**	
Local Advisory Council		**$1,216**	
AVAILABLE CASH BALANCE		**$2,863,276**	

REVENUE DESIGNATION



SOUTHWEST HEALTH AND HUMAN SERVICES CHECK REGISTER
OCTOBER 2018

DATE	RECEIPT or CHECK #	DESCRIPTION	+ DEPOSITS	-DISBURSEMENTS	BALANCE
	BALANCE FORWARD				982,987.50
10/1/18	9747	Disb		34,403.74	948,583.76
10/2/18	31231-31259	Dep	385,709.20		1,334,292.96
10/3/18	9748	Disb		10,141.83	1,324,151.13
10/5/18	4794-4796	Disp		151.78	1,323,999.35
10/5/18	92230-92280	Disp		20,718.07	1,303,281.28
10/5/18	4797-4850	Disp		47,611.14	1,255,670.14
10/5/18	92281-92344	Disp		119,924.71	1,135,745.43
10/5/18	31260-31312	Dep	249,822.22		1,385,567.65
10/9/18	9749	Disb		287,716.18	1,097,851.47
10/9/18	9750	Disb		2,554.80	1,095,296.67
10/9/18	31313-31340	Dep	82,585.87		1,177,882.54
10/11/18	9751	Disb		41,803.14	1,136,079.40
10/11/18	Transfer from Savings	Dep	1,000,000.00		2,136,079.40
10/12/18	8510-8528	Payroll		137,263.87	1,998,815.53
10/12/18	53423-53666 ACH	Payroll		487,700.09	1,511,115.44
10/12/18	92345-92351	Disb		1,222.82	1,509,892.62
10/12/18	4851 ACH	Disb		122.40	1,509,770.22
10/12/18	92352-92455	Disb		223,738.08	1,286,032.14
10/12/18	4852-4889 ACH	Disb		49,193.87	1,236,838.27
10/12/18	VOID 92209	Disb		(19.25)	1,236,857.52
10/12/18	9752	Disb		483.00	1,236,374.52
10/12/18	9753	Disb		38.00	1,236,336.52
10/12/18	31341-31397	Dep	180,523.15		1,416,859.67
10/15/18	9754	Disb		72,906.43	1,343,953.24
10/16/18	31398-31428	Dep	84,012.45		1,427,965.69
10/17/18	9755	Disb		10,066.99	1,417,898.70
10/19/18	4890 ACH	Disb		134.00	1,417,764.70
10/19/18	92456-92556	Disb		13,767.80	1,403,996.90
10/19/18	4891-4893 ACH	Disb		1,119.64	1,402,877.26
10/19/18	92557-92729	Disb		84,799.52	1,318,077.74
10/19/18	4894 ACH	Disb		64.04	1,318,013.70
10/19/18	92730-92795	Disb		6,025.68	1,311,988.02
10/19/18	4895-4907 ACH	Disb		5,598.14	1,306,389.88
10/19/18	92796-92849	Disb		79,528.63	1,226,861.25
10/19/18	31429-31492	Dep	327,043.41		1,553,904.66
10/17/18	Transfer to SS Ckg	Disb		10,000.00	1,543,904.66
10/17/18	VOID 49323	Disb		(12.00)	1,543,916.66
10/17/18	VOID 49713	Disb		(38.40)	1,543,955.06
10/17/18	VOID 52708	Disb		(39.60)	1,543,994.66
10/17/18	VOID 54685	Disb		(15.00)	1,544,009.66
10/17/18	VOID 55529	Disb		(93.32)	1,544,102.98
10/17/18	VOID 56553	Disb		(1.20)	1,544,104.18
10/17/18	VOID 56867	Disb		(1.25)	1,544,105.43
10/22/18	9756	Disb		25,608.00	1,518,497.43
10/23/18	31493-31520	Dep	230,266.41		1,748,763.84
10/22/18	9757	Disb		9,241.96	1,739,521.88
10/24/18	9758	Disb		885.90	1,738,635.98
10/24/18	VOID 92830	Disb		(50.00)	1,738,685.98
10/26/18	92850-92899	Disb		12,047.18	1,726,638.80
10/26/18	4908-4909 ACH	Disb		41.80	1,726,597.00
10/26/18	92900-92959	Disb		141,688.06	1,584,908.94
10/26/18	4910-4934 ACH	Disb		46,486.74	1,538,422.20
10/26/18	8529-8551	Payroll		136,244.21	1,402,177.99
10/26/18	53667-53919 ACH	Payroll		490,477.26	911,700.73
10/26/18	31521-31566	Dep	307,831.67		1,219,532.40
10/29/18	9759	Disb		64,593.63	1,154,938.77
10/30/18	VOID 92614	Disb		(1,458.93)	1,156,397.70
10/30/18	31567-31587	Dep	6,098.13		1,162,495.83
10/31/18	9760	Disb		10,016.83	1,152,479.00
10/31/18	31591-31604	Dep	198,775.67		1,351,254.67
					1,351,254.67
	Balanced 11/01/18 LMD	TOTALS	3,052,668.18	2,684,401.01	

Checking - SS Beneficiaries	10,000.00
Savings - Bremer	336,534.27
Savings - Great Western	75,826.96
Investments - Magic Fund	1,001,583.66
TOTAL CASH BALANCE	2,775,199.56

SOUTHWEST HEALTH AND HUMAN SERVICES SAVINGS & INVESTMENTS REGISTERS
2018

BREMER BANK

DATE	RECEIPT or CHECK #	DESCRIPTION	DEPOSITS	DISBURSEMENTS	BALANCE
01/01/18	BEGINNING BALANCE				3,811,895.63
01/03/18	33393	Interest	2,696.81		3,814,592.44
01/19/18	Transfer to Checking	Transfer		1,000,000.00	2,814,592.44
02/08/18	33907	Interest	2,599.17		2,817,191.61
03/07/18	34332	Interest	1,966.63		2,819,158.24
03/08/18	Transfer to Checking	Transfer		1,000,000.00	1,819,158.24
04/04/18	34803	Interest	1,710.09		1,820,868.33
04/12/18	Transfer to Checking	Transfer		1,000,000.00	820,868.33
05/04/18	35322	Interest	1,508.61		822,376.94
06/05/18	35884	Interest	1,255.42		823,632.36
06/18/18	Transfer from Checking	Transfer	1,500,000.00		2,323,632.36
06/25/18	Transfer to Checking	Transfer		1,000,000.00	1,323,632.36
07/05/18	36306	Interest	1,783.93		1,325,416.29
07/18/18	Transfer from Checking	Transfer	1,000,000.00		2,325,416.29
08/03/18	36765	Interest	3,109.27		2,328,525.56
09/05/18	37245	Interest	4,060.57		2,332,586.13
10/02/18	37677	Interest	3,948.14		2,336,534.27
10/11/18	Transfer to Checking	Transfer		1,000,000.00	1,336,534.27
					1,336,534.27
					1,336,534.27
	ENDING BALANCE				1,336,534.27

GREAT WESTERN BANK

DATE	RECEIPT or CHECK #	DESCRIPTION	DEPOSITS	DISBURSEMENTS	BALANCE
01/01/18	BEGINNING BALANCE				75,277.07
01/03/18	33394	Interest	52.63		75,329.70
02/08/18	33908	Interest	59.93		75,389.63
03/07/18	34333	Interest	50.90		75,440.53
04/04/18	34804	Interest	54.56		75,495.09
05/04/18	35323	Interest	56.43		75,551.52
06/05/18	35885	Interest	56.46		75,607.98
07/05/18	36307	Interest	52.87		75,660.85
08/03/18	36766	Interest	58.37		75,719.22
09/05/18	37246	Interest	56.59		75,775.81
10/02/18	37678	Interest	51.15		75,826.96
					75,826.96
					75,826.96
	ENDING BALANCE				75,826.96

MAGIC FUND INVESTMENT

DATE	RECEIPT or CHECK #	DESCRIPTION	DEPOSITS	DISBURSEMENTS	BALANCE
01/01/18	BEGINNING BALANCE				0.00
06/25/18	Transfer from Checking	Investment	1,000,000.00		1,000,000.00
07/05/18	36308	Interest	55.90		1,000,055.90
08/03/18	36767	Interest	56.00		1,000,111.90
09/05/18	37247	Interest	56.10		1,000,168.00
10/02/18	37679	Interest	58.88		1,000,226.88
10/02/18	37679	Interest	1,356.78		1,001,583.66
					1,001,583.66
					1,001,583.66
	ENDING BALANCE				1,001,583.66

Southwest Health and Human Services

Treasurer's Cash Trial Balance

As of 10/2018

Fund		Beginning Balance	This Month	YTD	Current Balance
1	Health Services Fund				
		1,709,545.07			
	Receipts		587,575.08	3,275,642.11	
	Disbursements		31,537.68-	633,741.73-	
	Payroll		225,463.16-	2,436,738.42-	
	Journal Entries		0.00	159,913.80-	
	Fund Total		330,574.24	45,248.16	1,754,793.23
5	Human Services Fund	410	General Administration		
		189,947.30			
	Receipts		50,358.96	514,329.15	
	Disbursements		60,236.77-	511,198.39-	
	Payroll		17,278.69-	164,488.92-	
	Dept Total		27,156.50-	161,358.16-	28,589.14
5	Human Services Fund	420	Income Maintenance		
		2,690,331.05-			
	Receipts		422,311.96	6,322,864.96	
	Disbursements		204,111.43-	2,634,314.17-	
	Payroll		343,940.00-	3,791,067.05-	
	Journal Entries		0.00	290,030.22-	
	Dept Total		125,739.47-	392,546.48-	3,082,877.53-
5	Human Services Fund	431	Social Services		
		8,275,091.90			
	Receipts		519,492.70	13,097,254.53	
	Disbursements		67,130.58-	1,048,038.67-	
	SSIS		522,713.50-	6,570,341.62-	
	Payroll		636,671.27-	7,050,119.39-	
	Journal Entries		0.00	550,055.98-	
	Dept Total		707,022.65-	2,121,301.13-	6,153,790.77
5	Human Services Fund	461	Information Systems		
		2,739,744.12-			
	Receipts		3,592.00	46,936.18	
	Disbursements		7.00	2,905.67-	

Southwest Health and Human Services

Treasurer's Cash Trial Balance

As of 10/2018

Fund		Beginning Balance		This Month	YTD	Current Balance
	Payroll			28,332.31-	295,306.37-	
	Dept Total.....			24,733.31-	251,275.86-	2,991,019.98-
5	Human Services Fund		471	LCTS Collaborative Agency		
		0.00				
	Receipts			0.00	190,439.00	
	Disbursements			0.00	190,439.00-	
	Dept Total.....			0.00	0.00	0.00
	Fund Total.....	3,034,964.03		884,651.93-	2,926,481.63-	108,482.40
61	Agency Health Insurance					
		753,857.36				
	Receipts			474,552.43	3,353,852.72	
	Disbursements			527,140.62-	3,417,644.54-	
	Fund Total.....			52,588.19-	63,791.82-	690,065.54
71	LCTS Lyon Murray Collaborative Fund		471	LCTS Collaborative Agency		
		93,353.73				
	Receipts			200.00	89,078.00	
	Disbursements			9,625.50-	69,425.50-	
	Dept Total.....			9,425.50-	19,652.50	113,006.23
	Fund Total.....	93,353.73		9,425.50-	19,652.50	113,006.23
73	LCTS Rock Pipestone Collaborative Fund		471	LCTS Collaborative Agency		
		44,725.46				
	Receipts			0.00	33,892.00	
	Disbursements			77.01-	2,711.01-	
	Dept Total.....			77.01-	31,180.99	75,906.45
	Fund Total.....	44,725.46		77.01-	31,180.99	75,906.45
75	Redwood LCTS Collaborative		471	LCTS Collaborative Agency		
		46,722.12				

Southwest Health and Human Services

Treasurer's Cash Trial Balance

As of 10/2018

Fund		Beginning Balance	This Month	YTD	Current Balance
	Receipts		0.00	72,607.00	
	Disbursements		149.49-	87,599.49-	
	Dept Total		149.49-	14,992.49-	31,729.63
	Fund Total	46,722.12	149.49-	14,992.49-	31,729.63
77	Local Advisory Council		477 Local Advisory Council		
		1,398.86			
	Disbursements		0.00	182.78-	
	Dept Total		0.00	182.78-	1,216.08
	Fund Total	1,398.86	0.00	182.78-	1,216.08
All Funds		5,684,566.63			
	Receipts		2,058,083.13	26,996,895.65	
	Disbursements		900,002.08-	8,598,200.95-	
	SSIS		522,713.50-	6,570,341.62-	
	Payroll		1,251,685.43-	13,737,720.15-	
	Journal Entries		0.00	1,000,000.00-	
	Total		616,317.88-	2,909,367.07-	2,775,199.56

Southwest Health and Human Services

Trial Balance
As of 10/2018 Report Basis: Cash

1 Health Services Fund

Account			Beginning Balance	Actual This- Month	Actual Year- To- Date	Current Balance
		----------Assets----------				
1001	Cash in Bank - Checking		1,709,545.07	330,574.24	45,248.16	1,754,793.23
1090	Investments		0.00	0.00	160,000.00	160,000.00
		Total Assets	1,709,545.07	330,574.24	205,248.16	1,914,793.23
		---Liabilities and Balance-----				
		Liabilities				
		Total Liabilities	0.00	0.00	0.00	0.00
		Fund Balance				
2881	Unassigned Fund Balance		1,709,545.07-	0.00	0.00	1,709,545.07-
2885	Revenue Control		0.00	587,564.03-	3,275,571.12-	3,275,571.12-
2887	Expenditure Control		0.00	256,989.79	3,070,322.96	3,070,322.96
		Total Fund Balance	1,709,545.07-	330,574.24-	205,248.16-	1,914,793.23-
		Total Liabilities and Balance	1,709,545.07-	330,574.24-	205,248.16-	1,914,793.23-
410	General Administration					
		----------Assets----------				
		Total Assets	0.00	0.00	0.00	0.00
		---Liabilities and Balance-----				
		Liabilities				
		Total Liabilities	0.00	0.00	0.00	0.00
		Total Liabilities and Balance	0.00	0.00	0.00	0.00
1	Health Services Fund		0.00	0.00	0.00	0.00

Southwest Health and Human Services

Trial Balance
As of 10/2018
Report Basis: Cash

Account		Beginning Balance	Actual This- Month	Actual Year- To- Date	Current Balance
410	General Administration				
	----------Assets----------				
1001	Cash In Bank - Checking	189,947.30	27,156.50-	161,358.16-	28,589.14
	Total Assets	189,947.30	27,156.50-	161,358.16-	28,589.14
	---Liabilities and Balance-----				
	Liabilities				
2090	Due To Flexible Plan Employees	220.17	60.87	586.84-	366.67-
	Total Liabilities	220.17	60.87	586.84-	366.67-
	Fund Balance				
2850	Assigned for Software Purchases	64,377.00	0.00	0.00	64,377.00
2881	Unassigned Fund Balance	254,544.47-	0.00	0.00	254,544.47-
2887	Expenditure Control	0.00	27,095.63	161,945.00	161,945.00
	Total Fund Balance	190,167.47-	27,095.63	161,945.00	28,222.47-
	Total Liabilities and Balance	189,947.30-	27,156.50	161,358.16	28,589.14-
420	Income Maintenance				
	----------Assets----------				
1001	Cash In Bank - Checking	2,690,331.05-	125,739.47-	392,546.48-	3,082,877.53-
1090	Investments	0.00	0.00	290,000.00	290,000.00
	Total Assets	2,690,331.05-	125,739.47-	102,546.48-	2,792,877.53-
	---Liabilities and Balance-----				
	Liabilities				
	Total Liabilities	0.00	0.00	0.00	0.00
	Fund Balance				
2881	Unassigned Fund Balance	2,690,331.05	0.00	0.00	2,690,331.05
2885	Revenue Control	0.00	422,291.66-	6,322,013.00-	6,322,013.00-
2887	Expenditure Control	0.00	548,031.13	6,424,559.48	6,424,559.48
	Total Fund Balance	2,690,331.05	125,739.47	102,546.48	2,792,877.53
	Total Liabilities and Balance	2,690,331.05	125,739.47	102,546.48	2,792,877.53
431	Social Services				
	----------Assets----------				

290,000.00 29%

Southwest Health and Human Services

Trial Balance
As of 10/2018 Report Basis: Cash

Account		Beginning Balance	Actual This- Month	Actual Year- To- Date	Current Balance
1001	Cash In Bank - Checking	8,275,091.90	707,022.65-	2,121,301.13-	6,153,790.77
1090	Investments	0.00	0.00	550,000.00	550,000.00 55%
1205	County Advances - MFIP (Chippewa Cty)	80,749.47	0.00	0.00	80,749.47
	Total Assets	8,355,841.37	707,022.65-	1,571,301.13-	6,784,540.24
	--- Liabilities and Balance-----				
	Liabilities				
	Total Liabilities	0.00	0.00	0.00	0.00
	Fund Balance				
2881	Unassigned Fund Balance	8,355,841.37-	0.00	0.00	8,355,841.37-
2885	Revenue Control	0.00	518,161.16-	13,040,809.62-	13,040,809.62-
2887	Expenditure Control	0.00	1,225,183.81	14,612,110.75	14,612,110.75
	Total Fund Balance	8,355,841.37-	707,022.65	1,571,301.13	6,784,540.24-
	Total Liabilities and Balance	8,355,841.37-	707,022.65	1,571,301.13	6,784,540.24-
461	Information Systems				
	----------Assets----------				
1001	Cash In Bank - Checking	2,739,744.12-	24,733.31-	251,275.86-	2,991,019.98-
	Total Assets	2,739,744.12-	24,733.31-	251,275.86-	2,991,019.98-
	---Liabilities and Balance-----				
	Liabilities				
	Total Liabilities	0.00	0.00	0.00	0.00
	Fund Balance				
2881	Unassigned Fund Balance	2,739,744.12	0.00	0.00	2,739,744.12
2885	Revenue Control	0.00	3,592.00-	46,861.56-	46,861.56-
2887	Expenditure Control	0.00	28,325.31	298,137.42	298,137.42
	Total Fund Balance	2,739,744.12	24,733.31	251,275.86	2,991,019.98
	Total Liabilities and Balance	2,739,744.12	24,733.31	251,275.86	2,991,019.98
471	LCTS Collaborative Agency				
	----------Assets----------				
	Total Assets	0.00	0.00	0.00	0.00
	---Liabilities and Balance-----				
	Liabilities				

Southwest Health and Human Services

Trial Balance
As of 10/2018 Report Basis: Cash

5 Human Services Fund

Account			Beginning Balance	Actual This- Month	Actual Year- To- Date	Current Balance
		Total Liabilities	0.00	0.00	0.00	0.00
		Fund Balance				
2885	Revenue Control		0.00	0.00	190,439.00-	190,439.00-
2887	Expenditure Control		0.00	0.00	190,439.00	190,439.00
		Total Fund Balance	0.00	0.00	0.00	0.00
		Total Liabilities and Balance	0.00	0.00	0.00	0.00
5	Human Services Fund		0.00	0.00	0.00	0.00

Southwest Health and Human Services

RM-Stmt of Revenues & Expenditures

As Of 10/2018 Report Basis: Cash

DESCRIPTION	CURRENT MONTH	YEAR TO-DATE	2018 BUDGET	% OF BUDG	% OF YEAR
FUND 1 HEALTH SERVICES FUND					
REVENUES					
CONTRIBUTIONS FROM COUNTIES	385,829.00-	899,407.25-	928,795.00-	97	83
INTERGOVERNMENTAL REVENUES	707.22-	187,001.63-	187,300.00-	100	83
STATE REVENUES	92,033.27-	736,592.91-	855,647.00-	86	83
FEDERAL REVENUES	88,610.29-	1,074,980.07-	1,362,742.00-	79	83
FEES	19,167.34-	361,442.76-	454,980.00-	79	83
EARNINGS ON INVESTMENTS	866.40-	4,479.53-	1,600.00-	280	83
MISCELLANEOUS REVENUES	350.51-	11,666.97-	8,900.00-	131	83
TOTAL REVENUES	587,564.03-	3,275,571.12-	3,799,964.00-	86	83
EXPENDITURES					
PROGRAM EXPENDITURES	0.00	0.00	0.00	0	83
PAYROLL AND BENEFITS	225,463.16	2,436,652.22	2,907,719.00	84	83
OTHER EXPENDITURES	31,526.63	633,670.74	892,245.00	71	83
TOTAL EXPENDITURES	256,989.79	3,070,322.96	3,799,964.00	81	83

Southwest Health and Human Services

RM-Stmt of Revenues & Expenditures

As Of 10/2018 Report Basis: Cash

DESCRIPTION	CURRENT MONTH	YEAR TO-DATE	2018 BUDGET	% OF BUDG	% OF YEAR
FUND 5 HUMAN SERVICES FUND					
REVENUES					
CONTRIBUTIONS FROM COUNTIES	122,103.46-	6,002,861.92-	10,127,818.00-	59	83
INTERGOVERNMENTAL REVENUES	0.00	71,909.68-	109,907.00-	65	83
STATE REVENUES	170,041.70-	4,385,419.93-	5,343,608.00-	82	83
FEDERAL REVENUES	431,777.51-	6,110,681.25-	7,756,313.00-	79	83
FEES	143,793.80-	1,925,121.59-	2,191,354.00-	88	83
EARNINGS ON INVESTMENTS	4,548.55-	22,488.66-	8,400.00-	268	83
MISCELLANEOUS REVENUES	71,779.80-	1,081,640.15-	993,200.00-	109	83
TOTAL REVENUES	944,044.82-	19,600,123.18-	26,530,600.00-	74	83
EXPENDITURES					
PROGRAM EXPENDITURES	681,394.70	8,409,988.31	10,064,471.00	84	83
PAYROLL AND BENEFITS	1,036,039.21	11,305,134.53	13,733,885.00	82	83
OTHER EXPENDITURES	111,201.97	1,972,068.81	2,732,244.00	72	83
TOTAL EXPENDITURES	1,828,635.88	21,687,191.65	26,530,600.00	82	83

Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
1 FUND	Health Services Fund							
410 DEPT	General Administration							
0 PROGRAM	---		Revenue					83
			Expend.	2,404.44	40,892.65	160.00	25,558	83
			Net	2,404.44	40,892.65	160.00	25,558	83
930 PROGRAM	Administration		Revenue	387,193.44-	936,516.44-	939,995.00-	100	83
			Expend.	41,229.24	500,430.05	614,515.00	81	83
			Net	345,964.20-	436,086.39-	325,480.00-	134	83
410 DEPT	General Administration	Totals:	Revenue	387,193.44-	936,516.44-	939,995.00-	100	83
			Expend.	43,633.68	541,322.70	614,675.00	88	83
			Net	343,559.76-	395,193.74-	325,320.00-	121	83
481 DEPT	Nursing							
100 PROGRAM	Family Health		Revenue	463.72-	16,380.64-	18,160.00-	90	83
			Expend.	4,178.29	22,556.68	14,764.00	153	83
			Net	3,714.57	6,176.04	3,396.00-	182-	83
103 PROGRAM	Follow Along Program		Revenue	2,709.45-	21,122.28-	26,966.00-	78	83
			Expend.	1,672.26	24,481.50	35,676.00	69	83
			Net	1,037.19-	3,359.22	8,710.00	39	83
110 PROGRAM	TANF		Revenue	0.00	47,223.49-	127,876.00-	37	83
			Expend.	0.00	110,026.23	127,876.00	86	83
			Net	0.00	62,802.74	0.00	0	83
130 PROGRAM	WIC		Revenue	32,875.00-	470,384.00-	435,696.00-	108	83
			Expend.	33,583.05	455,115.12	467,435.00	97	83
			Net	708.05	15,268.88-	31,739.00	48-	83
140 PROGRAM	Peer Breastfeeding Support Program		Revenue	0.00	41,077.00-	78,244.00-	52	83
			Expend.	3,838.05	41,587.22	78,244.00	53	83
			Net	3,838.05	510.22	0.00	0	83
210 PROGRAM	CTC Outreach		Revenue	42,058.06-	221,822.79-	271,412.00-	82	83
			Expend.	16,579.83	194,732.06	271,412.00	72	83
			Net	25,478.23-	27,090.73-	0.00	0	83
270 PROGRAM	Maternal Child Health		Revenue	2,193.25-	135,445.99-	334,648.00-	40	83
			Expend.	16,031.43	198,980.88	315,553.00	63	83
			Net	13,838.18	63,534.89	19,095.00-	333-	83

Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
280 PROGRAM	MCH Dental Health		Revenue	141.01-	23,070.78-	70,300.00-	33	83
			Expend.	1,210.56	16,826.04	48,549.00	35	83
			Net	1,069.55	6,244.74-	21,751.00-	29	83
285 PROGRAM	MCH Blood Lead		Revenue	0.00	0.00	1,000.00-	0	83
			Expend.	170.42	2,273.03	0.00	0	83
			Net	170.42	2,273.03	1,000.00-	227-	83
295 PROGRAM	MCH Car Seat Program		Revenue	480.20-	13,257.81-	33,200.00-	40	83
			Expend.	2,686.20	27,247.91	41,745.00	65	83
			Net	2,206.00	13,990.10	8,545.00	164	83
300 PROGRAM	Case Management		Revenue	16,116.92-	325,838.06-	368,800.00-	88	83
			Expend.	35,172.44	347,739.17	361,007.00	96	83
			Net	19,055.52	21,901.11	7,793.00-	281-	83
330 PROGRAM	MNChoices		Revenue	7,866.85-	193,424.40-	171,500.00-	113	83
			Expend.	18,816.09	233,063.60	293,918.00	79	83
			Net	10,949.24	39,639.20	122,418.00	32	83
603 PROGRAM	Disease Prevention And Control		Revenue	19,688.90-	153,359.27-	157,292.00-	97	83
			Expend.	12,833.87	181,495.21	240,454.00	75	83
			Net	6,855.03-	28,135.94	83,162.00	34	83
660 PROGRAM	MIIC		Revenue	0.00	0.00	1,500.00-	0	83
			Expend.	211.81	1,147.51	0.00	0	83
			Net	211.81	1,147.51	1,500.00-	77-	83
481 DEPT	Nursing	Totals:	Revenue	124,593.36-	1,662,406.51-	2,096,594.00-	79	83
			Expend.	146,984.30	1,857,272.16	2,296,633.00	81	83
			Net	22,390.94	194,865.65	200,039.00	97	83
483 DEPT	Health Education							
500 PROGRAM	Direct Client Services		Revenue	2,411.78-	10,377.89-	2,770.00-	375	83
			Expend.	2,541.84	14,263.32	61,613.00	23	83
			Net	130.06	3,885.43	58,843.00	7	83
510 PROGRAM	SHIP		Revenue	12,409.42-	206,662.85-	224,631.00-	92	83
			Expend.	14,760.18	164,680.24	220,396.00	75	83
			Net	2,350.76	41,982.61-	4,235.00-	991	83
540 PROGRAM	Toward Zero Deaths (TZD) Safe Roads		Revenue					83
			Expend.	0.91	327.54	0.00	0	83
			Net	0.91	327.54	0.00	0	83

Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
550 PROGRAM	P&I Grant		Revenue	34,494.00-	181,457.00-	188,679.00-	96	83
			Expend.	18,287.15	165,152.72	186,869.00	88	83
			Net	16,206.85-	16,304.28-	1,810.00-	901	83
900 PROGRAM	Emergency Preparedness		Revenue	0.00	72,027.25-	98,295.00-	73	83
			Expend.	8,962.78	85,701.04	124,290.00	69	83
			Net	8,962.78	13,673.79	25,995.00	53	83
901 PROGRAM	Med Reserve Corps		Revenue					83
			Expend.	0.00	1,039.58	0.00	0	83
			Net	0.00	1,039.58	0.00	0	83
483 DEPT	Health Education	Totals:	Revenue	49,315.20-	470,524.99-	514,375.00-	91	83
			Expend.	44,552.86	431,164.44	593,168.00	73	83
			Net	4,762.34-	39,360.55-	78,793.00	50-	83
485 DEPT	Environmental Health							
800 PROGRAM	Environmental		Revenue	26,462.03-	203,123.18-	229,000.00-	89	83
			Expend.	21,818.95	240,551.78	275,682.00	87	83
			Net	4,643.08-	37,428.60	46,682.00	80	83
820 PROGRAM	Healthy Homes Grant		Revenue	0.00	0.00	20,000.00-	0	83
			Expend.	0.00	0.00	19,806.00	0	83
			Net	0.00	0.00	194.00-	0	83
830 PROGRAM	FDA Standardization Grant		Revenue	0.00	3,000.00-	0.00	0	83
			Expend.	0.00	11.88	0.00	0	83
			Net	0.00	2,988.12-	0.00	0	83
485 DEPT	Environmental Health	Totals:	Revenue	26,462.03-	206,123.18-	249,000.00-	83	83
			Expend.	21,818.95	240,563.66	295,488.00	81	83
			Net	4,643.08-	34,440.48	46,488.00	74	83
1 FUND	Health Services Fund	Totals:	Revenue	587,564.03-	3,275,571.12-	3,799,964.00-	86	83
			Expend.	256,989.79	3,070,322.96	3,799,964.00	81	83
			Net	330,574.24-	205,248.16-	0.00	0	83

Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
5 FUND	Human Services Fund							
410 DEPT	General Administration							
0 PROGRAM	...		Revenue					83
			Expend.	27,095.63	161,945.00	83,935.00	193	83
			Net	27,095.63	161,945.00	83,935.00	193	83
410 DEPT	General Administration	Totals:	Revenue					83
			Expend.	27,095.63	161,945.00	83,935.00	193	83
			Net	27,095.63	161,945.00	83,935.00	193	83
420 DEPT	Income Maintenance							
600 PROGRAM	Income Maint Administrative/Overhea		Revenue	39,971.81-	1,935,876.28-	3,246,752.00-	60	83
			Expend.	106,684.01	1,331,033.90	1,666,654.00	80	83
			Net	66,712.20	604,842.38-	1,580,098.00-	38	83
601 PROGRAM	Income Maint/Random Moment Payro		Revenue					83
			Expend.	189,401.82	2,093,360.85	2,562,216.00	82	83
			Net	189,401.82	2,093,360.85	2,562,216.00	82	83
602 PROGRAM	Income Maint FPI Investigator		Revenue	0.00	35,288.00-	50,000.00-	71	83
			Expend.	4,838.27	51,898.91	61,111.00	85	83
			Net	4,838.27	16,610.91	11,111.00	149	83
605 PROGRAM	MN Supplemental Aid (MSA)/GRH		Revenue	1,996.44-	32,028.37-	28,000.00-	114	83
			Expend.	3,089.22	36,136.61	18,750.00	193	83
			Net	1,092.78	4,108.24	9,250.00-	44-	83
610 PROGRAM	TANF(AFDC/MFIP/DWP)		Revenue	337.00-	12,016.54-	25,000.00-	48	83
			Expend.	177.38	2,936.64	19,550.00	15	83
			Net	159.62-	9,079.90-	5,450.00-	167	83
620 PROGRAM	General Asst (GA)/General Relief/Buri.		Revenue	50.00-	21,430.72-	25,000.00-	86	83
			Expend.	20,105.00	179,374.49	251,250.00	71	83
			Net	20,055.00	157,943.77	226,250.00	70	83
630 PROGRAM	Food Support (FS)		Revenue	10,886.00-	374,409.35-	516,000.00-	73	83
			Expend.	319.35	18,964.53	7,500.00	253	83
			Net	10,566.65-	355,444.82-	508,500.00-	70	83
640 PROGRAM	Child Support (IVD)		Revenue	91,315.81-	1,138,321.28-	1,653,893.00-	69	83
			Expend.	84,600.73	970,044.12	1,153,303.00	84	83
			Net	6,715.08-	168,277.16-	500,590.00-	34	83

Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
650 PROGRAM	Medical Assistance (MA)		Revenue	277,734.60-	2,772,642.46-	3,350,000.00-	83	83
			Expend.	138,815.35	1,740,809.43	2,476,000.00	70	83
			Net	138,919.25-	1,031,833.03-	874,000.00-	118	83
680 PROGRAM	Refugee Cash Assistance (RCA)		Revenue	0.00	0.00	1,000.00-	0	83
			Expend.					83
			Net	0.00	0.00	1,000.00-	0	83
420 DEPT	Income Maintenance	Totals:	Revenue	422,291.66-	6,322,013.00-	8,895,645.00-	71	83
			Expend.	548,031.13	6,424,559.48	8,216,334.00	78	83
			Net	125,739.47	102,546.48	679,311.00-	15-	83
431 DEPT	Social Services							
700 PROGRAM	Social Service Administrative/Overhea		Revenue	129,717.75-	6,711,357.56-	9,991,780.00-	67	83
			Expend.	151,572.17	2,061,332.08	2,754,328.00	75	83
			Net	21,854.42	4,650,025.48-	7,237,452.00-	64	83
701 PROGRAM	Social Services/SSTS		Revenue					83
			Expend.	540,074.23	5,976,232.07	7,149,115.00	84	83
			Net	540,074.23	5,976,232.07	7,149,115.00	84	83
710 PROGRAM	Children's Social Services Programs		Revenue	97,241.93-	1,605,142.96-	1,934,098.00-	83	83
			Expend.	290,488.31	3,010,783.08	3,619,941.00	83	83
			Net	193,246.38	1,405,640.12	1,685,843.00	83	83
712 PROGRAM	CIRCLE Program		Revenue	0.00	11,000.00-	5,000.00-	220	83
			Expend.	600.75	5,737.69	8,000.00	72	83
			Net	600.75	5,262.31-	3,000.00	175-	83
713 PROGRAM	"SELF Program" Grant		Revenue	0.00	33,601.00-	54,100.00-	62	83
			Expend.	2,232.30	26,648.15	54,100.00	49	83
			Net	2,232.30	6,952.85-	0.00	0	83
715 PROGRAM	Childrens Waivers		Revenue	6,149.37-	72,418.89-	105,000.00-	69	83
			Expend.	0.00	0.00	10,000.00	0	83
			Net	6,149.37-	72,418.89-	95,000.00-	76	83
716 PROGRAM	FGDM/Family Group Decision Making		Revenue	0.00	45,724.89-	56,914.00-	80	83
			Expend.	3,629.00	20,239.11	56,914.00	36	83
			Net	3,629.00	25,485.78-	0.00	0	83
717 PROGRAM	AR/Alternative Response Discretion F		Revenue	0.00	40,972.50-	55,175.00-	74	83
			Expend.	1,044.51	20,105.50	55,175.00	36	83
			Net	1,044.51	20,867.00-	0.00	0	83

Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
718 PROGRAM	PSOP/Parent Support Outreach Progra		Revenue	0.00	21,150.00-	52,446.00-	40	83
			Expend.	538.36	10,226.24	40,446.00	25	83
			Net	538.36	10,923.76-	12,000.00-	91	83
720 PROGRAM	Ch Care/Ch Prot		Revenue	3,300.00-	27,750.00-	30,000.00-	93	83
			Expend.	90.00	5,400.26	4,500.00	120	83
			Net	3,210.00-	22,349.74-	25,500.00-	88	83
721 PROGRAM	CC-Basic Slide Fee/Cty Match to DHS		Revenue	2,597.00-	26,563.45-	40,035.00-	66	83
			Expend.	0.00	35,378.21	40,035.00	88	83
			Net	2,597.00-	8,814.76	0.00	0	83
722 PROGRAM	Child Care/MFIP		Revenue	0.00	1,050.50-	1,500.00-	70	83
			Expend.					83
			Net	0.00	1,050.50-	1,500.00-	70	83
726 PROGRAM	MFIP/SW MN PIC		Revenue	1,234.00-	12,287.00-	13,000.00-	95	83
			Expend.					83
			Net	1,234.00-	12,287.00-	13,000.00-	95	83
730 PROGRAM	Chemical Dependency		Revenue	10,483.40-	229,833.43-	293,000.00-	78	83
			Expend.	16,558.00	444,375.88	434,000.00	102	83
			Net	6,074.60	214,542.45	141,000.00	152	83
740 PROGRAM	Mental Health (Both Adults/Children)		Revenue	0.00	143.30-	0.00	0	83
			Expend.					83
			Net	0.00	143.30-	0.00	0	83
741 PROGRAM	Mental Health/Adults Only		Revenue	60,540.04-	1,130,393.20-	1,210,635.00-	93	83
			Expend.	80,458.59	1,356,206.69	1,598,082.00	85	83
			Net	19,918.55	225,813.49	387,447.00	58	83
742 PROGRAM	Mental Health/Children Only		Revenue	46,705.41-	767,186.45-	864,383.00-	89	83
			Expend.	93,847.10	1,224,807.11	1,405,984.00	87	83
			Net	47,141.69	457,620.66	541,601.00	84	83
750 PROGRAM	Developmental Disabilities		Revenue	55,374.71-	647,787.23-	856,835.00-	76	83
			Expend.	27,924.17	300,050.02	428,185.00	70	83
			Net	27,450.54-	347,737.21-	428,650.00-	81	83
760 PROGRAM	Adult Services		Revenue	48,144.86-	1,089,013.00-	1,355,500.00-	80	83
			Expend.	9,650.87	32,038.00	88,800.00	36	83
			Net	38,493.99-	1,056,975.00-	1,266,700.00-	83	83

Southwest Health and Human Services

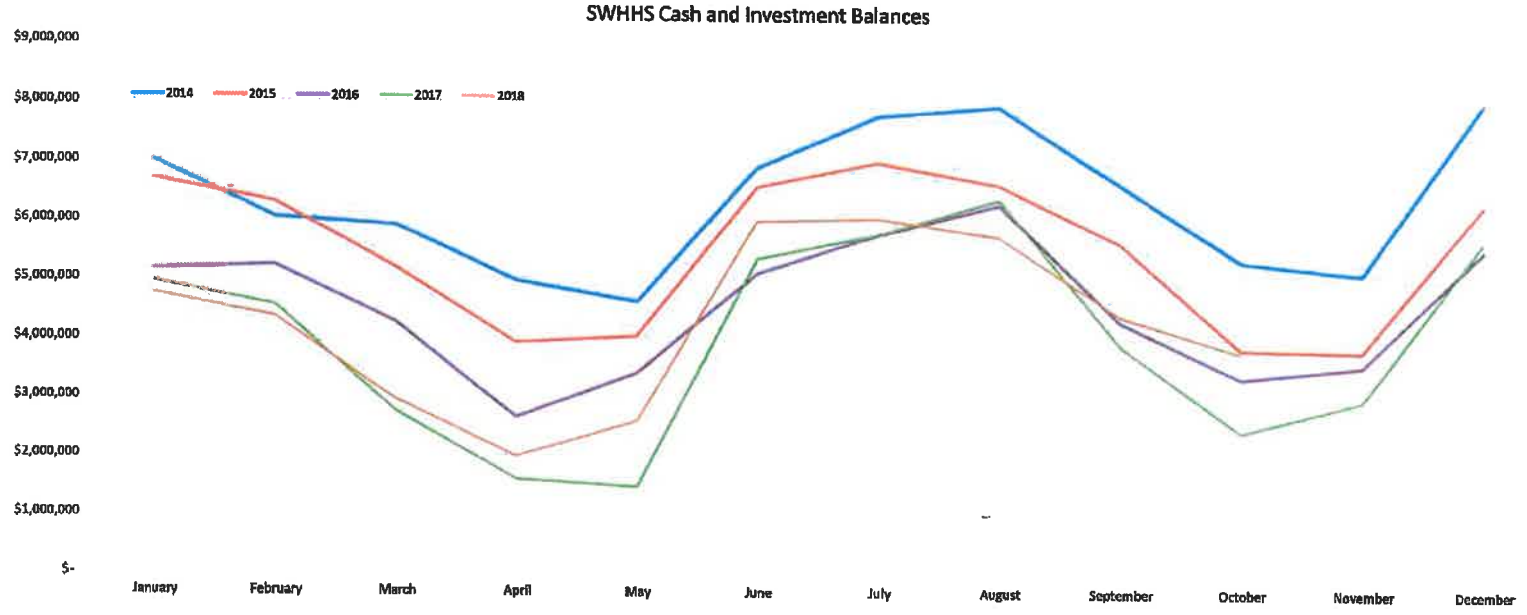
Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
765 PROGRAM	Adults Waivers		Revenue	56,672.69-	567,434.26-	680,000.00-	83	83
			Expend.	6,475.45	82,550.66	81,250.00	102	83
			Net	50,197.24-	484,883.60-	598,750.00-	81	83
431 DEPT	Social Services	Totals:	Revenue	518,161.16-	13,040,809.62-	17,599,401.00-	74	83
			Expend.	1,225,183.81	14,612,110.75	17,828,855.00	82	83
			Net	707,022.65	1,571,301.13	229,454.00	685	83
461 DEPT	Information Systems							
0 PROGRAM	...		Revenue	3,592.00-	46,861.56-	35,554.00-	132	83
			Expend.	28,325.31	298,137.42	401,476.00	74	83
			Net	24,733.31	251,275.86	365,922.00	69	83
461 DEPT	Information Systems	Totals:	Revenue	3,592.00-	46,861.56-	35,554.00-	132	83
			Expend.	28,325.31	298,137.42	401,476.00	74	83
			Net	24,733.31	251,275.86	365,922.00	69	83
471 DEPT	LCTS Collaborative Agency							
702 PROGRAM	LCTS		Revenue	0.00	190,439.00-	0.00	0	83
			Expend.	0.00	190,439.00	0.00	0	83
			Net	0.00	0.00	0.00	0	83
471 DEPT	LCTS Collaborative Agency	Totals:	Revenue	0.00	190,439.00-	0.00	0	83
			Expend.	0.00	190,439.00	0.00	0	83
			Net	0.00	0.00	0.00	0	83
5 FUND	Human Services Fund	Totals:	Revenue	944,044.82-	19,600,123.18-	26,530,600.00-	74	83
			Expend.	1,828,635.88	21,687,191.65	26,530,600.00	82	83
			Net	884,591.06	2,087,068.47	0.00	0	83
FINAL TOTALS	1,028 Accounts		Revenue	1,531,608.85-	22,875,694.30-	30,330,564.00-	75	83
			Expend.	2,085,625.67	24,757,514.61	30,330,564.00	82	83
			Net	554,016.82	1,881,820.31	0.00	0	83

SWHHS
Total Cash and Investment Balance by Month - All Funds

	January	February	March	April	May	June	July	August	September	October	November	December	Average for Year	Average for Jan-Mar
2014	$ 6,981,225	$ 6,024,758	$ 5,889,424	$ 4,951,093	$ 4,596,615	$ 6,893,383	$ 7,769,372	$ 7,943,229	$ 6,629,326	$ 5,325,639	$ 5,113,269	$ 8,050,538	$ 6,347,314	$ 6,298,469
2015	6,677,478	6,283,515	5,177,700	3,907,689	4,019,147	6,560,423	6,992,523	6,614,414	5,631,268	3,840,913	3,805,455	6,311,344	5,485,156	6,046,231
2016	5,132,902	5,204,953	4,246,694	2,626,629	3,394,917	5,088,798	5,750,966	6,275,435	4,290,910	3,346,310	3,560,417	5,533,702	4,537,719	4,861,516
2017	4,926,902	4,524,066	2,727,751	1,578,174	1,451,586	5,337,554	5,754,867	6,366,565	3,893,362	2,417,548	2,962,222	5,684,747	3,968,779	4,059,573
2018	4,721,045	4,333,939	2,935,770	1,965,450	2,570,091	5,977,407	6,033,328	5,731,634	4,391,517	3,775,200			4,243,538	3,996,918

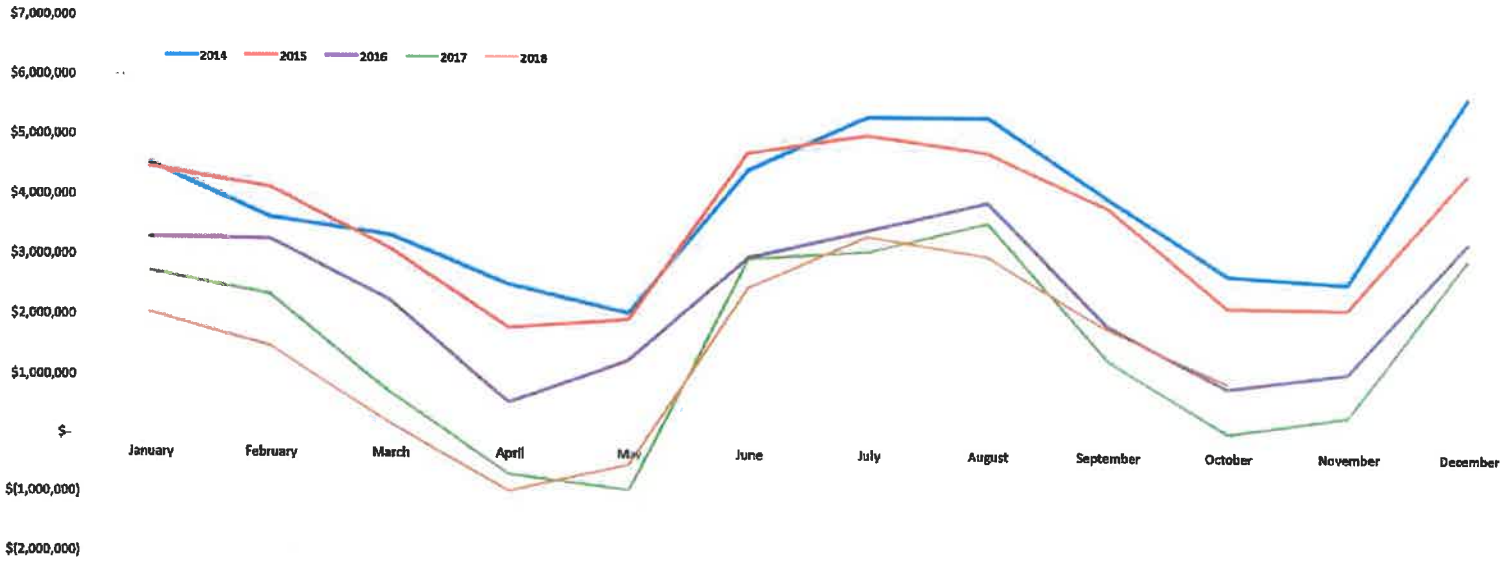


SWHHS

Total Cash and Investment Balance by Month - Human Services

	January	February	March	April	May	June	July	August	September	October	November	December	Average for Year	Average for Jan-Mar
2014	$ 4,524,112	$ 3,629,626	$ 3,337,291	$ 2,518,146	$ 2,049,973	$ 4,463,844	$ 5,363,273	$ 5,365,874	$ 4,025,227	$ 2,740,776	$ 2,617,746	$ 5,760,213	$ 3,866,342	$ 3,830,343
2015	4,463,245	4,128,666	3,114,956	1,805,843	1,948,746	4,743,406	5,052,793	4,776,089	3,868,017	2,206,083	2,192,119	4,467,384	3,563,944	3,902,289
2016	3,281,408	3,262,674	2,255,798	544,626	1,271,340	2,991,321	3,454,356	3,941,450	1,888,875	854,465	1,125,562	3,301,842	2,347,793	2,933,293
2017	2,721,514	2,337,060	710,989	(678,564)	(945,146)	2,972,036	3,098,421	3,593,642	1,322,586	84,999	377,553	3,035,264	1,552,363	1,923,188
2018	2,027,813	1,484,259	191,387	(965,732)	(501,975)	2,490,788	3,357,739	3,035,839	1,833,134	948,482			1,390,172	1,234,480

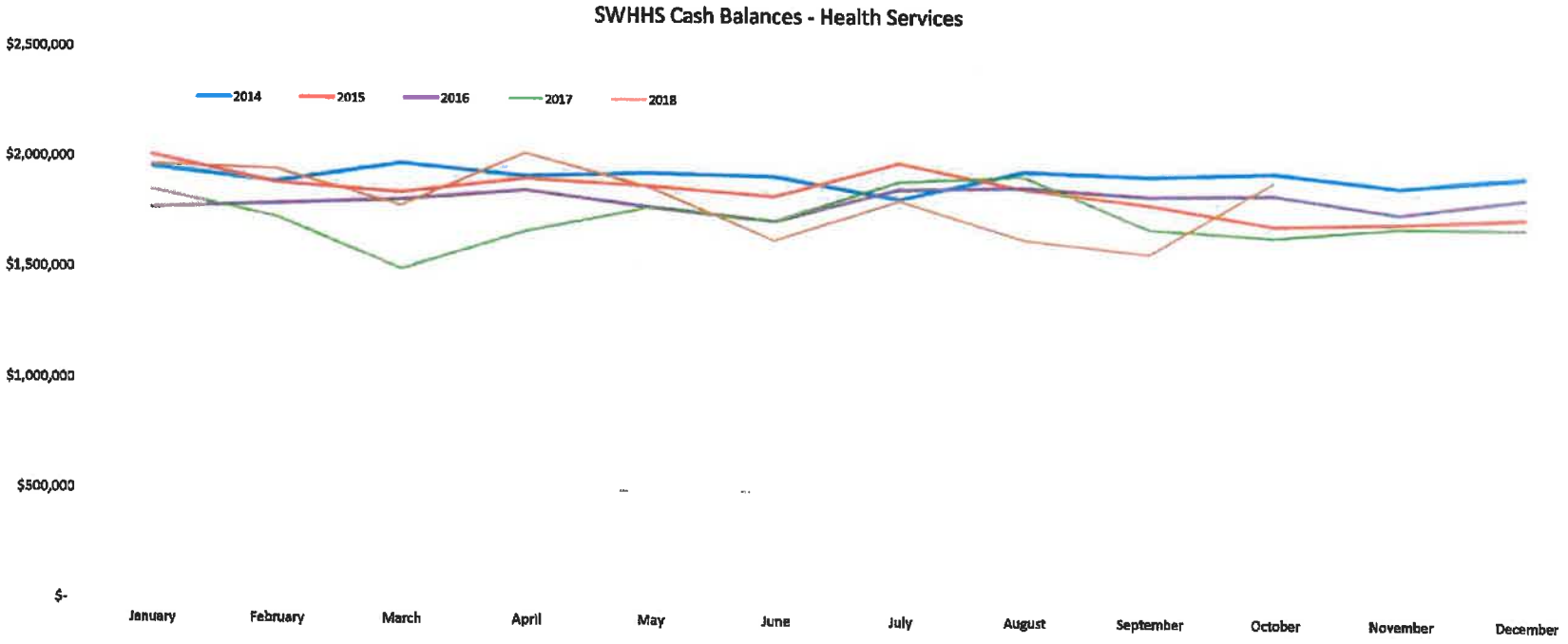
SWHHS Cash Balances - Human Services



SWHHS

Total Cash and Investment Balance by Month - Public Health Services

	January	February	March	April	May	June	July	August	September	October	November	December	Average for Year
2014	$ 1,952,348	$ 1,889,115	$ 1,972,829	$ 1,919,041	$ 1,935,611	$ 1,923,131	$ 1,822,890	$ 1,953,891	$ 1,934,989	$ 1,954,397	$ 1,894,110	$ 1,942,821	$ 1,924,598
2015	2,005,575	1,862,682	1,841,150	1,906,755	1,876,427	1,832,808	1,987,157	1,874,490	1,806,827	1,714,863	1,730,381	1,755,463	1,851,215
2016	1,767,113	1,786,986	1,807,700	1,854,930	1,779,529	1,719,936	1,868,440	1,880,565	1,844,832	1,854,297	1,772,887	1,845,354	1,815,214
2017	1,847,930	1,726,464	1,494,924	1,667,704	1,778,697	1,720,045	1,903,355	1,930,710	1,695,806	1,663,861	1,709,269	1,709,425	1,737,349
2018	1,962,215	1,943,638	1,780,623	2,023,316	1,870,383	1,633,344	1,816,127	1,843,851	1,584,219	1,914,793			1,817,251

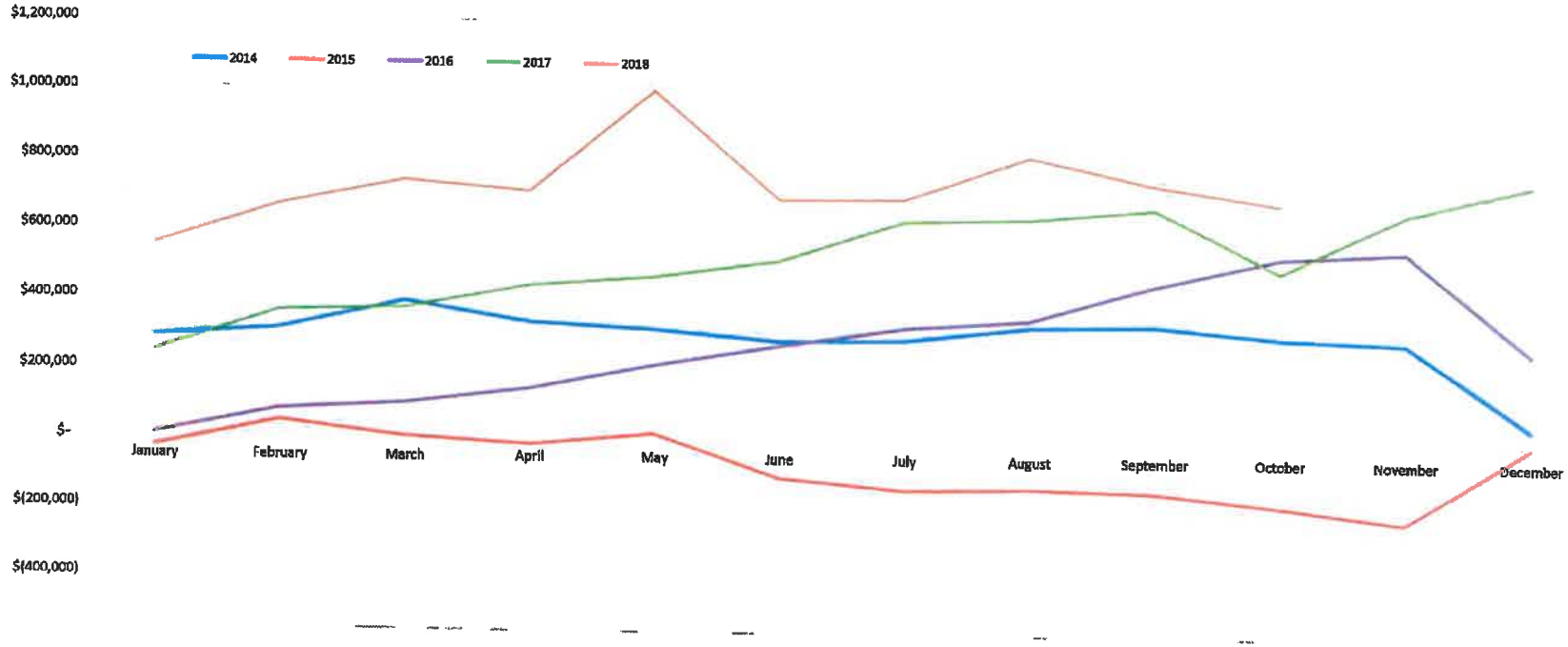


SWHHS

Total Cash Balance by Month - Health Insurance

	January	February	March	April	May	June	July	August	September	October	November	December	Average for Year
2014	$ 285,359	$ 308,046	$ 387,989	$ 330,279	$ 312,752	$ 283,536	$ 290,485	$ 330,402	$ 338,696	$ 307,535	$ 295,838	$ 52,722	$ 293,637
2015	(33,351)	43,793	830	(19,686)	13,869	(109,950)	(141,431)	(134,243)	(141,679)	(178,110)	(221,024)	-	(76,749)
2016	4,998	75,943	95,154	139,472	210,786	270,693	325,644	350,734	455,033	538,192	558,493	269,062	274,517
2017	243,432	360,090	369,064	436,168	485,169	514,005	629,735	640,875	673,434	497,528	665,075	753,857	520,703
2018	547,461	661,779	734,591	705,227	998,994	688,218	893,432	820,833	742,654	690,066			728,325

SWHHS Cash and Investment Balances - Health Insurance



Social Services Caseload:

Yearly Averages	Adult Services	Children's Services	Total Programs
2015	2648	481	3129
2016	2669	518	3187
2017	2705	604	3308
2018			

2018	Adult Services	Children's Services	Total Programs
January	2647	604	3251
February	2650	627	3277
March	2662	632	3294
April	2699	660	3359
May	2702	651	3353
June	2721	609	3330
July	2668	590	3258
August	2694	597	3291
September	2689	601	3290
October	2742	598	3340
November			
December			
	26874	**6169**	**3304**

Adult - Social Services Caseload

Average	Adult Brain Injury (BI)	Adult Community Alternative Care (CAC)	Adult Community Access for Disability Inclusion (CADI)	Adult Essential Community Supports	Adult Mental Health (AMH)	Adult Protective Services (APS)	Adult Services (AS)	Alternative Care (AC)	Chemical Dependency (CD)	Developmental Disabilities (DD)	Elderly Waiver (EW)	Total Programs
2015	12	227	13		306	34	817	23	403	460	352	2652
2016	13	240	12	0	298	50	829	18	396	452	362	2669
2017	12	266	12	0	315	45	828	16	422	444	343	2705
2018												

*Note: CADI name change and there is a new category (Adult Essential Community Supports)

2018	Adult Brain Injury (BI)	Adult Community Access for Disability Inclusion (CADI)	Adult Community Alternative Care (CAC)	Adult Essential Community Supports	Adult Mental Health (AMH)	Adult Protective Services (APS)	Adult Services (AS)	Alternative Care (AC)	Chemical Dependency (CD)	Developmental Disabilities (DD)	Elderly Waiver (EW)	Total Programs
January	12	270	13	0	293	59	862	17	338	453	330	2647
February	12	268	13	0	293	49	856	17	366	453	323	2650
March	11	289	14	0	292	47	859	18	357	450	325	2662
April	11	293	14	0	302	45	866	19	375	453	321	2699
May	11	304	14	0	290	41	871	18	374	451	328	2702
June	11	307	14	0	296	37	882	20	370	447	337	2721
July	11	309	14	0	282	34	876	19	344	446	333	2668
August	11	307	14	0	280	39	890	17	357	448	331	2694
September	11	309	15	0	272	38	916	16	333	448	331	2689
October	11	310	15	0	265	43	907	16	389	449	337	2742
November												
December												
	11	**297**	**14**	**0**	**287**	**43**	**879**	**18**	**360**	**450**	**330**	**2687**

Children's - Social Services Caseload

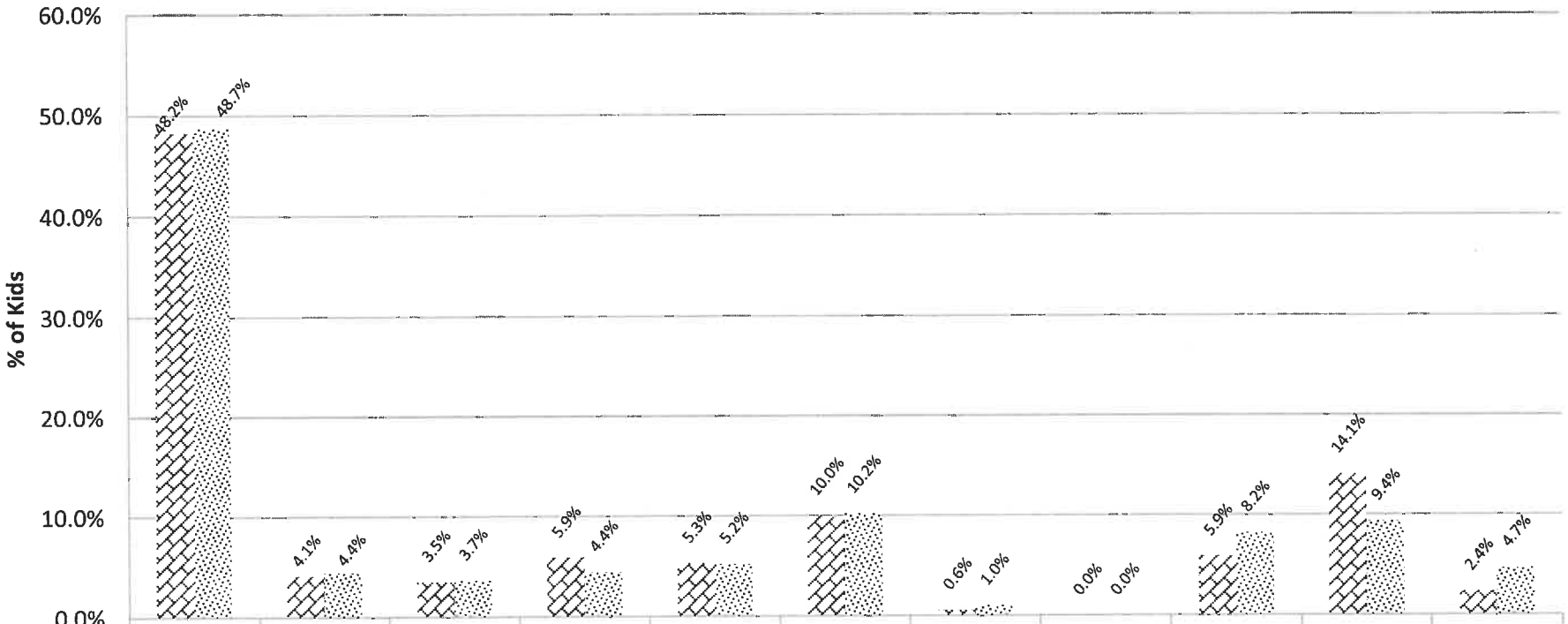
Average	Adolescent Independent Living (ALS)	Adoption	Child Brain Injury (BI)	Child Community Alternative Care (CAC)	Child Community Alternatives for Disabled Individuals (CADI)	Child Protection (CP)	Child Welfare (CW)	Children's Mental Health (CMH)	Early Inter vention: Infants & Toddlers with Disabilities	Minor Parents (MP)	Parent Support Outreach Program (PSOP)	Total Programs
2015	38	15	1	3	30	153	127	96	0	1	18	482
2016	41	17	2	5	35	175	145	86	0	0	13	518
2017	49	21	0	10	35	195	174	103	0	0	17	604
2018												

2018	Adolescent Independent Living (ALS)	Adoption	Child Brain Injury (BI)	Child Community Alternative Care (CAC)	Child Community Alternatives for Disabled Individuals (CADI)	Child Protection (CP)	Child Welfare (CW)	Children's Mental Health (CMH)	Early Inter vention: Infants & Toddlers with Disabilities	Minor Parents (MP)	Parent Support Outreach Program (PSOP)	Total Programs
January	46	20	0	10	34	188	184	104	0	0	18	604
February	46	20	0	10	36	194	196	109	0	0	16	627
March	47	21	0	10	39	194	190	113	0	0	18	632
April	46	23	0	10	39	218	204	107	0	0	13	660
May	46	26	0	11	39	203	192	115	0	0	19	651
June	46	26	0	11	41	170	176	115	0	0	24	609
July	46	26	0	11	41	164	158	115	0	0	29	590
August	46	26	0	11	42	152	170	117	0	0	33	597
September	45	23	0	11	43	173	172	107	0	0	27	601
October	45	19	0	11	42	158	176	109	0	0	38	598
November												
December												
	46	**23**	**0**	**11**	**40**	**181**	**182**	**111**	**0**	**0**	**24**	**617**

2018 KIDS IN OUT OF HOME PLACEMENT - BY COUNTY

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	YTD Average	2017 Average
Lincoln	6	7	9	9	9	9	9	10	10	11			9	7
Lyon	46	44	44	49	43	43	44	48	49	43			45	38
Murray	11	14	16	15	13	9	9	10	12	12			12	10
Pipestone	15	15	16	15	15	13	13	16	17	18			15	19
Redwood	96	92	88	85	83	77	82	72	74	71			82	95
Rock	14	16	16	17	17	17	17	19	14	15			16	16
Monthly Totals	**188**	**188**	**189**	**190**	**180**	**168**	**174**	**175**	**176**	**170**	**0**	**0**		

October 2018 - Placement by Category
170 Kids in Placement



	Foster home: 82	Foster home - corporate: 7	Group Home: 6	Residential treatment center: 10	Supervised independent living: 9	Pre-adoptive home: 17	Juvenile correctional facility (non-secure): 1	Non-custodial parent's home: 0	Child's reunification home: 10	Other: Pre-Kinship home: 23 Hospital: 1	Probation Placement: 4
Month %	48.2%	4.1%	3.5%	5.9%	5.3%	10.0%	0.6%	0.0%	5.9%	14.1%	2.4%
Yearly Avg	48.7%	4.4%	3.7%	4.4%	5.2%	10.2%	1.0%	0.0%	8.2%	9.4%	4.7%

October 2018: Total kids in placement = 170

Total of 6 Children entered placement

1	Lincoln	Group Home
1	Lyon	Juvenile Correctional Facility
1	Pipestone	Residential Treatment Facility
1	Pipestone	Foster Home
2	Rock	Foster Home

Total of 12 Children were discharged from placement (discharges from previous month)

5	Lyon	Child's Reunification Home
1	Lyon	Foster Home
1	Lyon	ADOPTED
1	Pipestone	ADOPTED
2	Redwood	ADOPTED
1	Redwood	Probation
1	Rock	Residential Treatment Facility

NON IVD COLLECTIONS

OCTOBER 2018

PROGRAM	ACCOUNT	TOTAL
MSA/GRH	05-420-605.5802	1,996
TANF (MFIP/DWP/AFDC)	05-420-610.5803	337
GA	05-420-620.5803	50
FS	05-420-630.5803	86
CS (PI Fee, App Fee, etc)	05-420-640.5501	513
MA Recoveries & Estate Collections (25% retained by agency)	05-420-650.5803	33,673
REFUGEE	05-420-680.5803	0
CHILDRENS		
Court Visitor Fee	05-431-700.5514	0
Parental Fees, Holds	05-431-710.5501	19,286
OOH/FC Recovery	05-431-710.5803	22,084
CHILDCARE		
Licensing	05-431-720.5502	1,000
Corp FC Licensing	05-431-710.5505	2,300
Over Payments	05-431-721&722.5803	100
CHEMICAL DEPENDENCY		
CD Assessments	05-431-730.5519	3,926
Detox Fees	05-431-730.5520	2,839
Over Payments	05-431-730.5803	0
MENTAL HEALTH		
Insurance Copay	05-431-740.5803	0
Over Payments	05-431-741 or 742.5803	0
DEVELOPMENTAL DISABILITIES		
Insurance Copay/Overpayments	05-431-750.5803	0
ADULT		
Court Visitor Fee	05-431-760.5803	0
Insurance Copay/Overpayments	05-431-760.5803	0
TOTAL NON-IVD COLLECTIONS		**88,192**

SOUTHWEST HEALTH & HUMAN SERVICES

2018 Public Health Statistics

	WIC	Family Home Visiting	PCA Assessments	Managed Care	Dental Varnish	Refugee Health	Latent TB/DOT Medication Distribution
'12 Avg	1857	48	15	187	81		
'13 Avg	2302	37	21	211	90		
'14 Avg	2228	60	25	225	112	6	30
'15 Avg	2259	86	23	238	112	12	36
'16 Avg	2313	52	22	265	97	12	27
'17 Avg	2217	47	22	290	56	9	25

	WIC	Family Home Visiting	MnChoices PCA Assessments	Managed Care	Dental Varnish	Refugee Health	LTBI Medication Distribution	Water Tests	FPL Inspections	Immunizations	Car Seats
12/17	2187	52	16	283	24	7	18	n/a	n/a	n/a	n/a
1/18	2207	44	21	347	46	5	17	106	45	56	22
2/18	2166	42	20	308	6	7	15	96	46	70	13
3/18	2177	49	23	378	35	8	14	93	43	60	18
4/18	2167	69	21	357	30	1	10	96	42	48	21
5/18	2196	62	22	347	21	2	9	80	46	44	30
6/18	2189	55	21	287	16	8	9	119	76	88	16
7/18	2168	45	26	315	24	4	16	182	58	49	23
8/18	2154	47	29	348	15	1	14	163	67	58	20
9/18	2115	48	13	299	17	5	26	168	38	33	15
10/18		43	23	356	19	1	31	222	44	48	15
11/18											
12/18											

6 County Local Advisory Council on Mental Health

The purpose of the 6 County LAC is to use knowledge from a broad range of people who use or provide mental health services to find ways to improve local mental health services.

November 2018

Dear Members of the Board of Directors,

The 6-County Local Advisory Council (LAC) on Adult Mental Health, serving, Lincoln, Lyon, Murray, Redwood, Pipestone, and Yellow Medicine Counties, is pleased to report on its activities during the past calendar year.

The LAC is comprised of four members who have mental health diagnosis, eight community partners, as well as representatives from SWHHS for both children and adult mental health case management. Our attendance on average is 13 participates each month. To increase membership, we have offered attendance via phone and increased the per diem. So far, in 2018, we have met nine out of the eleven months.

We continue to have presenters at our meetings to share about their programs and raise awareness of the LAC. These speakers are crucial as the availability and the presence of providers is ever changing. We strive to have our LAC be an informational outlet for both our consumers and providers. Our presenters this year included Southwest Minnesota Housing Partnership, SWHHS Public Health, SWCIL, Western Mental Health Center, United Community Action Food Shelf, and Adult Basic Education. We also have been invited and plan to participate in Healthy 56258's subcommittee on mental health.

The gaps listed below are the same gaps addressed last year. In order to make a difference with the gaps in mental health, we felt that some require a change in legislature or at least representation from our part of the state. In September, we invited the State Representative District 16A candidates, Chris Swedzinski and Tom Wyatt-Yerka to attend our LAC meetings. Unfortunately, we have not had a response or participation from either candidate.

- Lack of providers:
  - For individuals to get into a program for services they must have a diagnosis. To get a diagnosis, they have to find a provider, schedule an appointment, obtain a diagnosis and then there is a delay in receiving services.
  - There is a lack of providers for medication management and it is difficult to get an appointment.
  - There are no inpatient treatment options for individuals with personal care (PCA) needs.
  - There is a lack of autism services in our communities. An individual can have an autism assessment completed, get recommendations, and then have no options for providers locally.
  - There are no training opportunities for the Peer Support Specialist positions in our areas.
- Transportation:
  - Transportation providers do not have a funding source to provide transportation for people in rural areas.
  - When transportation is payable by insurance having drivers available is an issue.
- Housing: Lack of affordable housing in our communities.
- Financial:
  - When an individual is slightly over income guidelines and does not qualify for services, programs, or income based housing. There are little or no other options to assist them with these items.
  - There are no financial programs to help support the costs of support animals. For example, there are no programs to help with health maintenance, food support, care when the owner is hospitalized, etc.

In closing, we would like to extend our gratitude for the continued support of our local LAC by our member counties: Lincoln, Lyon, Murray, Redwood, Pipestone, and Yellow Medicine.

Respectfully submitted,

Jennifer Lundberg, LSW & Nathaniel Kuhnau
County Agency Social Workers
Southwest Health and Human Services
607 W. Main St, Suite 100
Marshall, MN 56258
Phone 507-537-6747, Fax 507-537-6088

Southwest Health and Human Services Budget	SWHHS (combined)	SWHHS (combined)	SWHHS	SWHHS	SWHHS	SWHHS	SWHHS	SWHHS	SWHHS
HUMAN SERVICES	2012	2013	2014	2015	2016	2017	2018	2019	2019
Category	Final	Final	Final	Final	Final	Final	Final	Preliminary	Final
EXPENDITURES									
420 Income Maintenance / Child Support									
6100 - Personnel	$2,345,803	$4,111,265	$4,351,283	$4,564,427	$4,762,548	$4,917,132	$4,639,776	$4,671,663	$4,435,784
6200- Services & Charges	$301,105	$404,775	$382,200	$397,680	$382,628	$327,965	$379,530	$346,790	$355,610
6300/6800- Administrative Overhead Costs	$281,425	$474,727	$461,470	$726,861	$1,037,253	$943,395	$882,278	$821,362	$819,796
6000- Payment for/behalf clients	$1,374,670	$2,130,605	$1,837,000	$1,815,000	$2,213,800	$1,760,500	$2,314,750	$2,417,000	$2,417,000
Reserves									$35,000
Subtotal	$4,303,003	$7,121,372	$7,031,953	$7,503,968	$8,396,229	$7,948,992	$8,216,334	$8,256,815	$8,063,190
431 Social Services									
710-718 - Children's Services	$1,773,689	$2,497,988	$2,555,041	$2,875,490	$3,039,801	$3,123,763	$3,688,385	$4,148,639	$4,148,639
720-727 - Child Care/MFIP Admin./PIC.	$277,933	$489,988	$68,665	$64,965	$81,400	$49,365	$44,535	$331,755	$331,755
730 - Chemical Dependency	$260,270	$426,600	$496,500	$540,000	$434,600	$435,500	$431,000	$516,500	$516,500
740-742 - Mental Health	$2,016,599	$3,153,603	$3,681,539	$2,834,860	$2,966,187	$2,999,527	$2,999,066	$3,647,864	$3,579,782
750 - Developmental Dis.	$352,159	$577,924	$455,633	$408,451	$417,435	$362,111	$428,185	$389,361	$389,361
760-765 - Adult Services	$222,688	$239,200	$243,300	$176,000	$127,500	$126,500	$158,550	$133,150	$133,150
Subtotal	$4,903,338	$7,385,303	$7,500,678	$6,899,766	$7,066,923	$7,096,766	$7,749,721	$9,167,269	$9,099,187
6100- Personnel	$3,955,317	$5,810,344	$6,461,067	$7,021,719	$7,908,882	$8,870,997	$8,616,638	$8,626,939	$8,739,674
6200- Services and Charges			$264,089	$420,270	$417,049	$539,500	$458,270	$391,610	$407,990
6300/6800- Administrative Overhead	$681,655	$1,053,083	$733,555	$732,016	$713,758	$1,060,742	$1,004,226	$920,715	$940,303
Reserves									$65,000
Subtotal	$4,636,972	$6,863,427	$7,458,711	$8,174,005	$9,039,689	$10,471,239	$10,079,134	$9,939,264	$10,152,967
410 General Administration									
6100-Personel						$116,273	$83,095	$83,944	$81,189
6890-Employee Recognition Exp.						$6,720	$840	$840	$840
Subtotal						$122,993	$83,935	$84,784	$82,029
461 Information Systems									
6100- Personnel	$322,555	$280,577	$274,547	$343,715	$341,547	$400,450	$394,376	$280,640	$280,640
6200- Services and Charges			$250	$700	$2,810	$3,770	$2,200	$750	$750
6300/6400-Administrative Overhead Costs	$7,250	$9,600	$7,000	$5,800	$4,550	$2,100	$4,900	$3,000	$3,000
Subtotal	$329,805	$290,177	$281,797	$350,215	$348,907	$406,320	$401,476	$284,390	$284,390
Combined									
6100- Personnel	$6,623,675	$10,202,186	$11,086,897	$11,929,861	$13,012,977	$14,304,852	$13,733,885	$13,663,186	$13,537,287
6200- Services & Charges	$301,105	$404,775	$646,539	$818,650	$802,487	$871,235	$840,000	$739,150	$764,350
6300/6800- Administrative Overhead	$970,330	$1,537,410	$1,202,025	$1,464,677	$1,755,561	$2,012,957	$1,892,244	$1,745,917	$1,763,939
6000- Payments for/behalf of clients	$6,278,008	$9,515,908	$9,337,678	$8,714,766	$9,280,723	$8,857,266	$10,064,471	$11,584,269	$11,516,187
Reserves									$100,000
Total Expenditures	**$14,173,118**	**$21,660,279**	**$22,273,139**	**$22,927,954**	**$24,851,748**	**$26,046,310**	**$26,530,600**	**$27,732,522**	$27,681,763
REVENUE									
420 Income Maintenance / Child Support									
5400 - Federal	$2,016,400	$3,017,900	$3,470,000	$3,747,000	$4,010,500	$4,258,000	$3,859,000	$3,817,500	$3,817,500
5200/5300 - State	$393,800	$865,575	$777,500	$884,550	$1,052,100	$1,065,400	$944,857	$966,846	$966,846
5500/5900 - Other	$680,520	$1,161,550	$785,700	$696,295	$914,000	$768,701	$648,330	$678,168	$678,168
Reserve spending	$0	$0	$0	$0	$0	$0	$0	$0	$0
5000 - County Taxes	$1,052,971	$1,738,824	$1,635,908	$3,671,709	$3,341,255	$3,441,493	$3,443,458	$3,684,500	$3,684,500
Subtotal	$4,143,691	$6,783,849	$6,669,108	$8,999,554	$9,317,855	$9,533,594	$8,895,645	$9,147,014	$9,147,014
431 Social Services									
5400 - Federal	$2,469,458	$2,849,187	$3,100,948	$3,122,028	$3,305,162	$3,412,294	$3,897,313	$4,206,138	$4,230,138
5200/5300 - State	$1,772,613	$2,595,881	$3,001,862	$3,018,682	$3,660,244	$3,919,879	$4,508,658	$4,457,945	$4,389,577
5500/5900 - Other	$1,055,397	$2,025,299	$1,990,741	$2,201,628	$2,334,800	$2,764,200	$2,509,070	$2,733,604	$2,727,213
Reserve spending	$0	$0	$0	$0	$0	$0	$0	$0	$0
5000 - County Taxes	$4,672,259	$7,349,563	$7,452,480	$5,507,562	$6,205,187	$6,391,343	$6,684,360	$7,152,267	$7,152,267
Subtotal	$9,969,727	$14,819,930	$15,546,031	$13,849,900	$15,505,393	$16,487,716	$17,599,401	$18,549,954	$18,499,195
461 Information Systems									
5500/5900- Participating Entities	$59,700	$56,500	$58,000	$78,500	$28,500	$25,000	$35,554	$35,554	$35,554
Subtotal	$59,700	$56,500	$58,000	$78,500	$28,500	$25,000	$35,554	$35,554	$35,554
Combined									
5400 - Federal	$4,485,858	$5,867,087	$6,570,948	$6,869,028	$7,315,662	$7,670,294	$7,756,313	$8,023,638	$8,047,638
5300 - State	$2,166,413	$3,461,456	$3,779,362	$3,903,232	$4,712,344	$4,985,279	$5,453,515	$5,424,791	$5,356,423
5500/5800 - Other	$1,795,617	$3,243,349	$2,834,441	$2,976,423	$3,277,300	$3,557,901	$3,192,954	$3,447,326	$3,440,935
Reserve spending	$0	$0	$0	$0	$0	$0	$0	$0	$0
5000- County Taxes	$5,725,230	$9,088,387	$9,088,388	$9,179,271	$9,546,442	$9,832,836	$10,127,818	$10,836,767	$10,836,767
Total Revenues	**$14,173,118**	**$21,660,279**	**$22,273,139**	**$22,927,954**	**$24,851,748**	**$26,046,310**	**$26,530,600**	**$27,732,522**	$27,681,763
Summary									
Revenue	$14,173,118	$21,660,279	$22,273,139	$22,927,954	$24,851,748	$26,046,310	$26,530,600	$27,732,522	$27,681,763
Expenditures	$14,173,118	$21,660,279	$22,273,139	$22,927,954	$24,851,748	$26,046,310	$26,530,600	$27,732,522	$27,681,763
Difference	$0	$0	$0	$0	$0	$0	$0	$0	$0

2019 Human Services Levy Funding

County	Net Tax Capacity	%	Population	%	SEAGRs	%	% Used for Funding
Lyon	$ 39,008,589	24.21%	25,857	34.10%	$ 7,458,636	33.38%	30.57%
Murray	$ 26,922,353	16.71%	8,725	11.51%	$ 1,175,998	5.26%	11.16%
Redwood	$ 35,697,617	22.16%	16,059	21.18%	$ 6,622,516	29.64%	24.33%
Lincoln	$ 14,510,173	9.01%	5,896	7.78%	$ 1,142,491	5.11%	7.30%
Rock	$ 26,167,158	16.24%	9,687	12.78%	$ 2,754,423	12.33%	13.78%
Pipestone	$ 18,815,509	11.68%	9,596	12.66%	$ 3,189,692	14.28%	12.87%
Total	$ 161,121,399	100.00%	75,820	100.00%	$ 22,343,756	100.00%	100.00%

LAST THREE YEARS OF SEAGR DATA

County	2015	2016	2017	Totals
Lyon	$ 2,587,733	$ 2,593,529	$ 2,277,374	$ 7,458,636
Murray	$ 413,002	$ 392,704	$ 370,292	$ 1,175,998
Redwood	$ 1,705,865	$ 2,338,458	$ 2,578,193	$ 6,622,516
Lincoln	$ 413,205	$ 398,923	$ 330,363	$ 1,142,491
Rock	$ 724,524	$ 1,011,799	$ 1,018,100	$ 2,754,423
Pipestone	$ 969,347	$ 1,121,456	$ 1,098,889	$ 3,189,692

County	2018 Levy	%	2019 Proposed levy	Difference	over 10 years	2019 Levy Payable	7% Levy Increase	2019 Levy with Increase
Lyon	$ 3,029,416	29.91%	$ 3,095,572	$ 66,156	$ 6,616	$ 3,036,032	$ 212,522	$ 3,248,554
Murray	$ 1,204,494	11.89%	$ 1,130,268	$ (74,226)	$ (7,423)	$ 1,197,071	$ 83,795	$ 1,280,866
Redwood	$ 2,414,840	23.84%	$ 2,463,605	$ 48,765	$ 4,877	$ 2,419,717	$ 169,380	$ 2,589,097
Lincoln	$ 934,311	9.23%	$ 739,172	$ (195,139)	$ (19,514)	$ 914,797	$ 64,036	$ 978,833
Rock	$ 1,283,658	12.67%	$ 1,395,764	$ 112,106	$ 11,211	$ 1,294,869	$ 90,641	$ 1,385,509
Pipestone	$ 1,261,101	12.45%	$ 1,303,440	$ 42,339	$ 4,234	$ 1,265,335	$ 88,573	$ 1,353,908
Total	**$ 10,127,820**	**100.00%**	**$ 10,127,820**	**$ (0.00)**	**$ (0.00)**	**$ 10,127,820**	$ 708,947	**$ 10,836,767**

	IM - 600 - 30%	IV-D - 640 - 4%	SS - 700 - 66%	Total
Lyon	$974,566	$129,942	$2,144,046	**$3,248,554**
Murray	$384,260	$51,235	$845,372	**$1,280,866**
Redwood	$776,729	$103,564	$1,708,804	**$2,589,097**
Lincoln	$293,650	$39,153	$646,030	**$978,833**
Rock	$415,653	$55,420	$914,436	**$1,385,509**
Pipestone	$406,172	$54,156	$893,579	**$1,353,908**
				$10,836,767

SOUTHWEST
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Pipestone, MN • 507-825-6720 Luverne, MN • 507-283-5070
Marshall, MN • Human Services 507-537-6747 • Health Services 507-537-6713

Environmental Health Program Update
SWHHS Board of Health--November

1. MN Food Code Revision

MDH has completed the revision of the Minnesota Food Code, Minnesota Rules, Chapter 4626. These rule changes will take effect on January 1, 2019. We are providing information about Food Code changes to our licensed establishments.

Action Items: Update Food and Beverage Ordinances and EH Program Policies—I will be contacting county administrators to begin the Food and Beverage Ordinance revision process. MDH requires this update as part of our delegation agreement. Our ordinance must be changed in the following manner:

SECTION V - - ADOPTION OF FOOD & BEVERAGE ESTABLISHMENT STANDARDS

5.1 The standards for Food & Beverage Establishments outlined in the Minnesota Food Code Minnesota Rules Chapter 4626 and the Certified Food Protection Manager Requirements for Food Establishments Minnesota Rules 4626.0033A-F, are hereby incorporated in and made part of this Ordinance. Minnesota Rules 4626.0033G-O are enforced by the Minnesota Department of Health and not delegated to Southwest Health and Human Services. Wherein Minnesota Rules Chapter 4626 refers to the Commissioner, Commissioner shall mean Southwest Health and Human Services Community Health Board and its designated agents.

2. EH Manager Software

We currently use Rapid Inspection Report. This program was developed by MDH in about 2000. This software has gone through many revisions and updates. MDH provided this software to local delegated programs at no cost. However, Rapid Inspection Report is not very stable and MDH will not provide IT assistance if issues develop with the program after 2018. MDH is currently switching from using Rapid Inspection Report to a new e-licensing enterprise system. Local Delegate Programs will not be allowed to utilize MDH's new system.

EH Manager Software—EH Manager is a software solution that leverages the most current cloud and mobile technologies to efficiently record and manage environmental health data for inspections, licensing, complaints, plan review, and enforcement. This product was designed, constructed and tested by environmental health field inspectors. This situation allowed the designer to build a database solution that closely follows the common data collection practices that is efficient and accurate for typical Environmental Health program areas.

This program not only has the ability to write inspection reports, it also includes the following features: licensing, plan review, enforcement and complaints. Rapid Inspection Report does not include these features.

The cost of EH Manager Inspection Software is $7388 for the first year and $4088 for subsequent years.

3. Fee Increase

To pay for the EH Manager Inspection Software, I propose the following:

- $15 license fee increase on each establishment.
- $25 increase in each pool category. We spend significant time doing pool inspections and this rate is still much lower than the MDH fee.
- $.32 increase on the site fee in campgrounds and MHPs.
- Plan review increase; clarify plan review fee definitions. To promote continuous improvement in our establishments, I would like to not charge existing establishments when improvements are made that are less than $20,000.
- See the attached 2019 license fee increase proposal.

These fee increases will generate approximately $7400 in additional revenue in 2019.

Fees for Food, Pools and Lodging Establishments, Youth Camps, MHP/RCA

	2018	2019	MDH
Base Fee (all establishments)	$150	$165	$165
Limited Food Menu	$56	$56	$110 (low risk/Category 1)
Small Establishment	$105	$105	$245 (med risk/Category 2)
Medium Establishment	$252	$252	$385 (high risk/Category 3)
Large Establishment	$398	$398	
Alcohol Bar Service	$152	$152	$175 (additional food service)
Additional Alcohol Service	$43	$43	$175
Beer or Wine Table Service	$40	$40	n/a
Licensed Facility Individual Water	$56	$56	$60
Licensed Facility Individual Sewer	$56	$56	$60
Lodging - No. of unit X (max $850)	$8.50	$8.50	$11
Seasonal Food Stand	$85	$85	$85
Pool	$200	$225	$355
Each Additional Pool	$120	$145	$200
Spa/Whirlpool/Wading Pool	$127	$152	$200
Each Additional Spa/Whirlpool/Wading Pool	$64	$89	$110
Re-inspection Fee	$150	$150	
Late Penalty Fee (1-7 days after Jan 1)	$55	$55	
Late Penalty Fee (more than 7 days after Jan 1)	$110	$110	
Youth Camp			$325 (≤99 campers)
Youth Camp Fee	$125	$140	$550 (100-199 campers)
			$750 (200+ campers)
School (no base fee)	$275	$290	$550 (base fee+cat 3)
			$250 (additional inspection fee)
Fees for MHP/RCA			
MHP/RCA Base Fee	$42	$57	$165(MHP)
County/City RCA—no fee			$55(≤24 sites)
			$230(25-99 sites)
			$330 (100+ sites)
MHP/RCA site fee	$3.68	$4	$5
Special Event Food Stand:			
One Day License	$10	$10	$55
Two Day License	$20	$20	
Three or More Day License	$30	$30	

All license fees are due before January 31st in any calendar year. A late penalty fee is due for any establishment, which has not made application and paid the required license fee prior to January 31st.

Fees for Plan Review:
A plan review is required for all new construction and remodeling for above licensed establishments except special event stands.

FBL Plan Fee:			
Plan Review—New Establishment	$250	$300	$400-$500
Plan Review—Mobile Food/Seasonal Stand/Existing Est.	$125	$150	$250-$350
Plan Review— Existing Establishment less than $20,000		$0	
MHP/RCA Plan Fee:			
Base Fee	$42	$57	$375-$500
Per site fee	$3.68	$4	

SOUTHWEST HEALTH & HUMAN SERVICES

Southwest Health and Human Services
Public Health
2019 Fees

Dental Varnish	$25/Visit
~~Flu Vaccine~~	~~Cost of vaccine + $20 administration fee~~ ~~$40~~ ~~$50~~
Non MNVFC Hepatitis B	$60.00
Refugee Health/Green Card	$20
Immunizations	$20/immunization administration
Mantoux Testing	$25/test
Sharps Containers	2 gal $12, 1 gal $9, 1 qt $7 - includes disposal fee
Public Health Nursing Clinic and Family Home Visits	
Home	$150.00
Office Visit	$120/visit
New Day Care Inspections	$75/hour/staff with minimum of one hour charge
Education/Wellness/Car Seat Presentations	$75/hour/staff with minimum of one hour charge
Radon Kits-Short Term	$6.00/kit (fee includes tax)
Blood Lead Education (per 15 min)	$30
Blood Lead Education (per 30 min)	$50.00
Blood Lead Screening	$15
Depression Screening	$25
ASQ or ASQ-SE (staff administered)	$25
Car Seat Install and Educations	~~$80~~ 85
Urine Analysis (Drug Screening)	$40
Personal Care Assessment	$300/visit

Service will not be denied to anyone who is unable to pay.
Client unable to pay the set rate will be asked for a donation.

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Marshall, MN • Human Services 507-537-6747 • Health Services 507-537-6713

November 21, 2018

To Whom It May Concern;

On behalf of the Southwest Health and Human Services (SWHHS) Community Health Board (CHB), we strongly support the Minnesota Evidence-Based Family Home Visiting Grant Program. Our agency will be applying for the grant in partnership with SWHHS Human Services Mental Health and Chemical Dependency Unit to implement the Family Spirit Model. This was formally approved at the SWHHS CHB meeting on November 21, 2018.

If you have questions, please feel free to contact Carol Biren, Public Health Director, at 507-532-4136 or carol.biren@swmhhs.com.

Sincerely,

Sherry Thompsen
Rock County Commissioner
SWHHS CHB Board Chair

2019 Public Health Levy Funding

County	Population	2018 Per Capita	2018 Tax Levy	2019 Per Capita	Amount Change	Difference	% Change	2019 Tax Levy
Lyon	25,857	$12.25	$316,748	$12.75	$0.50	$12,929	3.9%	$329,677
Murray	8,725	$12.25	$106,881	$12.75	$0.50	$4,363	3.9%	$111,244
Redwood	16,059	$12.25	$196,723	$12.75	$0.50	$8,030	3.9%	$204,752
Lincoln	5,896	$12.25	$72,226	$12.75	$0.50	$2,948	3.9%	$75,174
Rock	9,687	$12.25	$118,666	$12.75	$0.50	$4,844	3.9%	$123,509
Pipestone	9,596	$12.25	$117,551	$12.75	$0.50	$4,798	3.9%	$122,349
Total	75,820		$928,795			$37,910	3.9%	$966,705

REBECCA OTTO
STATE AUDITOR

STATE OF MINNESOTA
OFFICE OF THE STATE AUDITOR

SUITE 500
525 PARK STREET
SAINT PAUL, MN 55103-2139

(651) 296-2551 (Voice)
(651) 296-4755 (Fax)
state.auditor@state.mn.us (E-Mail)
1-800-627-3529 (Relay Service)

August 10, 2018

Beth Wilms, Director
Southwest Health and Human Services
607 West Main Street, Suite 200
Marshall, Minnesota 56258

Dear Director Wilms,

The Office of the State Auditor (OSA) received your recent letter. In it you indicate that Southwest Health and Human Services (SWHHS) has decided to notify the OSA that it will retain a CPA firm as auditors.

Although your letter does not state any legal authority under which the SWHHS believes it has this option, we anticipate the SWHHS may be relying on Minn. Stat. § 6.481 (County Audits). Some clarity regarding the application of Minn. Stat. § 6.481 may be helpful. This statute, including its notice procedure, applies to counties; it makes no reference to community health boards, local social services agencies or human services boards.

Therefore, although the statute, Minn. Stat. § 6.481, allows a county to choose the auditor for the county's annual financial audit and provides a process for changing auditors which includes notice, (*see* Minn. Stat. § 6.481, subds 2 and 7), it provides no similar permission for a community health board, local social services agency or human services board to opt out of an OSA audit and choose on its own to use a private CPA firm instead.

To the contrary, another statute, Minn. Stat. § 402.065, specifically states: "[t]he state auditor shall audit the books and accounts of the human services board once each year. The human services board shall pay to the state the total cost and expenses of the examination, including the salaries paid to auditors while actually engaged in making the examination."

In addition, SWHHS is a "special district" and a "political subdivision" under Minn. Stat. § 6.465, subds. 2 and 3. The Office of the State Auditor therefore has authority to audit the SWHHS under Minn. Stat. §§ 6.50 and 6.51, and other provisions of Minn. Stat., ch. 6.

Pursuant to its authority under Minnesota law, the OSA will continue to perform the SWHHS's audit.

Thank you for contacting the OSA.

Sincerely,

Mark F. Kerr, JD, CFE
Internal Investigations Director
(651) 296-4717

Ann R. Goering
Direct Phone: (612) 225-6844
arg@ratwiklaw.com

September 18, 2018

Mark Kerr, JD CFE
Internal Investigations Director
Office of the State Auditor
525 Park Street
Suite 500
Saint Paul, MN 55103-2139

Re: Southwest Health and Human Services

Dear Mr. Kerr:

We are writing in response to respond to your letter to Beth Wilms dated August 10, 2018. In that letter, you assert that Southwest Health and Human Services ("SWHHS") falls under various types of political subdivisions that are subject to audit by the Office of the State Auditor ("OSA"). Your letter, however, does not take into account the nature of SWHHS and the OSA's past classification of SWHHS.

SWHHS was formed in 2011 pursuant to Minnesota Statutes, section 471.59. All of SWHHS's members are counties. SWHHS only exercises powers that its county members could exercise. *See* Minn. Stat. § 471.59.

SWHHS is not a "human services board" created pursuant to Minnesota Statutes, chapter 402. Nothing in the Joint Powers Agreement creating SWHHS references Chapter 402, SWHHS does not follow the provisions of Chapter 402 and it does not now nor has it ever had any responsibility for community corrections.

SWHHS does not fall within the broad definition of "other political subdivision." As an agency comprised entirely of counties, exercising only county powers, SWHHS must be considered a "county" for purposes of Minnesota Statutes, Chapter 6.

Indeed, the OSA already recognizes that SWHHS is a "county." In the last two audits it performed, OSA applied the *Minnesota Legal Compliance Audit Guide for Counties* to SWHHS.

In light of both its nature as an entity comprised entirely by counties and the fact that the OAS itself treats SWHHS as a "county" for purposes of its legal compliance and audit, SWHHS asserts that the OAS must permit SWHHS to act as a "county" and, if it so chooses, select a certified public accountant to perform its audits, as authorized by Minnesota Statutes, section 6.481.

If you have any further questions, please contact us.

Sincerely,

Ann R. Goering
Christian R. Shafer

Cc: Beth Wilms, SWHHS
Nancy Walker, SWHHS

RRM: #304120

STATE OF MINNESOTA
OFFICE OF THE STATE AUDITOR

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525 PARK STREET
SAINT PAUL, MN 55103-2139

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state.auditor@state.mn.us (E-Mail)
1-800-627-3529 (Relay Service)

REBECCA OTTO
STATE AUDITOR

November 9, 2018

Ann R. Goering
Ratwik, Roszak & Maloney, P.A.
730 Second Avenue South, Suite 300
Minneapolis, Minnesota 55402

Dear Ms. Goering,

As I indicated when we exchanged voice messages on October 26, 2018, the position of the Office of the State Auditor (OSA), communicated in my August 10, 2018 letter to Southwest Health and Human Services (SWHHS) Director Wilms has not changed. Pursuant to its authority under Minnesota law, the OSA will continue to perform the SWHHS's audit.

Minn. Stat. § 6.481 provides no permission for a community health board, local social services agency or human services board to opt out of an OSA audit and choose on its own to use a private CPA firm instead.

Your letter suggested that SWHHS does not fit the broad definition of "political subdivision." This is not the case. As we previously noted, SWHHS is a "special district" as defined in Minn. Stat. § 6.465, Subd. 3. Subdivision 2 of that same section defines "political subdivision" to include "special districts." Under Minn. Stat. §§ 6.50 and 6.51, and other provisions of Minn. Stat., ch. 6, the OSA has authority to audit political subdivisions, including SWHHS.

Contrary to your suggestion, the OSA does not recognize the SWHHS as a county. To the contrary, the OSA has consistently included SWHHS in the annual Special District Finances Report, not the Minnesota County Finances Report, and its audits are appropriately categorized with those of other special districts on the OSA website.[1]

[1] *See* https://www.auditor.state.mn.us/list.aspx?get=51 (Special Districts Reports & Data), 2011, 2012, 2013, 2014, 2015, and 2016 Special District Finances reports, and 2011, 2012, 2013, 2014, 2015, 2016, and 2017 Southwest Health and Human Services Financial Statements and Management Letters.

The reference in your letter to the legal compliance audit guide is unavailing. Until recently, a single annual audit guide version was used for all local governments; the use by an auditor of one or another version for a special district auditee does not change the nature of the special district auditee.

In addition, your suggestion is inconsistent with SWHHS's representations. Each year the SWHHS submits to the OSA the Annual Financial Reporting Form for "Special Districts Reporting using the GAAP Basis of Accounting." On each of these forms, SWHHS has acknowledged, "[t]his report has been prepared from the records of the special district and includes, to the best of my knowledge, all transaction for all funds of the special district" for the year. SWHHS is not a county.

Thank you for contacting the OSA.

Sincerely,

Mark F. Kerr, JD, CFE
Special Investigations Director
(651) 296-4717

SOUTHWEST
HEALTH & HUMAN
SERVICES

607 West Main Street, Suite 200
Marshall, MN 56258
Phone: 507-532-1248
Fax: 507-537-6088

July 18, 2018

The Honorable Rebecca Otto
Office of State Auditor
Suite 500
525 Park Street
Saint Paul, MN 55103-2139

Dear State Auditor Otto,

This letter is to serve as notice that Southwest Health and Human Services, a Joint Powers Organization, pursuant to Minn. Stat. § 471.59 plans to retain a CPA firm for auditing fiscal year 2018 going forward.

At the meeting on July 18, 2018, the Southwest Health and Human Services Governing Board of Commissioners unanimously approved the decision to retain a CPA firm as auditors and to notify your office of the decision.

Sincerely,

Beth Wilms
SWHHS Director

cc: Nancy Walker, SWHHS Deputy Director
Sarah Kirchner, SWHHS Fiscal Manager

SOUTHWEST HEALTH AND HUMAN SERVICES
FLEXIBLE BENEFITS PLAN

Amended and Restated Effective January 1, 2018

Prepared by:
Hitesman & Wold, P.A.
12900 - 63rd Avenue North
Maple Grove, MN 55369
Tele. 763-503-6620

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ARTICLE I.
INTRODUCTION

1.1 **Establishment.** Effective January 1, 2018, Southwest Health and Human Services (hereinafter the "Employer") hereby amends and restates the Southwest Health and Human Services Flexible Benefits Plan (the "Plan").

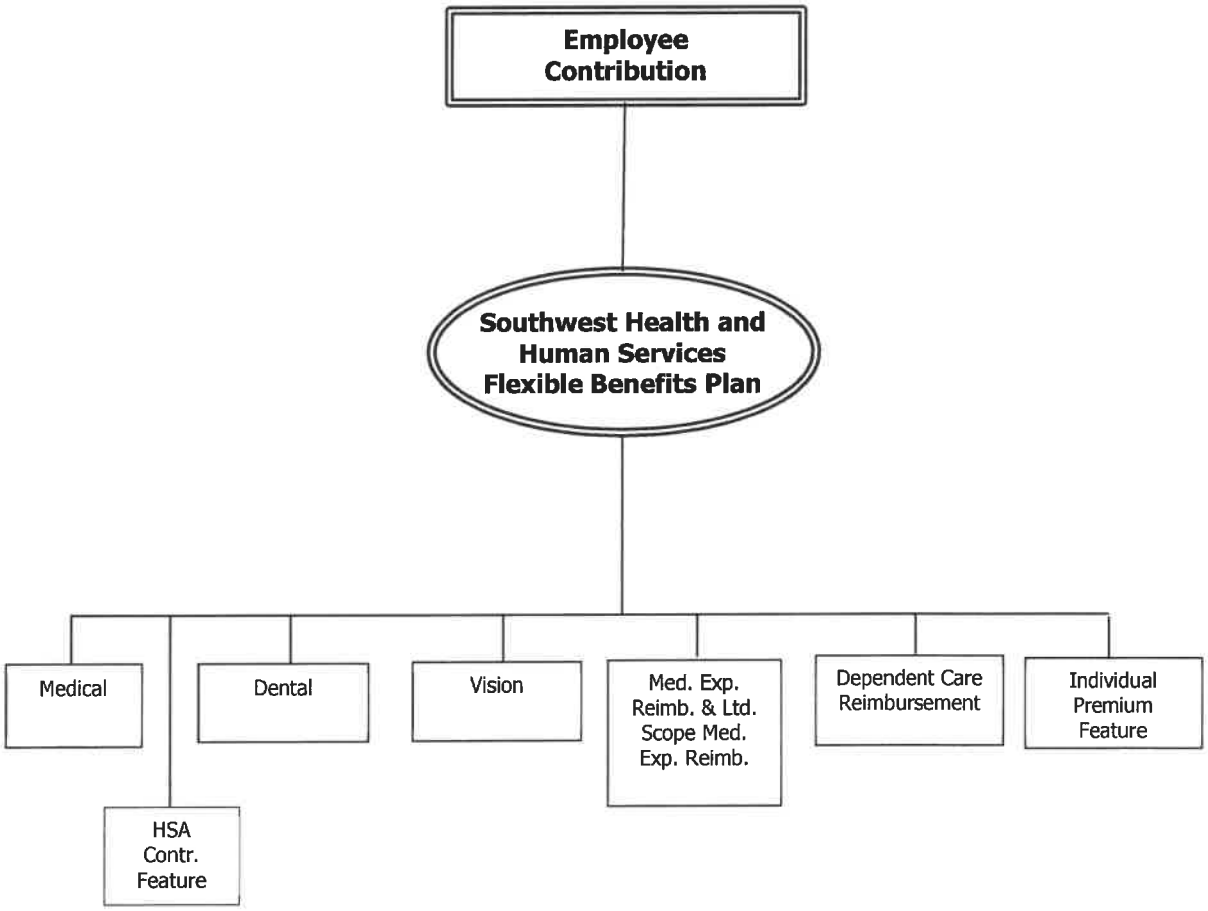
1.2 **Purpose.** The purpose of the Plan is to provide Participants with a choice between cash and certain "qualified benefits" as defined in Section 125 of the Code. The Plan is intended to qualify as a "Cafeteria Plan" under Section 125 of the Code so that Optional Benefits a Participant elects to receive under the Plan will be eligible for exclusion from the Participant's gross income to the fullest extent possible under the Code.

1.3 **HIPAA Privacy and Security Rules.** Portions of this Plan are "covered entities" for purposes of the Privacy Rules and the Security Rules.

1.4 **Gender and Number.** Pronoun references in this Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.

1.5 **Not ERISA Plan.** This Plan is not an employee welfare plan for purposes of ERISA because the Plan is a governmental plan within the meaning of Act. Sec. 3(32) of ERISA. Any resemblance of the Plan to an ERISA plan shall not bind the Plan to comply with ERISA.

ILLUSTRATION 1



ARTICLE II.
DEFINITIONS

The following words and phrases are used in this Plan and shall have the meanings set forth in this Article unless a different meaning is clearly required by the context or is defined within an Article.

2.1 **Cafeteria Plan Regulations** means any final regulations, or proposed regulations on which employers may rely, issued by the Department of Treasury under Section 125 of the Code.

2.2 **Change in Status** means the situations that permit an Eligible Employee or Participant to make a change in his or her Election mid-Plan Year and include events that:

(a) change an Eligible Employee's or Participant's legal (under applicable state and federal law) marital status;

(b) change the number of an Eligible Employee's or Participant's dependents (as defined in Section 5.4);

(c) change an Eligible Employee's or Participant's employment status, or the employment status of the Participant's Spouse or dependents (as defined in Section 5.4);

(d) cause an Eligible Employee's or Participant's dependent (as defined in Section 5.4) to satisfy or cease to satisfy the eligibility requirements for an Optional Benefit; and

(e) change the place of residence of an Eligible Employee or Participant, or his or her Spouse or dependents (as defined in Section 5.4).

2.3 **Claims Administrator** means the entity described in Section 6.1(c).

2.4 **Claims Run-out Period** means the period of time following the end of the Plan Year during which claims incurred during such Plan Year may be submitted as provided in the Optional Benefit.

2.5 **Code** means the Internal Revenue Code of 1986, as amended from time to time.

2.6 **Compensation** means the total salary, wages, bonuses, pay for overtime, vacation pay, sick pay, pay for shift differentials, and other cash compensation paid by the Employer to a Participant (without regard to any salary reduction under this Plan or any pre-tax program recognized under the Code), but excluding reimbursed expenses, car expense allowances, credits for benefits under any plan of deferred compensation to which the Employer contributes, and any additional compensation payable in a form other than cash.

2.7 **Covered Individual** means a person, including a Participant, a Dependent of a Participant, a Spouse of a Participant, and any other person, appropriately covered under an Optional Benefit subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and as reflected in the Public Health Services Act ("PHSA"), as amended.

2.8 **Dependent** means "Dependent" as defined in each Optional Benefit provision in which such term is used. Dependent is not necessarily the same as a dependent for tax purposes. See the definition of Tax Dependent in Section 2.37.

2.9 **Effective Date** means the effective date of this amended and restated document, which is January 1, 2018.

2.10 **Election** means the choice of Optional Benefits and means of payment made by the Participant, as described in Article V.

2.11 **Election Period** means the period of time identified by the Plan Administrator prior to the start of a Plan Year during which a Participant may change his or her Election. For a Participant who enters the Plan other than at the start of a Plan Year, Election Period means the period of time identified by the Plan Administrator prior to the date on which the Eligible Employee begins participation during which an Eligible Employee may make an Election or change a deemed Election.

2.12 **ePHI** means PHI maintained or transmitted in electronic media including, but not limited to, electronic storage media (i.e., hard drives, digital memory medium) and transmission media used to exchange information in electronic storage media (i.e., internet, extranet, and other networks). PHI transmitted via facsimile and telephone is not considered to be transmissions via electronic media.

2.13 **Eligible Employee** means each Employee who has met the eligibility requirements of Section 3.1.

2.14 **Employee** means any person employed by the Employer on the Employer's W-2 payroll on or after the Effective Date and any elected official of the Employer whose term begins on or after the Effective Date. Employee does not include:

(a) any self-employed individual as described in Section 401(c) of the Code;

(b) any employee included within a unit of employees covered by a collective bargaining unit unless such agreement provides, whether specifically or generally, for coverage of the employee under this Plan;

(c) any employee who is a nonresident alien and receives no earned income from the Employer from sources within the United States; and

(d) any leased employee (including, but not limited to, those individuals defined in Code Section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer; and

(e) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency such as "Kelly," "Manpower," etc., whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer.

2.15 **Employer** means Southwest Health and Human Services and any affiliate that, with the consent of the Employer, becomes an Employer by adopting the Plan.

2.16 **Entry Date** means the date(s) as of which Eligible Employees may become Participants in this Plan provided all necessary forms have been completed. The initial Entry Date for an Eligible Employee is the date of hire or, if later, the date on which the Employee becomes an Eligible Employee. Thereafter, the Entry Date is the first day of each Plan Year unless a Change in Status occurs.

2.17 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended. Governmental entities are not subject to ERISA.

2.18 **Healthcare Reform** means the provisions of the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (Reconciliation Act), applicable to Optional Benefits available through this Plan.

2.19 **Highly Compensated Individual** means individuals who are highly compensated as defined in Section 125(e)(2) of the Code.

2.20 **Highly Compensated Participant** means Participants who are highly compensated as defined in Section 125(e)(1) of the Code.

2.21 **HIPAA** means Health Insurance Portability and Accountability Act of 1996, and regulations thereunder, as amended from time to time.

2.22 **HSA** means a health savings account within the meaning of Section 223 of the Code.

2.23 **Insurer** means any insurance company that has issued a policy through which benefits are made available under this Plan.

2.24 **IRS** means the Internal Revenue Service.

2.25 **Marketplace** means the public marketplace authorized under Health Care Reform, whether operated by the state government, federal government, or a combination of the two.

2.26 **Optional Benefits** means the benefits made available through this Plan, which include the following:

Non-Reimbursement:

- Group Medical Benefits
- Group Dental Benefits
- Group Vision Benefits
- HSA Contribution Feature
- Individual Premium Feature

Reimbursement:

- Medical Expense Reimbursement Plan
- Limited Scope Medical Expense Reimbursement Plan
- Dependent Care Expense Reimbursement Plan

2.27 **PHI** ("Protected Health Information") means information that:

(a) is created or received by a health plan, health care provider, or health care clearinghouse;

(b) relates to the past, present, or future physical or mental health or condition of an individual (including "genetic information" as that term is defined in the Genetic Information Nondiscrimination Act of 2008); the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and

(c) either identifies the individual or reasonably could be used to identify the individual.

PHI includes ePHI.

2.28 **Participant** means an Eligible Employee who participates in the Plan in accordance with Article III and has not ceased to be a Participant under Section 3.4.

2.29 **Plan** means the Southwest Health and Human Services Flexible Benefits Plan, as it may be amended from time to time.

2.30 **Plan Administrator** means the entity determined under Section 6.1.

2.31 **Plan Year** means the twelve-month period commencing on the first day of January and ending on the last day of December.

2.32 **Privacy Rules** means the *Standards and Privacy of Individually Identifiable Health Information* at 45 C.F.R. Part 160 and Part 164 at subparts A and E.

2.33 **Security Incident** means "security incident" as defined in 45 C.F.R. Section 164.304, which generally defines "security incident" to include attempted or successful unauthorized access, use, disclosure, modification or destruction of ePHI.

2.34 **Security Rules** means the *Security Standards and Implementation Specifications* at 45 C.F.R. Part 160 and Part 164, subpart C.

2.35 **Spouse** means an individual who is (a) legally married to a Participant under applicable state law, and (b) treated as a "spouse" under the Code.

2.36 **Summary Health Information** means "summary health information" as defined in 45 C.F.R. Section 164.504, which generally defines "summary health information" to include information, which may be PHI, that summarizes claims history, claims expenses, or the type of claims experienced by individuals receiving benefits under the Plan from which certain identifiers have been deleted.

2.37 **Tax Dependent** means an individual (other than the Participant and the Participant's Spouse) with respect to whom amounts expended for medical care are excluded from the Participant's gross income under Section 105(b) of the Code, as amended.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility Requirements.** In general, an Eligible Employee is an Employee employed by the Employer and who meets the following requirements:

(a) **Employees**. An Employee working thirty (30) hours or more per week.

(b) **Elected Officials**. An elected official of the Employer who is also an Employee because he or she is an elected official. There is no hours requirement for elected officials.

3.2 **Notification to Participants**. The Plan Administrator shall provide each Eligible Employee written notice of the Employee's eligibility to participate in the Plan in sufficient time to enable such Eligible Employee to submit an application for participation in the Plan on or before the applicable Entry Date. The amount of time that is "sufficient" shall be determined by the Plan Administrator.

3.3 **Application for Participation.** In general, unless an Eligible Employee is deemed to have made an Election as provided in Section 5.1, to become a Participant, an Eligible Employee shall execute and deliver to the Plan Administrator prior to the applicable Entry Date, a written application signed by the Eligible Employee in which the Eligible Employee:

(a) applies to participate in the Plan;

(b) designates the required portion of Compensation for the pre-tax and after-tax (if any) contributions;

(c) makes a benefit Election; and

(d) supplies any other pertinent information that the Plan Administrator may reasonably require.

For new hires, an Eligible Employee shall execute and deliver to the Plan Administrator within thirty (30) days of employment, such written application. In this situation, participation in this Plan is retroactive to the date of hire pursuant to Section 1.125-2(d) of the proposed regulations.

By signing such application or agreement, the Eligible Employee shall be deemed for all purposes to have agreed to participate and to conform to the requirements of the Plan. Such application or agreement may be the same as, or separate from, the application or agreement required to participate in any Optional Benefit under this Plan. Alternatively, or in addition to, the Plan Administrator may require or permit application of same scope by electronic means. Participation shall begin on the applicable Entry Date.

3.4 **Termination of Participation**. A Participant automatically ceases to be a Participant at midnight of the earliest of the following dates:

(a) the date of the death of the Participant;

(b) the date of termination of the Participant's employment with the Employer;

(c) the date of the Participant's failure to meet the eligibility requirements of Section 3.1, as may be amended from time to time; or

(d) the date of termination of the Plan in accordance with Article VII.

Note: This provision applies to *participation* in this Plan. With respect to the Optional Benefits that involve premium payments for other plans sponsored by the Employer, coverage under the underlying plan may extend beyond the date a Participant ceases to be a Participant in this Plan.

In the event the Plan does not learn that a Participant has automatically ceased to be a Participant until a date after the date participation ceased, participation will be terminated retroactively and the Plan shall be entitled to recover any benefits paid after the date participation terminated. Termination of participation in this Plan shall not prevent a former Participant from continuation coverage, conversion coverage or benefits under the respective benefit plans if and to the extent provided by such plans.

3.5 **Conditions of Participation**. As a condition of participation and receipt of benefits under this Plan, the Participant agrees to:

(a) observe all Plan rules and regulations;

(b) consent to inquiries by the Plan Administrator with respect to any provider of services involved in a claim under this Plan; and

(c) submit to the Plan Administrator all notifications, reports, bills, and other information required by the Plan or which the Plan Administrator may reasonably require.

Failure to do so relieves the Plan, Plan Administrator, and Claims Administrator from any and all obligations under this Plan.

3.6 **Participation in Optional Benefit Plans.** In order to elect a specific Optional Benefit provided under this Plan, a Participant must elect that Optional Benefit on such forms as the Plan Administrator may require (unless the benefit is provided to all Participants) and, if the cost of the Optional Benefit is not fully paid by the Employer, shall be required to share the cost of the Optional Benefit as provided in Article IV. Further, the Participant must meet any eligibility, participation, etc., requirements applicable to that Optional Benefit in accordance with the terms of the underlying plan through which the Optional Benefit is provided.

ARTICLE IV.
CONTRIBUTIONS

4.1 **Salary Reduction Contributions**. A Participant may elect in accordance with the Election procedures described in Article V to receive his or her full Compensation in cash, or to have a portion of such Compensation applied by the Employer toward the Participant's share of the cost of Optional Benefits. The Participant's share of the cost of an Optional Benefit (other than the Medical Expense Reimbursement Plan and Dependent Care Expense Reimbursement Plan) shall be determined by the Employer. Such cost may vary based upon the coverage option and coverage level elected by the Participant under the Optional Benefits. If so elected, the Participant's Compensation will be reduced, and an amount equal to the reduction shall be allocated by the Employer to the Optional Benefits designated by the Participant. A Participant's Compensation shall be reduced by pro-rata amounts of the Participant's total salary reduction Election. Salary reduction is done on a pre-tax basis before any withholdings have been made. Only two paychecks per calendar month will reflect the salary reduction.

4.2 **Imputation of Income**. To the extent a Participant participates in an Optional Benefit that covers a Dependent who is not the Participant's Spouse or Tax Dependent, the entire cost of coverage for Optional Benefits for which the Participant is responsible shall be paid pre-tax through this Plan and the fair market value of the coverage for that Dependent shall be imputed as income to the Participant as the coverage is provided (pursuant to Cafeteria Plan Regulations).

4.3 **Salary Deduction Contributions**. The Employer may permit amounts for which the Participant is responsible, but (a) cannot be paid with pre-tax dollars through salary reduction, or (b) cannot be paid with pre-tax dollars without a corresponding imputation of income described above, be funded with after-tax dollars pursuant to a salary deduction agreement. Such salary deductions shall be made on a periodic basis and relate to a Participant's Compensation after taxes and withholdings have been made.

4.4 **Maximum Under the Plan**. Under no circumstances may a Participant's total salary reduction exceed the sum of (a) the cost of benefits paid on a pre-tax basis provided through insurance or insurance-types of benefits, plus (b) the maximum Election amounts permitted under the reimbursement-type of benefits.

4.5 **No Trust**. Nothing in this Plan is intended to require the establishment of a trust. Benefits paid under this Plan attributable to Participant contributions including, but not limited to, salary reduction amounts is paid from the Employer's general assets.

ARTICLE V.
ELECTION OF AVAILABLE BENEFITS

5.1 **Initial Elections.** An Election must have been made prior to the date on which an Eligible Employee becomes a Participant. An affirmative Election to participate is required. If the Election Period ends and an Eligible Employee has not returned an Election form to the Plan Administrator, the Eligible Employee will be deemed to have elected to not participate in the Plan.

5.2 **Subsequent Annual Elections.** During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to make a new Election. Such new Election may include the following:

(a) an Eligible Employee who is not participating in Optional Benefits may elect to begin participating by electing Optional Benefits during the Election Period;

(b) a Participant may terminate participation in Optional Benefits; or

(c) a Participant may elect different Optional Benefits or different levels of Optional Benefits.

An Election must have been made, or deemed to have been made, prior to the start of the Plan Year to which it relates.

5.3 **Failure to Elect.** If an Eligible Employee (including a Participant) does not make a new Election during the Election Period prior to each Plan Year, the Eligible Employee will be deemed to have elected to not participate in the Plan for the upcoming Plan Year.

5.4 **Elections Irrevocable.**

For purposes of this Section 5.4, the term "dependent" shall mean (1) a Tax Dependent if the election relates to health benefits, or (2) a Qualifying Individual (as defined in Article XIII) if the election relates to the Dependent Care Expense Reimbursement Plan.

An Election becomes effective and shall be irrevocable for the Plan Year or the remainder of the Plan Year except under the following circumstances:

(a) **Change in Status.** A Participant may change or terminate his or her actual or deemed Election under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status that affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's dependent (referred to as the general consistency requirement). The Plan Administrator (in its sole discretion) 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 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 that change.

(1) **Loss of Dependent Eligibility**. 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 ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance, or insurance-type, coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or dependent, or the dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other

individual under these circumstances fails to correspond with that Change in Status.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan**. For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's dependent gains eligibility for coverage under another employer's flexible benefits plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage only if that coverage becomes actually effective or is increased under the other employer's plan.

(3) **Dependent Care Expense Reimbursement Plan**. With respect to the Dependent Care Expense Reimbursement Plan, a Participant may change or terminate his or her Election only if (i) such a change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (ii) 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 available under the Code.

(b) **HIPAA Special Enrollment Rights**. If a Participant, a Participant's Spouse, and/or a Participant's dependent enrolls in a group health plan that is an Optional Benefit of this Plan pursuant to the HIPAA special enrollment rights provided by Code § 9801(f), the Participant may make a new election that corresponds with the special enrollment. For purposes of this provision (1) an Election to add previously eligible dependents as a result of the acquisition of a new Spouse or dependent child (a/k/a the Tag-along Rule), shall be considered consistent with the special enrollment right; and (2) a HIPAA special enrollment Election attributable to the birth or adoption of a new dependent child may be effective retroactive (up to thirty (30) days), provided it applies to Compensation not yet currently available.

(c) **Certain Judgments, Decrees and Orders**. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage for a Participant's dependent child (including a foster child who is a dependent of the Participant), a Participant may: (1) change his or her Election to provide coverage for the dependent child (provided that the Order requires the Participant to provide coverage and subject to the provisions of the underlying group health plan); or (2) change his or her Election to revoke coverage for the dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan.

(d) **Medicare and Medicaid**. If a Participant, a Participant's Spouse, or a Participant's dependent who is enrolled in a health or accident benefit under this Plan (including the Medical Expense Reimbursement Plan) becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's 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 health or accident coverage provided under this Plan (including the Medical Expense Reimbursement Plan) of the person losing entitlement to Medicare or Medicaid.

(e) **Change in Cost.**

(1) **Automatic Increase or Decrease for Insignificant Cost Changes.** If the cost of an Optional Benefit (other than the Medical Expense Reimbursement Plan) increases or decreases during a Plan Year by an insignificant amount, then the pre-tax contributions or after-tax contributions (as applicable) under each affected Participant Election shall be prospectively increased or decreased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in Participant contributions in accordance with such cost changes. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

(2) **Significant Cost Increases.** If the Plan Administrator determines that the cost of an Optional Benefit (other than the Medical Expense Reimbursement Plan) significantly increases during a Plan Year, the Participant may, on a prospective basis, either: (i) make a corresponding increase in his or her Election, (ii) enroll in another benefit package option providing similar coverage and make a corresponding Election change, or (iii) revoke his or her Election if no other benefit package option providing similar coverage is available. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) **Significant Cost Decrease.** If the Plan Administrator determines that the cost of an Optional Benefit (other than the Medical Expense Reimbursement Plan) significantly decreases during a Plan Year: (i) an Eligible Employee or Participant may commence participation in such Optional Benefit; and (ii) the Plan Administrator shall automatically effectuate a prospective decrease in a Participant's Election with respect to such Optional Benefit in accordance with the cost decrease.

(f) **Change in Coverage.**

(1) **Significant Curtailment.** If the Plan Administrator determines that coverage under an Optional Benefit (other than the Medical Expense Reimbursement Plan) is significantly curtailed during a Plan Year, the Participant may prospectively enroll in another benefit package option providing similar coverage and make a corresponding Election change. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(2) **Loss of Coverage.** If the Plan Administrator determines that coverage under an Optional Benefit (other than the Medical Expense Reimbursement Plan) is lost during a Plan Year, the Participant may, on a prospective basis: (i) enroll in another benefit package option providing similar coverage and make a corresponding Election change, or (ii) revoke his or her Election if no other

benefit package option providing similar coverage is available. Coverage under an accident or health plan is deemed "lost" only if there is a complete loss of coverage under the benefit package option (e.g., due to elimination of the benefit package option or application of an annual or lifetime maximum) or other fundamental loss of coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a "loss" has occurred, and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) **Addition or Improvement of an Optional Benefit**. If during a Plan Year, the Plan adds a new Optional Benefit or a new benefit package option under the Optional Benefit (other than the Medical Expense Reimbursement Plan), or if coverage under an existing Optional Benefit (other than the Medical Expense Reimbursement Plan) is significantly improved: (i) an affected Participant may prospectively change his/her Election with respect to the newly-added or improved Optional Benefit; and (ii) an Eligible Employee may commence participation in such Optional Benefit. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether an Optional Benefit has been "significantly improved" based upon all the surrounding facts and circumstances.

(4) **Change Under Another Employer-Sponsored Plan**. A Participant may make a prospective Election change (other than with respect to the Medical Expense Reimbursement Plan) that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan of the Employer or a plan of another employer), provided (i) the other Flexible Benefits Plan or qualified benefits plan permits its participants to make an Election change that would be permitted under the Cafeteria Plan Regulations, or (ii) this Plan permits Participants to make an Election for a Plan Year period of coverage which is different from the plan year period of coverage under the other Flexible Benefits Plan or Optional Benefit. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under another employer-sponsored plan.

(5) **Loss of Governmental or Educational 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 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).

(6) **Participant's Enrollment in Marketplace Coverage.** In accordance with IRS Notice 2014-55, a Participant who has made an Election to pay for Group Medical Benefits may revoke that payment Election if the following conditions are satisfied:

(i) The Participant either (a) is eligible to enroll in a qualified health plan through the Marketplace (i.e., a public exchange) via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable

guidance), or (b) seeks to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(ii) The Participant cancels Group Medical Benefits in accordance with the requirements of that Optional Benefit; and

(iii) The Participant represents that the Participant, and any related individuals who were also enrolled in the Group Medical Benefits, have enrolled or intend to enroll in a qualified health plan through the Marketplace and such coverage will be effective no later than the day immediately following the last day for which the Group Medical Benefits were effective (i.e., there is no break in coverage).

(7) **Spouse/Dependent's Enrollment in Marketplace Coverage**. Consistent with IRS Notice 2014-55, and unless determined by the IRS not to be available, a Participant who has made an election to pay for Group Medical Benefits may reduce that payment Election if the following conditions are satisfied:

(i) The Participant's Spouse and/or Dependents either (a) are eligible to enroll in a qualified health plan through the Marketplace via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (b) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(ii) The Participant cancels Group Medical Benefits for such Spouse and/or Dependents in accordance with the requirements of that Optional Benefit; and

(iii) The Participant represents that such Spouse and/or Dependents have enrolled or intend to enroll in a qualified health plan through the Marketplace and such coverage will be effective no later than the day immediately following the last day for which the Group Medical Benefits were effective (i.e., there is no break in coverage).

(g) **Reduction in Hours**. A Participant who has made an election to pay for Group Medical Benefits may revoke that payment election if the following conditions are satisfied:

(1) The Participant has been in an employment status under which the Participant was reasonably expected to average at least thirty (30) hours of service per week;

(2) The Participant has experienced a change in employment status such that the Participant will reasonably be expected to average less than thirty (30) hours of service per week after the change but nevertheless will remain eligible for Group Medical Benefits;

(3) The Participant cancels Group Medical Benefits in accordance with the requirements of that Optional Benefit; and

(4) The Participant represents that the participant, and any related individuals who were also enrolled in the group medical coverage, have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage and

that will be effective no later than the first day of the second month following the month in which coverage under the Group Medical Benefits ends.

(h) **Family and Medical Leave Act.** A Participant taking a leave governed by the Family and Medical Leave Act of 1993 ("FMLA") may revoke or change an Election as may be provided for under the FMLA and the Employer's FMLA policy required thereunder, provided the Employer is subject to FMLA.

(i) **Other.** The Plan Administrator shall have the discretion to allow a change to or termination of an Election to the extent such change or termination is the result of any other situation informally recognized by the IRS as providing an exception to the general rule that Elections are irrevocable (e.g., corrections of mistakes, changes to meet nondiscrimination requirements, failure to satisfy underwriting).

A Participant entitled to make a new Election under this Section must do so within thirty (30) days of the event. An Employee who is eligible to elect benefits but declined to do so during the initial Election period, or during a subsequent Election period, may file a new Election if the new Election is made on account of and corresponds with the event. To be effective, such new Election must typically be filed within thirty (30) days of the occurrence of an event described above. The Plan Administrator may extend such deadline for good cause. Subject to the provisions of the underlying group health plan, Elections made to add medical coverage for a newborn or newly adopted dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to thirty (30) days. All other new Elections shall be effective prospectively immediately following the date the Participant files the new Election with the Plan Administrator or, if later, the date of the event giving rise to the Election change. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the Election is made unless a subsequent event (described above) allows a further Election change.

5.5 **Rehire and Eligibility Loss.** Termination of employment shall automatically revoke any Election. Former Participants who are rehired:

(a) After thirty (30) days following a termination of employment, shall have two "periods of coverage;" that period prior to the termination of employment and that period following the re-employment of the terminated Employee. Expenses incurred prior to the termination of employment shall be subject to the Election in effect upon termination; while the Employee shall have an opportunity to make a new Election and expenses incurred after re-employment shall be subject to the Election made upon re-employment.

(b) Within thirty (30) days following a termination of employment, shall have the Election in effect prior to the termination of employment reinstated upon re-employment.

5.6 **Benefit Descriptions.** While an Election to receive one or more of the Optional Benefits may be made under this Plan, the benefits themselves may be provided in accordance with Plan documents or contracts which describe the types and amounts of benefits available, the requirements for participation, procedures for submitting claims, and the other terms and conditions of coverage. Such underlying Plan documents or contracts, if any, are incorporated into this Plan by reference.

5.7 **Forfeiture.** Any amounts, whether obtained through salary reduction, salary deduction, or otherwise, under this Plan which cannot be distributed by the Plan Administrator to cover the cost of Optional Benefits for the applicable Plan Year, shall be forfeited by the Participant. Forfeited amounts, in accordance with the Cafeteria Plan Regulations, may be: (a) retained by the Employer, (b) used to defray the reasonable administrative costs of the Plan, (c) used to

reduce required salary reduction amounts for the immediately following Plan Year on a reasonable and uniform basis, and/or (d) returned to the Participants on a reasonable and uniform basis. Under no circumstances shall the Plan Administrator establish an outside formal or informal arrangement under which the forfeited amounts are allocated among Participants based (directly or indirectly) on their individual claims experience under the Plan.

5.8 **Limitations on Benefits**. Benefits shall be limited as determined by the Plan Administrator in accordance with Section 6.16 for the purpose of ensuring compliance with any nondiscrimination requirement applicable to the Plan or an Optional Benefit.

ARTICLE VI.
ADMINISTRATION

6.1 **Plan Administrator.**

(a) The Plan Administrator shall be responsible for the general supervision of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan.

(b) The Employer shall be the Plan Administrator unless the Employer's managing body designates a person or persons other than the Employer to be the Plan Administrator. The Employer shall also be the Plan Administrator if the person or persons so designated cease to be the Plan Administrator.

(c) The Plan Administrator may designate an individual or entity to act on its behalf with respect to certain powers, duties, responsibilities, etc. with respect to the operation and administration of this Plan. Where benefits under this Plan are provided through an insurance company, Health Maintenance Organization ("HMO"), or Dental Maintenance Organization ("DMO"), or similar entity, that entity shall be the Claims Administrator with respect to those benefits. In all other situations, the Plan Administrator shall be the Claims Administrator unless the Plan Administrator contracts with a third party to act on its behalf.

6.2 **Agent for Service of Legal Process**. The agent for service of legal process for the Plan is the Plan Administrator.

6.3 **Allocation of Responsibility for Administration**. The Plan Administrator shall have the sole responsibility for the administration of this Plan as is specifically described in this Plan. The designated representatives of the Plan Administrator shall have only those specific powers, duties, responsibilities, and obligations as are specifically given to them under this Plan. The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. It is intended under this Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Plan Administrator (including any designee) nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

6.4 **Rules and Decisions**. Except as otherwise specifically provided in the Plan, the Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate to fulfill the purposes of the Plan. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or legal counsel.

6.5 **Procedures**. The Plan Administrator may act at a meeting or in writing. The Plan Administrator may adopt by-laws and regulations as it deems desirable for the conduct of the Plan's affairs and as are consistent with the terms of the Plan.

6.6 **Records and Reports**. The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

6.7 **Claim for Benefits**. This Section addresses the requirements for claims for reimbursement-type Optional Benefits and the provisions of general applicability. Claims requirements for other Optional Benefits shall be handled in accordance with the governing documents for those Optional Benefits.

A Participant may apply to the Claims Administrator for reimbursement of eligible expenses incurred during such Plan Year by submitting a paper claim as described below. In some cases, eligible expenses may be reimbursed automatically as provided below.

(a) **Paper Claims**. A Participant may make a claim by completing a claim form and submitting such form to the Claims Administrator (or its designee) via email, facsimile, mail, or the Claims Administrator's website, setting forth at least the following:

(1) the amount, date and nature of the expense, including the identity of the individual who incurred the expense;

(2) the name of the person or entity to which the expense was paid;

(3) the Participant's statement that the expense has not been reimbursed and the Participant will not seek reimbursement for the expense; and

(4) such other information as the Claims Administrator may require.

Such claim form shall be accompanied by bills, invoices, receipts, or other statements from an independent third party, or by an explanation of benefits ("EOB") issued by a health plan, stating the eligible expense has been incurred and the amount of the expense. The Claims Administrator is entitled to rely on the information provided on the claim form in processing claims under this Plan. Where circumstances beyond the Participant's control prevent submission within the described time frame, notice of a claim with an explanation of the circumstances may be accepted by the Claims Administrator as a timely filing. Claims shall be determined in accordance with this Article VI.

(b) **Electronic Payment – Medical Expense Reimbursement Plan and Limited Scope Medical Expense Reimbursement Plan**. A Participant may receive reimbursement of an eligible expense under the Medical Expense Reimbursement Plan and Limited Scope Medical Expense Reimbursement Plan by use of an electronic payment card (to the extent made available by the Claims Administrator) at the time the eligible expense is incurred. A Participant must elect to use the electronic payment card, must agree to pay the debit card fee from his/her account, and must agree to abide by the terms and conditions of the electronic payment card program as set forth in a separate agreement with the electronic payment card provider. A new agreement must be executed prior to the start of each Plan Year. In addition to the terms and conditions of the electronic payment card program, the use of the electronic payment card shall be subject following conditions:

(1) The electronic payment card may be used only while a Participant is employed by the Employer.

(2) The balance of the electronic payment card shall be limited to the amount in the applicable Participant's reimbursement-type account(s).

(3) A Participant must certify at the time of enrollment in the Plan and each year thereafter that:

(i) the electronic payment card will be used only for eligible expenses that have not been reimbursed under any other plan covering similar benefits; and

(ii) the Participant will not seek reimbursement for any expense paid with the electronic payment card under any other plan covering benefits.

Such certification shall also be stated on the back of the electronic payment card and each use of the card shall constitute a reaffirmation of the certification.

(4) For eligible expenses, the electronic payment card may be used only at merchants who are health care providers (e.g., doctor's office, hospital, pharmacy, etc.) or other merchants identified in applicable IRS guidance.

(5) Each time the electronic payment card is used, a Participant shall obtain and retain a third party statement from the health care provider containing the information necessary to substantiate that the expense paid by the card was an eligible expense.

(6) Claims (other than claims subject to paragraph (7) below) shall be substantiated in one of the following manners:

(i) The Participant shall provide, upon request by the Claims Administrator (or its designee), the third party statement with respect to the claim.

(ii) The payment was made to a merchant who is a health care provider and it matches a specific co-payment the Participant has under a group medical or group dental plan sponsored by the Employer or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment.

(iii) The payment was made to a merchant who is a health care provider and is for an expense with the same amount, duration, and health care provider as a previously approved expense under this Plan.

(iv) The payment was made to a merchant who is a health care provider and the electronic claim file with respect to the expense is accompanied by an electronic or written confirmation from the health care provider that verifies the nature and amount of the expense and that the expense is an eligible expense.

(v) The electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

(7) Claims for over-the-counter drugs and medicines (other than insulin) shall be e substantiated in accordance with IRS Notice 2011-5 and/or other applicable IRS guidance.

(8) A Participant shall repay the Plan for a payment with respect to any claim not substantiated (and therefore not eligible for reimbursement) as required above.

(9) The use of an electronic payment card does not constitute a "claim" under the claims procedures.

6.8 **Determination of Benefits**. This Section addresses the claims determination and appeal procedures for reimbursement-type Optional Benefits, and the provisions of general applicability. Claims determination and appeal procedures for other Optional Benefits shall be handled in accordance with the governing documents for those Optional Benefits.

(a) **Initial Determination**. The Plan Administrator, or Plan Administrator's designee, shall notify a person within thirty (30) days of receipt of a written claim for benefits of that person's eligibility or non-eligibility for benefits under the Plan. If it is determined that a person is not eligible for benefits or for full benefits, the notice shall set forth:

(1) the specific reasons for the denial;

(2) a specific reference to the provision of the Plan on which the denial is based;

(3) a description of any additional information or material necessary for the claimant to perfect the claim and an explanation of why it is needed; and

(4) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken if the Participant wishes to have the claim reviewed.

If the Plan Administrator, or Plan Administrator's designee, determines that there are special circumstances requiring additional time to make a decision, the Plan Administrator, or Plan Administrator's designee, shall notify the Participant of the special circumstances and the date by which a decision is expected to be made, and may extend the time for up to an additional fifteen (15) days.

(b) **Appeals**. If a Participant is determined by the Plan Administrator, or Plan Administrator's designee, not to be eligible for benefits, or if the Participant believes that he or she is entitled to greater or different benefits, the Participant shall have the opportunity to have the claim reviewed by the Plan Administrator, or Plan Administrator's designee, by filing an appeal within one hundred eighty (180) days after receipt by the Participant of the notice issued by the Plan Administrator, or the Plan Administrator's designee. The appeal shall state the specific reasons the Participant believes he or she is entitled to benefits or greater or different benefits.

Within sixty (60) days after receipt of the appeal, the Plan Administrator, or Plan Administrator's designee, shall afford the Participant (and the Participant's counsel, if any) an opportunity to present the Participant's position to the Plan Administrator, or Plan Administrator's designee, orally or in writing, and the Participant (or the Participant's counsel) shall have the right to review the pertinent documents.

(c) **Decision on Appeal**. The Plan Administrator shall notify the Participant of its decision on appeal in writing within sixty (60) days after receipt of the appeal. If it is determined that a person is not eligible for benefits or for full benefits, the notice shall set forth:

(1) the specific reasons for the denial;

(2) a specific reference to the provision of the Plan on which the denial is based;

(3) a statement of the Participant's right to review (on request and at no charge) relevant documents and other information;

(4) if the Plan Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to Participant upon request.

In the event of the death of a Participant, the same procedure shall be applicable to the Participant's beneficiaries.

6.9 **Authorization of Benefit Payments.** The Plan Administrator shall issue directions to the Employer concerning all benefits to be paid from the Employer's assets pursuant to the provisions of the Plan, and shall warrant at the time the directions are provided that all such directions are in accordance with the Plan.

6.10 **Benefit Payments.** The Participant shall be reimbursed at least either (a) once per month, or (b) when the total reimbursement for eligible expenses first equals or exceeds a reasonable minimum amount that the Plan Administrator may communicate to Employees from time to time.

6.11 **Overpayments.** If a payment for benefits is made by the Plan in excess of the benefit to which a Covered Individual is entitled under the Plan, the Plan shall have the right to recover such overpayment from the payee. Repayment of an overpayment is a condition of participation in the Plan.

6.12 **Inability to Locate Payee.** If benefits are due under this Plan and the Plan Administrator is unable, after reasonable attempts to do so, to locate the Participant to whom such benefits are payable, such benefits shall be handled in accordance with applicable state law regarding unclaimed property or escheat. For purposes of the foregoing, the Plan Administrator shall be deemed to be unable to locate a Participant if a check issued for benefits payable under the Plan has been sent to the payee's last known address and has not been cashed within three (3) years of its date of issuance.

6.13 **Facility of Payment.** Whenever, in the Plan Administrator's opinion, a person entitled to receive any payment of a benefit or installment under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage their financial affairs, the Plan Administrator may request the Employer to make payments to such person, or the Plan Administrator may request the Employer to apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment of a benefit, or installment, in accordance with the provisions of this Section, shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

6.14 **Other Powers and Duties of the Administrator.** The Plan Administrator shall also have such other duties and powers as may be necessary to discharge its duties under the Plan including, but not limited to, the following:

(a) discretion to construe and interpret the Plan in a non-discriminatory manner, to decide all questions of eligibility, except to the extent the eligibility determinations are governed by an insurance contract, and to determine all questions arising in the administration and

application of the Plan, except to the extent such eligibility determinations are governed by an insurance contract;

(b) to receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(c) to furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and

(d) to appoint individuals to assist in the administration of the Plan and any other agents the Plan Administrator deems advisable, including legal and actuarial counsel. The Plan Administrator shall not have the power to add to, subtract from, or modify any of the terms of the Plan, to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under this Plan.

6.15 **Indemnification.** To the maximum extent allowed by, and in accordance with applicable law, the Employer shall indemnify and hold harmless any Employee that is deemed to be a fiduciary against any and all losses, claims, damages, expense (including court costs and attorneys' fees), and liability arising from the Employee's duties and responsibilities in connection with the Plan, unless the same is determined to be intentional or willful.

6.16 **Changes by the Plan Administrator**. If the Plan Administrator determines before or during any Plan Year, the Plan or an Optional Benefit may fail to satisfy any nondiscrimination requirement imposed by the Code or other applicable law, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of Elections by Highly Compensated Participants with or without consent of such Employees and/or a re-characterization within the Plan Year of benefits provided under the Plan as taxable income with or without consent of such Employees.

6.17 **Plan Interpretation.** This Plan will be administered in accordance with its terms. The Plan Administrator and/or a third party to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate this Plan, to make factual findings, to construe the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of this Plan, including, but not limited to, the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on this Plan, Covered Individuals, claimants, and all interested parties.

ARTICLE VII.
PLAN AMENDMENT AND TERMINATION

7.1 **Employer Amendments.** The Employer reserves the right to amend the Plan, or any portion of the Plan, at any time. The Employer expressly may make any amendment it determines necessary or desirable, with or without retroactive effect, to comply with the law. Such amendment shall not affect any right to benefits that accrued prior to such amendment. Such amendment shall be made in writing and in accordance with Section 8.4.

7.2 **Employer's Right to Terminate.** Although the Employer expects the Plan to be maintained for an indefinite time, the Employer reserves the right to terminate the Plan, or any portion of the Plan, at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by a successor to the Employer in accordance with the resolution of such successor's managing body. Such termination shall not affect any right to benefits that accrued prior to any termination. Such action shall be taken in writing and in accordance with Section 8.4.

ARTICLE VIII.
GENERAL PROVISIONS

8.1 **Plan Not a Contract of Employment.** The Plan is not an employment contract and does not assure the continued employment of any Employee or Participant for any period of time. Nothing contained in the Plan shall interfere with the Employer's right to discharge an Employee or Participant at any time, regardless of the effect such discharge may have upon the individual as a Participant in this Plan.

8.2 **No Right to Employer's Assets.** No Employee, Participant or beneficiary thereof shall have any right to, or interest in, any assets of the Employer upon termination of employment, or otherwise except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such Employee, Participant or beneficiary thereof. In addition, the Claims Administrator shall not be liable in any manner for such payments.

8.3 **Non-Alienation of Benefits.** Benefits payable under this Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Employer, Plan Administrator and/or Claims Administrator shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

8.4 **Action by Employer.** Whenever the Employer, under the terms of this Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by the managing body of the Employer or such representatives of the Employer as the managing body may designate.

8.5 **No Guarantee of Tax Consequences.** Notwithstanding any provision in this Plan to the contrary, neither this Plan nor the Employer make any commitment or guarantee that any amounts paid to or on behalf of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

8.6 **Indemnification of Employer by Participants.** To the maximum extent allowed by, and in accordance with, applicable law, if any Participant receives one or more payments or reimbursements under this Plan that are not for eligible expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

8.7 **Benefits Provided Through Third Parties.** In the case of any Optional Benefit provided through a third party (e.g., an insurance company pursuant to a contract or policy with that third party), if there is any conflict or inconsistency between the description of benefits contained in

this Plan and the contract or policy, the terms of the contract or policy shall control, unless prohibited by applicable law or specifically addressed in this Plan.

8.8 **Mistakes and Errors**. It is recognized that in the administration of the Plan, certain administrative and accounting errors may be made or situations may arise by reason of factual errors in information supplied to the Employer or the Plan Administrator. The Employer and/or the Plan Administrator shall have the power to take such equitable steps as may be necessary to correct the mathematical, accounting or factual errors, as they, in their sole discretion, determine(s) to be appropriate.

8.9 **Limitation on Liability**. The Employer does not guarantee benefits payable under any insurance policy or other similar contract described or referred to herein, and any benefits thereunder shall be the exclusive responsibility of the Insurer or other entity that is required to provide such benefits under such policy or contract.

8.10 **Governing Law**. This Plan shall be construed and enforced according to the laws of Minnesota except to the extent preempted by federal law.

8.11 **Family and Medical Leave Act of 1993**. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the Family and Medical Leave Act of 1993 ("FMLA") and the Employer's FMLA policy required thereunder.

8.12 **Uniformed Services Employment and Reemployment Rights Act of 1994**. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"). The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA and such policies shall be incorporated herein by reference

8.13 **Genetic Information Nondiscrimination Act of 2008**. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008 ("GINA").

8.14 **Children's Health Insurance Program Reauthorization Act of 2009**. Notwithstanding any provision of the Plan to the contrary, the Plan shall be operated and maintained in a manner consistent with the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA").

ARTICLE IX.
GROUP MEDICAL BENEFITS

9.1 **Purpose**. The purpose of this Article is to provide for the pre-tax payment opportunity for Group Medical Benefits under this Plan as an Optional Benefit. The Employer provides Group Medical Benefits through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

9.2 **Separate Written Plan**. For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of Insurance Premium expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

9.3 **Definitions**.

(a) **Dependent** means an individual (e.g., Spouse, child, domestic partner, etc.) who qualifies as a "dependent" under the terms and conditions of the applicable plan document governing the Group Medical Benefits.

(b) **Group Medical Benefits** means the medical coverage made available by the Employer to which the Insurance Premiums relate.

(c) **HMO** means a health maintenance organization authorized to do business in the state in which it operates with which an agreement has been entered for the purpose of providing benefits under the Plan.

(d) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(e) **Insurance Contract** means (1) any insurance contract secured from an insurance company or HMO authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing benefits under this portion of the Plan; or (2) a self-insured plan sponsored by the Employer as reflected in a separate written plan document.

(f) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract, including continuation coverage under the Insurance Contract.

9.4 **Terms, Conditions and Limitations**. The Employer shall secure the necessary Insurance Contract. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this Plan.

9.5 **Payments**. The Plan Administrator shall make Insurance Premium payments for the Group Medical Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant. The Plan Administrator shall also make such payments on behalf of the Participant's Dependents who are enrolled in the Group Medical Benefits. To the extent a Dependent is provided coverage under the Group Medical Benefits and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.2.

9.6 **Nondiscrimination.** To the extent the Group Medical Benefits are subject to Section 105(h) of the Code or Section 2716 of the Public Health Services Act, they shall not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result as described in Section 6.16.

9.7 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under the Group Medical Benefits to the extent required by applicable law.

9.8 **Continuation of Coverage**. Continued coverage shall be provided under the Group Medical Benefits as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by COBRA, which shall be incorporated herein by reference. There shall also be compliance with state laws concerning continuation of coverage to the extent not preempted by federal law.

9.9 **HIPAA.** The Group Medical Benefits shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract. In addition, the Group Medical Benefits shall comply with the portability requirements under HIPAA.

ARTICLE X.
GROUP DENTAL BENEFITS

10.1 **Purpose**. The purpose of this Article is to allow Participants to make pre-tax payments for Group Dental Benefits using Employee salary reduction contributions under this Plan. The Employer provides Group Dental Benefits through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

10.2 **Separate Written Plan**. For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of Insurance Premium expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

10.3 **Definitions**.

(a) **Dependent** means an individual (e.g., Spouse, child, domestic partner, etc.) who qualifies as a "dependent" under the terms and conditions of the applicable plan document governing the Group Dental Benefits.

(b) **DMO** means a dental maintenance organization authorized to do business in the state in which an agreement has been entered for the purpose of providing benefits under this portion of the Plan.

(c) **Group Dental Benefits** means the dental coverage made available by the Employer through this Article to which the Insurance Premiums relate. It does not include individual Insurance Contracts.

(d) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(e) **Insurance Contract** means (1) any insurance contract secured from an insurance company or DMO authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing benefits under this portion of the Plan; or (2) a self-insured plan administered by a third party.

(f) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract.

10.4 **Terms, Conditions and Limitations**. The Employer shall secure the necessary Insurance Contracts. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are identified in Exhibit A and expressly incorporated into and made part of this Plan.

10.5 **Payments**. The Plan Administrator shall make Insurance Premium payments for the Group Dental Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant. The Plan Administrator shall also make such payments on behalf of the Participant's Dependents who are enrolled in the Group Dental Benefits. To the extent a Dependent is provided coverage under the Group Dental Benefits and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.2.

10.6 **Nondiscrimination**. To the extent the Group Dental Benefits are subject to Section 105(h) of the Code, it shall not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate or benefits. If the Plan Administrator determines that the Group Dental Benefits are or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result as described in Section 6.16.

10.7 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under the Group Dental Benefits to the extent required by applicable law. Participants involved in a divorce or child custody matter should be directed to have their legal counsel contact the Plan Administrator.

10.8 **Continuation of Coverage**. Continued coverage shall be provided under the Group Dental Benefits if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and, as reflected in the Public Health Services Act ("PHSA"), as amended. There shall also be compliance with applicable state laws concerning continuation of coverage to the extent not preempted by federal law.

10.9 **HIPAA.** The Group Dental Benefits shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract.

ARTICLE XI.
GROUP VISION BENEFITS

11.1 **Purpose.** The purpose of this Article is to allow Participants to make pre-tax payments for Group Vision Benefits using Employee salary reduction contributions under this Plan. The Employer provides Group Vision Benefits through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

11.2 **Separate Written Plan.** For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of Insurance Premium expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

11.3 **Definitions.**

(a) **Dependent** means an individual (e.g., Spouse, child, domestic partner, etc.) who qualifies as a "dependent" under the terms and conditions of the applicable plan document governing the Group Vision Benefits.

(b) **Group Vision Benefits** means the vision coverage made available by the Employer through this Article to which the Insurance Premiums relate. It does not include individual Insurance Contracts.

(c) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(d) **Insurance Contract** means (1) any insurance contract secured from an insurance company authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing benefits under this portion of the Plan; or (2) a self-insured plan administered by a third party.

(e) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract.

11.4 **Terms, Conditions and Limitations.** The Employer shall secure the necessary Insurance Contracts. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are identified in Exhibit A and expressly incorporated into and made part of this Plan.

11.5 **Payments.** The Plan Administrator shall make Insurance Premium payments for the Group Vision Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant. The Plan Administrator shall also make such payments on behalf of the Participant's Dependents who are enrolled in the Group Vision Benefits. To the extent a Dependent is provided coverage under the Group Vision Benefits and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.2.

11.6 **Nondiscrimination.** To the extent the Group Vision Benefits is subject to Section 105(h) of the Code, it shall not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate or benefits. If the Plan Administrator determines that the Group Vision

Benefits is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result as described in Section 6.16.

11.7 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under the Group Vision Benefits to the extent required by applicable law.

11.8 **Continuation of Coverage**. Continued coverage shall be provided under the Group Vision Benefits if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and, as reflected in the Public Health Services Act ("PHSA"), as amended. There shall also be compliance with applicable state laws concerning continuation of coverage to the extent not preempted by federal law.

11.9 **HIPAA.** The Group Vision Benefits shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract.

ARTICLE XII.
MEDICAL EXPENSE REIMBURSEMENT PLAN

12.1 **Purpose.** The purpose of this Article is to provide Participants with the opportunity to be reimbursed from Employee salary reduction contributions for certain eligible Medical Expenses as an Optional Benefit under the Plan. This Article is intended to qualify as a self-insured medical reimbursement plan under Section 105 of the Code so that payments received under this portion of the Plan are excludable from the gross income of the Participant under Section 105(b) of the Code. Participation in this portion of the Plan will make a Participant ineligible to participate in the HSA Contribution Feature and will make the Participant's Spouse and/or Dependent(s) covered by this portion of the Plan ineligible to make or receive contributions to a health savings account.

12.2 **Separate Written Plan.** For purposes of Section 105 of the Code, this Article shall constitute a separate written plan providing for the reimbursement of certain Medical Expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

12.3 **Definitions.**

(a) **Claims Run-out Period** means the ninety (90) day period beginning on the first day following the close of the Plan Year and ending on the last day of March following the close of the Plan Year.

(b) **Dependent** means a Tax Dependent.

(c) **Grace Period** means the period of time beginning on the first day following the last day of a Plan Year and continuing through the fifteenth day of the third calendar month following the close of the Plan Year.

(1) **Claims Incurred during the Grace Period.** An eligible expense incurred during the Grace Period shall be deemed to have been incurred during both the preceding Plan Year and the current Plan Year.

(2) **Processing of Claims.** Claims incurred during the Grace Period, and submitted prior to the close of the Claims Run-out Period, shall be first allocated to and reimbursed from the Participant's respective reimbursement-type account for the preceding Plan Year until such reimbursement-type account is exhausted. Thereafter, any such claims shall be allocated to and reimbursed from the Participant's reimbursement-type account for the current Plan Year. Claims incurred during the Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated, there shall be no changes, modifications, or adjustments to the allocation of the account. In accordance with this part (b), a claim incurred during the preceding Plan Year and submitted during the Claims Run-out Period will be processed subsequent to a previously submitted claim incurred during the Grace Period, even if the account from the preceding Plan Year is exhausted by reimbursement of the claim incurred during the Grace Period.

(3) **Elections.** No adjustment to a Participant's election for the current Plan Year shall be made or allowed based upon the amount of claims reimbursed from the prior Plan Year's account in accordance with part (b) hereof.

(d) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(e) **Medical Expense** means an expense incurred during the applicable Plan Year or Grace Period by a Participant, Spouse, or Dependent for medical care as defined in Section 213 of the Code, excluding premiums for health coverage and long-term care coverage. Medical care generally refers to the diagnosis, cure, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. Also included, are reasonable transportation expenses for and essential to medical care. "Medical Expense" includes over-the-counter drugs and medicines only to the extent allowed by Section 106(f) of the Code.

(f) **Medical Expense Account ("ME Account")** means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.

12.4 **Medical Expense Account ("ME Account").** The ME Account will be credited with the amount elected by the Participant at the beginning of the Plan Year. The annual maximum reimbursement amount applies to the Participant, Spouse, and Dependent on an aggregate basis, not an individual basis. A Participant's ME Account will be decreased from time to time in the amount of payments made to the Participant for eligible Medical Expenses incurred during the Plan Year and the Grace Period.

12.5 **Annual Maximum.** The maximum reimbursement a Participant may receive for a Plan Year under this portion of the Plan shall be an amount equal to the annual limit on salary reduction contributions to a health flexible spending account imposed under Section 125(i) of the Code (the "Section 125(i) limit"). The maximum reimbursement amount applies to the Participant, Spouse, and Dependent children on an aggregate basis, not an individual basis. Notwithstanding the foregoing, salary reduction contributions to this portion of the Plan shall not exceed any maximum imposed under applicable law.

12.6 **Claims Determination**. Claim submission, determination, and appeals shall be handled in accordance with Article VI.

12.7 **Incurred Expenses**. To be reimbursable, an eligible Medical Expense must have been incurred after participation in this portion of the Plan began and during the Plan Year for which reimbursement is claimed or the Grace Period related to such Plan Year. An expense is "incurred" when the Participant is provided with the care which gives rise to the eligible Medical Expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses.

12.8 **Reimbursement of Expense**. The Participant shall be reimbursed as specified in Article VI from the Participant's ME Account for eligible Medical Expenses incurred during the applicable Plan Year and the Grace Period for which the Participant submits the documentation required under Article VI. An amount up to the Participant's Election reduced as of any particular time for prior reimbursements for the same Plan Year and the Grace Period shall be available for reimbursement at all times during the Plan Year and the Grace Period. Claims for reimbursement within a Plan Year and the Grace Period must be submitted prior to the close of the Claims Run-Out Period for such Plan Year and the Grace Period.

In no case shall a payment be made which exceeds the balance in the Participant's ME Account at the time reimbursement is processed. If a claim for reimbursement exceeds the balance in the Participant's NE Account, the excess part of the claim will be denied. Under no circumstances (a)

will any balance remaining in a Participant's ME Account at the end of the Plan Year be carried over to the next Plan Year, or (b) will an otherwise eligible Medical Expense be carried over to the next Plan Year.

12.9 **Reimbursement Upon Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan, coverage shall cease (which means that reimbursements shall cease) unless benefits under the Plan are continued as provided in Section 12.14, if applicable. If coverage ceases, reimbursements for eligible Medical Expenses incurred before participation terminated may be reimbursed if submitted within ninety (90) days of the cate on which participation ceased.

12.10 **Participant's Death**. In the event a Participant dies having incurred an eligible Medical Expense (a) which would have been reimbursable out of the Participant's ME Account had the Participant not died, and (b) for which a person or the Participant's estate has paid for or assumed liability, reimbursement may be made to that person or the estate for that payment or assumption. The remainder of the Participant's ME Account shall be forfeited in accordance with Section 5.7.

12.11 **Nondiscrimination**. This portion of the Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such result as provided in Section 6.16. If the Plan fails any applicable nondiscrimination requirements, Highly Compensated Individuals shall have taxable income imputed to the extent required by law.

12.12 **ME Account Forfeiture**. Amounts attributed to a Participant's ME Account for any Plan Year shall be used only to reimburse the Participant for eligible Medical Expenses incurred during such Plan Year and the Grace Period. Any balance remaining in a Participant's ME Account for a Plan Year shall be forfeited following the Claims Run-out Period and shall be forfeited in accordance with Section 5.7. The Plan Administrator may extend this period in the event the Participant cannot obtain proper documentation until after the expiration of the period. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.

12.13 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under this Plan to the extent required by applicable law.

12.14 **Continuation of Coverage.** Continued coverage shall be provided if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and, as reflected in the Public Health Services Act ("PHSA"), as amended. The Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage, which shall be incorporated into the Plan by reference.

12.15 **HIPAA.** The Medical Expense Reimbursement Plan shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in Article XVII.

12.16 **Qualified Reservist Distribution**. A Participant may request, in writing on a form provided by the Plan Administrator, a "Qualified Reservist Distribution" from the Participant's ME Account if: (a) the Participant is a member of the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service; and (b) the Participant has been ordered or called to active duty for either (1) at least one hundred eighty (180) days, or (2)

an indefinite period of time. Such request must be made on or after the date of the order or call to active duty and before the last day of the Plan Year. A copy of the order or call to duty must accompany the form. The amount available to the Participant as a Qualified Reservist Distribution shall be the amount contributed to the ME Account as of the date of the request minus any reimbursements of Medical Expenses provided under the ME Account as of that date. Such distributions shall be included in the Participant's taxable income and shall be subject to normal wage withholding requirements to the extent required by law. If a balance remains in the Participant's ME Account following the Qualified Reservist Distribution, the Participant may continue to submit claims for reimbursement.

12.17 **Health Care Reform.** The Medical Expense Reimbursement Plan is intended to be an excepted benefit under HIPAA because:

(a) all Participants of this Optional Benefit are eligible for Group Medical Benefits, and

(b) the maximum reimbursement available does not exceed the greater of (1) two times the Participant's salary reduction election or (i2) the Participant's salary reduction election plus $500.

Accordingly, certain mandates of Health Care Reform, as amended, including the preventive care mandate, do not apply to the Medical Expense Reimbursement Plan.

12.18 **Further Limitations on Benefits.**

(a) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any worker's compensation law or other employer, union, association or governmental sponsored group insurance plan.

(b) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are received by the Participant, the Participant's Spouse or the Participant's Dependent under any health and accident insurance policy or program, whether or not premiums are paid by the Employer or the Participant, the Participant's Spouse or the Participant's Dependent child.

(c) Amounts reimbursed under a dependent care assistance program described in Section 129 of the Code shall not be reimbursed under this Plan.

ARTICLE XIII.
LIMITED SCOPE MEDICAL EXPENSE REIMBURSEMENT PLAN

13.1 **Purpose**. The purpose of this Article is to provide Participants with the opportunity to be reimbursed from Employee salary reduction contributions for certain eligible Limited Scope Medical Expenses as an Optional Benefit under the Plan. This Article is intended to qualify as a self-insured medical reimbursement plan under Section 105 of the Code so that payments received under this portion of the Plan are excludable from the gross income of the Participant under Section 105(b) of the Code. Participation in this portion of the Plan will make a Participant ineligible to participate in the HSA Contribution Feature and will make the Participant's Spouse and/or Dependent(s) covered by this portion of the Plan ineligible to make or receive contributions to a health savings account.

13.2 **Separate Written Plan**. For purposes of Section 105 of the Code, this Article shall constitute a separate written plan providing for the reimbursement of certain Limited Scope Medical Expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

13.3 **Definitions**.

(a) **Claims Run-out Period** means the ninety (90) day period immediately following the last day of each Plan Year..

(b) **Dependent** means a Tax Dependent.

(c) **Grace Period** means the period of time beginning on the first day following the last day of a Plan Year and continuing through the fifteenth day of the third calendar month following the close of the Plan Year.

(1) **Claims Incurred during the Grace Period**. An eligible expense incurred during the Grace Period shall be deemed to have been incurred during both the preceding Plan Year and the current Plan Year.

(2) **Processing of Claims**. Claims incurred during the Grace Period, and submitted prior to the close of the Claims Run-out Period, shall be first allocated to and reimbursed from the Participant's respective reimbursement-type account for the preceding Plan Year until such reimbursement-type account is exhausted. Thereafter, any such claims shall be allocated to and reimbursed from the Participant's reimbursement-type account for the current Plan Year. Claims incurred during the Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated, there shall be no changes, modifications, or adjustments to the allocation of the account. In accordance with this part (b), a claim incurred during the preceding Plan Year and submitted during the Claims Run-out Period will be processed subsequent to a previously submitted claim incurred during the Grace Period, even if the account from the preceding Plan Year is exhausted by reimbursement of the claim incurred during the Grace Period.

(3) **Elections**. No adjustment to a Participant's election for the current Plan Year shall be made or allowed based upon the amount of claims reimbursed from the prior Plan Year's account in accordance with part (b) hereof.

(d) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(e) **Limited Scope Medical Expense** means an expense for dental or vision care, within the meaning of "medical care" as defined in Section 213(d) of the Code, incurred during the applicable Plan Year or Grace Period by a Participant or by the Participant's Spouse or Dependent. Notwithstanding the foregoing, Limited Scope Medical Expenses shall not include: (1) expenses incurred prior to satisfaction of the Minimum Annual Deductible for dental and vision care of the type covered under the Participant's "qualifying high deductible plan" under Section 223(c)(2) of the Code, and (2) premiums for any health (e.g., dental, vision, etc.) or long-term care insurance or coverage. Over-the-counter drugs and medicines constitute Limited Scope Medical Expenses only to the extent allowed by Section 106(f) of the Code.

(f) **Limited Scope Medical Expense Account ("Limited Scope ME Account")** means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.

13.4 **Limited Scope Medical Expense Account ("Limited Scope ME Account")**. The Limited Scope ME Account will be credited with the amount elected by the Participant at the beginning of the Plan Year. The annual maximum reimbursement amount applies to the Participant, Spouse, and Dependent on an aggregate basis, not an individual basis. A Participant's Limited Scope ME Account will be decreased from time to time in the amount of payments made to the Participant for eligible Limited Scope Medical Expenses incurred during the Plan Year and the Grace Period.

13.5 **Annual Maximum.** The maximum reimbursement a Participant may receive for a Plan Year under this portion of the Plan shall be an amount equal to the annual limit on salary reduction contributions to a health flexible spending account imposed under Section 125(i) of the Code (the "Section 125(i) limit"). The maximum reimbursement amount applies to the Participant, Spouse, and Dependent children on an aggregate basis, not an individual basis. Notwithstanding the foregoing, salary reduction contributions to this portion of the Plan shall not exceed any maximum imposed under applicable law.

13.6 **Claims Determination**. Claim submission, determination, and appeals shall be handled in accordance with Article VI.

13.7 **Incurred Expenses**. To be reimbursable, an eligible Limited Scope Medical Expense must have been incurred after participation in this portion of the Plan began and during the Plan Year for which reimbursement is claimed or the Grace Period related to such Plan Year. An expense is "incurred" when the Participant is provided with the care which gives rise to the eligible Limited Scope Medical Expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses.

13.8 **Reimbursement of Expense**. The Participant shall be reimbursed as specified in Article VI from the Participant's Limited Scope ME Account for eligible Limited Scope Medical Expenses incurred during the applicable Plan Year and the Grace Period for which the Participant submits the documentation required under Article VI. An amount up to the Participant's Election reduced as of any particular time for prior reimbursements for the same Plan Year and the Grace Period shall be available for reimbursement at all times during the Plan Year and the Grace Period. Claims for reimbursement within a Plan Year and the Grace Period must be submitted prior to the close of the Claims Run-Out Period for such Plan Year and the Grace Period.

In no case shall a payment be made which exceeds the balance in the Participant's Limited Scope ME Account at the time reimbursement is processed. If a claim for reimbursement exceeds the balance in the Participant's NE Account, the excess part of the claim will be denied. Under no circumstances (a) will any balance remaining in a Participant's Limited Scope ME Account at the

end of the Plan Year be carried over to the next Plan Year, or (b) will an otherwise eligible Limited Scope Medical Expense be carried over to the next Plan Year.

13.9 **Reimbursement Upon Termination of Participation.** If an individual ceases to be a Participant in this portion of the Plan, coverage shall cease (which means that reimbursements shall cease) unless benefits under the Plan are continued as provided in Section 12.14, if applicable. If coverage ceases, reimbursements for eligible Limited Scope Medical Expenses incurred before participation terminated may be reimbursed if submitted within ninety (90) days of the cate on which participation ceased.

13.10 **Participant's Death.** In the event a Participant dies having incurred an eligible Limited Scope Medical Expense (a) which would have been reimbursable out of the Participant's Limited Scope ME Account had the Participant not died, and (b) for which a person or the Participant's estate has paid for or assumed liability, reimbursement may be made to that person or the estate for that payment or assumption. The remainder of the Participant's Limited Scope ME Account shall be forfeited in accordance with Section 5.7.

13.11 **Nondiscrimination.** This portion of the Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such result as provided in Section 6.16. If the Plan fails any applicable nondiscrimination requirements, Highly Compensated Individuals shall have taxable income imputed to the extent required by law.

13.12 **Limited Scope ME Account Forfeiture.** Amounts attributed to a Participant's Limited Scope ME Account for any Plan Year shall be used only to reimburse the Participant for eligible Limited Scope Medical Expenses incurred during such Plan Year and the Grace Period. Any balance remaining in a Participant's Limited Scope ME Account for a Plan Year shall be forfeited following the Claims Run-out Period and shall be forfeited in accordance with Section 5.7. The Plan Administrator may extend this period in the event the Participant cannot obtain proper documentation until after the expiration of the period. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.

13.13 **Medical Child Support Orders.** Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under this Plan to the extent required by applicable law.

13.14 **Continuation of Coverage.** Continued coverage shall be provided if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and, as reflected in the Public Health Services Act ("PHSA"), as amended. The Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage, which shall be incorporated into the Plan by reference.

13.15 **HIPAA.** The Limited Scope Medical Expense Reimbursement Plan shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in Article XVII.

13.16 **Qualified Reservist Distribution.** A Participant may request, in writing on a form provided by the Plan Administrator, a "Qualified Reservist Distribution" from the Participant's Limited Scope ME Account if: (a) the Participant is a member of the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service; and (b) the Participant has been ordered or called to active duty for either (1) at least one hundred eighty (180) days, or

(2) an indefinite period of time. Such request must be made on or after the date of the order or call to active duty and before the last day of the Plan Year. A copy of the order or call to duty must accompany the form. The amount available to the Participant as a Qualified Reservist Distribution shall be the amount contributed to the Limited Scope ME Account as of the date of the request minus any reimbursements of Limited Scope Medical Expenses provided under the Limited Scope ME Account as of that date. Such distributions shall be included in the Participant's taxable income and shall be subject to normal wage withholding requirements to the extent required by law. If a balance remains in the Participant's Limited Scope ME Account following the Qualified Reservist Distribution, the Participant may continue to submit claims for reimbursement.

13.17 **Health Care Reform.** The Limited Scope Medical Expense Reimbursement Plan is intended to be an excepted benefit under HIPAA because:

(a) all Participants of this Optional Benefit are eligible for Group Medical Benefits, and

(b) the maximum reimbursement available does not exceed the greater of (1) two times the Participant's salary reduction election or (i2) the Participant's salary reduction election plus $500.

Accordingly, certain mandates of Health Care Reform, as amended, including the preventive care mandate, do not apply to the Limited Scope Medical Expense Reimbursement Plan.

13.18 **Further Limitations on Benefits**.

(a) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any worker's compensation law or other employer, union, association or governmental sponsored group insurance plan.

(b) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are received by the Participant, the Participant's Spouse or the Participant's Dependent under any health and accident insurance policy or program, whether or not premiums are paid by the Employer or the Participant, the Participant's Spouse or the Participant's Dependent child.

(c) Amounts reimbursed under a dependent care assistance program described in Section 129 of the Code shall not be reimbursed under this Plan.

ARTICLE XIV.
DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

14.1 **Purpose.** The purpose of this Article is to provide Participants with the opportunity to be reimbursed from Employee salary reduction contributions for eligible Dependent Care Expenses under this Plan as an Optional Benefit under the Plan. This Article is intended to qualify as a "dependent care assistance program" under Section 129 of the Code so that payments received under this portion of the Plan are excludable from the gross income of the Participant under Section 129(a) of the Code.

14.2 **Separate Written Plan**. For purposes of Section 129 of the Code, this Article shall constitute a separate written plan providing reimbursement of certain Dependent Care Expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

14.3 **Definitions.**

(a) **Claims Run-out Period** means the ninety (90) day period immediately following the last day of each Plan Year..

(b) **Dependent Care Account ("DC Account")** means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.

(c) **Dependent Care Center** shall have the meaning given such term in Sections 21(b)(2)(C) and 21(b)(2)(D) of the Code: a facility that (1) complies with all applicable laws and regulations of the state and town, city or village in which it is located; (2) provides care for more than six individuals (other than individuals who reside at the facility); and (3) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

(d) **Dependent Care Expenses** means amounts paid by the Participant for services that would be considered employment-related expenses under Section 21(b)(2) of the Code, any applicable proposed or final regulations issued thereunder, or any guidance issued by the IRS interpreting or applying any of the foregoing. Employment-related expenses for purposes of this Plan include expenses incurred to enable a Participant to be Gainfully Employed during any period for which there are one or more Qualifying Individuals with respect to the Participant for (1) household services, and (2) care of a Qualifying Individual. However, employment-related expenses which are incurred for services outside the Participant's household shall be considered Dependent Care Expenses only if incurred for the care of a Qualifying Individual described in Section 16.3(i)(1)(i) below or a Qualifying Individual not described in Section 16.3(i)(1)(i) below who regularly spends at least eight (8) hours each day in the Participant's household. Dependent Care Expenses do not include expenses which are incurred for services provided by a Dependent Care Center if such center does not comply with all applicable laws and regulations of the applicable state or other unit of local government which regulates the center. In addition, Dependent Care Expenses shall not include any amounts paid to an individual who:

(1) is a child of such Participant (within the meaning of Section 152(f)(1) of the Code) who is under the age of nineteen (19) at the close of such taxable year;

(2) with respect to whom, for such taxable year, a deduction is allowable under Section 151(c) of the Code (relating to personal exemptions for dependents) to such Participant or the Spouse of such Participant;

(3) is the Spouse of the Participant at any time during the taxable year; or

(4) is the parent of the Participant's child who is a Qualifying Individual.

(e) **Earned Income** shall have the meaning given such term in Section 32(c)(2) of the Code (which refers to wages, salaries, tips and other Employee Compensation as well as net earnings from self-employment), but shall not include any amounts reimbursed by the Employer under this portion of the Plan. Further, if a Participant's Spouse is a Student or incapable of caring for himself or herself, the provisions of Section 21(d)(2) of the Code shall apply in determining the Earned Income of that Spouse. Generally, this Section provides that a Spouse of a Participant shall be deemed to have Earned Income of not less than $250 per month if there is one Qualifying Individual with respect to the Participant or $500 per month if there are two or more Qualifying Individuals with respect to the Participant.

(f) **Gainfully Employed** means the earning of income for services performed or the period of active search for gainful employment. Nominal reimbursement for volunteer work is not considered gainful employment.

(g) **Highly Compensated Employees** means Employees who are "highly compensated" as defined in Section 414(q) of the Code.

(h) **Non-Highly Compensated Participants** means Employees who are not Highly Compensated Employees.

(i) **Qualifying Individual** means a person for whom expenses can be submitted for reimbursement.

(1) A Qualifying Individual is:

i) the Participant's "qualifying child" under Section 152 of the Code who is under age thirteen (13);

ii) the Participant's "qualifying child" under Section 152 of the Code (determined without regard to Sections 152(b)(1) and (b)(2) of the Code) who is mentally or physically unable to care for himself or herself;

iii) the Participant's "qualifying relative" under Section 152 of the Code (determined without regard to Sections 152(b)(1), (b)(2), and (d)(1)(B) of the Code) who: (1) is mentally or physically unable to care for himself or herself, and (2) has the same principal place of abode as the Participant for at least one-half of the year; or

iv) the Participant's Spouse who: (1) is mentally or physically unable to care for himself or herself, and (2) has the same principal place of abode as the Participant for at least one-half of the year.

(2) With the exception of two parents that file income taxes jointly, only one person is entitled to treat the child as a Qualifying Individual. Where multiple people are

involved, there are two special rules to determine which person is entitled to treat the child as a Qualifying Individual.

i) **Divorced or Separated Parents, or Parents Living Apart.** If a child's parents are divorced, legally separated, separated pursuant to a written agreement, or live apart at all times during the last six (6) months of the calendar year, a special rule applies if: (i) the child is under age 13 or is mentally or physically unable to care for himself or herself; (ii) the child receives more than 50% of his or her support from the parents (in aggregate); and (iii) the child resides with the parents (in aggregate) for more than 50% of the year. In such situations, the child is the Qualifying Individual of the custodial parent even if the custodial parent has released the right to claim the child as a dependent. The custodial parent is the parent identified in Section 152(e) of the Code (i.e., generally the parent with whom the child resides for the greater number of nights during the calendar year or, if the child resides with both parents for an equal number of nights, the parent with the higher adjusted gross income for the year).

ii) **Two or More Persons Claiming a Child as a Qualifying Individual.** If the special rule described above regarding divorce, etc. does not apply, the special tie-breaker rules of Section 152(c)(4) of the Code may apply. If an individual is a qualifying child (as defined in Section 152 of the Code) with respect to more than one person, then:

a. If both persons are the individual's parents and they file a joint federal income tax return, the child is the Qualifying Individual of both parents.

b. If both persons are the individual's parents and they file separate federal income tax returns, then the child is the Qualifying Individual of the parent with whom the child resided for the longest period of time during the calendar year (or, if child resides with both parents for the same amount of time during the year, the parent with the highest adjusted gross income for the year). However, if that parent (i.e., the custodial parent or the parent with the highest adjusted gross income) does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other parent (i.e., the non-custodial parent or the parent with the lowest adjusted gross income). This is the one person that is entitled to treat the child as a Qualifying Individual.

c. If one person is the individual's parent and the other is not, the child is the Qualifying Individual of the parent. However, if the parent does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual

of the other person (i.e., the non-parent). This is the one person that is entitled to treat the child as a Qualifying Individual.

d. If neither person is the individual's parent, the child is the Qualifying Individual of the person with the highest adjusted gross income for the year in question. However, if that person does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the person with the lowest adjusted gross income). This is the one person that is entitled to treat the child as a Qualifying Individual.

(j) **Student** shall have the meaning provided in Section 21(e)(7) of the Code which means an individual who during each of five (5) calendar months during the taxable year is a full time student at an educational organization which normally maintains a regular facility and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on as provided in Sections 21(e)(8) and 170(b)(1)(A)(ii) of the Code.

14.4 **Dependent Care Account**. The DC Account will be credited as of each date Compensation is paid to the Participant with a pro-rated portion of the Participant's Election for the Plan Year. A Participant's DC Account will be decreased from time to time in the amount of payments made to the Participant for eligible Dependent Care Expenses incurred during the Plan Year.

14.5 **Claims Determination**. Claim submission, determination, and appeals shall be handled in accordance with Article VI.

14.6 **Incurred Expenses**. To be reimbursable, an eligible Dependent Care Expense must have been incurred after participation in this portion of the Plan began and during the Plan Year for which reimbursement is claimed. An expense is "incurred" when the Participant is provided with the care which gives rise to the eligible Dependent Care Expense, not when the service is billed or paid. Reimbursement shall not be made for future or projected expenses.

14.7 **Reimbursement of Expense**. The Participant shall be reimbursed as specified in Section 6.7(a) from the Participant's DC Account for eligible Dependent Care Expenses incurred during the applicable Plan Year for which the Participant submits the documentation required under Article VI. In no case shall a payment be made which exceeds the balance in the Participant's DC Account at the time reimbursement is processed. Claims for reimbursement with respect to a Plan Year must be submitted prior to the close of the Claims Run-out Period for such Plan Year. If a claim for reimbursement exceeds the available balance in the Participant's DC Account, the excess part of the claim will be carried over and paid as the Participant's DC Account becomes adequate. Under no circumstances (a) will any balance remaining in a Participant's DC Account at the end of the Plan Year be carried over to the next Plan Year, or (b) will an otherwise eligible Dependent Care Expense be carried over to the next Plan Year.

14.8 **Maximum Reimbursement**. The maximum reimbursement that a Participant may receive in a tax year under this portion of the Plan shall be the lesser of:

(a) the Participant's Election with respect to the Dependent Care Expense Reimbursement Plan;

(b) the Participant's Earned Income for the tax year;

(c) the actual or deemed Earned Income of the Participant's Spouse for the tax year; or

(d) $5,000 (or in the case of a Participant who is married and filing a separate income tax return from his or her Spouse, $2,500).

This maximum includes the DC Account forfeitures and the Participant's salary reduction. If a Participant is married and the Spouse of the Participant also participates in a dependent care program under Section 129 of the Code, the combined reimbursements may not exceed the limits described above for the tax year. It shall be the Participant's responsibility to monitor the combined reimbursements.

14.9 **Reimbursement Upon Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan during a Plan Year, no further contributions will be credited to the DC Account. However, expenses incurred while a Participant may be reimbursed if submitted within ninety (90) days of the cate on which participation ceased.

14.10 **Participant's Death**. In the event a Participant dies having incurred an eligible Dependent Care Expense (a) which would have been reimbursable out of the Participant's DC Account had the Participant not died, and (b) for which a person or the Participant's estate has paid for or assumed liability, reimbursement may be made to that person or the estate for that payment or assumption. The remainder of the Participant's DC Account shall be forfeited in accordance with Section 5.7.

14.11 **Nondiscrimination.** This portion of the Plan shall not discriminate in favor of Highly Compensated Employees or their Dependents with respect to eligibility, contributions or benefits. The average eligible Dependent Care Expenses paid to Non-Highly Compensated Employees shall be at least fifty-five percent (55%) of the average eligible Dependent Care Expenses paid to Highly Compensated Employees. If benefits are provided through salary reduction agreements, Employees with annual compensation less than $25,000 may be excluded. If the Plan Administrator determines that the Plan is or will be discriminatory, the Plan Administrator may take any action permitted by law to avoid such result in accordance with Section 6.16. If this portion of the Plan fails any applicable nondiscrimination requirements, Highly Compensated Employees shall have taxable income imputed to the extent required by law.

14.12 **DC Account Forfeiture**. Amounts attributed to a Participant's DC Account for any Plan Year shall be used only to reimburse the Participant for eligible Dependent Care Expenses incurred during such Plan Year. Any balance remaining in a Participant's DC Account for a Plan Year shall be forfeited following the Claims Run-out Period and shall be forfeited in accordance with Section 5.7. The Plan Administrator may extend this period in the event the Participant cannot obtain proper documentation until after the expiration of the period. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.

14.13 **Dependent Care Limitations**. Reimbursement or payment of eligible Dependent Care Expenses shall be made to the Participant only in the event and to the extent that such

reimbursement or payment is: (a) not otherwise provided under any insurance policy, whether the premium on such policy is paid by the Employer or an individual, and (b) not provided for or reimbursable under any other plan or policy.

14.14 **Reporting and Disclosure**. Each Participant must be furnished with a written statement showing the amounts paid under this portion of the Plan by an Employer on behalf of the Participant for a calendar year. The statement must be furnished before January 31st of the following year. If the actual amount paid is not known by this deadline, the Employer may report a reasonable estimate of the amounts paid under this portion of the Plan.

ARTICLE XV.
HSA CONTRIBUTION FEATURE

15.1 **Purpose.** The purpose of this Article is to allow Participants to make pre-tax contributions to an HSA using Employee salary reduction contributions under this Plan. The Employer may also make contributions to an Employee's HSA, in which case such contributions will be deemed to have been made through this Plan.

15.2 **Separate Written Plan.** For purposes of Section 223 of the Code, this Article shall constitute a separate written plan. To the extent necessary, other provisions of the Plan are incorporated by reference.

15.3 **Definitions.**

(a) **HSA** means a health savings account under Section 223 of the Code established and owned by a Participant to which contributions are made under this portion of the Plan. The Employer does not sponsor a Participant's HSA, and a Participant's HSA is not an employer-sponsored group health plan. The trustee or custodian of the HSA must be an authorized trustee or custodian of health savings accounts, and shall be selected by the Employer.

(b) **HSA Contribution Feature** means the portion of the Plan described in this Article, which consists of the ability to contribute to a Participant's HSA through salary reduction and allocation of Employer Contributions, if any.

(d) **High Deductible Health Plan** means a "qualifying high deductible health plan" under Section 223(c)(2) of the Code sponsored by the Employer.

(e) **Permitted Insurance** or **Permitted Coverage** means:

(1) insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities related to ownership or use of property, or similar liabilities as specified by the IRS;

(2) insurance for specified disease or illness (e.g., cancer insurance);

(3) insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance);

(4) coverage for accidents, disability, dental care, vision care, preventive care, or long-term care;

(5) some medical reimbursement accounts and health reimbursement arrangements ("HRAs") (e.g., limited scope medical reimbursement accounts and HRAs, suspended HRAs, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs); and

(6) some wellness programs and employee assistance programs (e.g., those that do not provide significant benefits in the nature of non-preventive medical care or treatment).

15.4 **Eligibility.** To be eligible for HSA contributions, the Employee must:

(a) be eligible to participate in this Plan under Section 3.1;

(b) be covered by the High Deductible Health Plan; and

(c) not have any health coverage through the Employer other than Permitted Insurance, Permitted Coverage, or coverage under the High Deductible Health Plan.

A Participant who ceases to satisfy the foregoing eligibility requirements during a calendar year shall remain eligible to participate in this HSA Contribution Feature until he/she reaches the applicable limit on contributions described in Section 12.6.

15.5 **Contributions**.

(a) **Employer Contributions**. Employer contributions, if any, will be contributed to the Participant's HSA at the times established by the Employer.

(b) **Employee Contributions**. Amounts withheld from a Participant's Compensation pursuant to an agreement authorizing salary reduction with respect to this Optional Benefit shall be contributed to the Participant's HSA as soon as administratively feasible.

15.6 **Limits on Contributions**. The maximum contributions a Participant may make through this HSA Contribution Feature shall be determined in accordance with the following rules:

(a) **General Limit.** During a taxable year, contributions to the HSA may not exceed the statutory indexed amount applicable under Code § 223.

(b) **Catch Up Contributions.** An additional "catch-up" amount (determined on a monthly basis) can be contributed for Participants who attain age 55 before the close of the taxable year.

(c) **Pro-rated Limit if Not Eligible on December 1st.** If a Participant ceases to satisfy the eligibility requirements described in Section 12.4 prior to December 1st of any calendar year, the contribution limit for that year shall be determined by multiplying 1/12 of the applicable limit by the number of months the first day of which the Participant had satisfied the eligibility requirements described in Section 12.4. The Employer shall not be required to take an corrective action in the event the amount of HSA contributions made by the Participant prior to the date on which he/she ceased to satisfy the eligibility requirements described in Section 12.4 exceed the pro-rated limit described herein (as adjusted under paragraph (e)).

(d) **Special Rule if Eligible on December 1st.** If a Participant becomes eligible to make contributions under this HSA Contribution Feature (as provided in Section 12.4) during the taxable year and is eligible on December 1st of such year, the Participant shall be deemed to have been eligible for each month in such taxable year and may make HSA contributions up to the full annual limit. This special rule applies to all contributions made during the applicable taxable year, including contributions made prior to or after December 1st.

> **Example:** An Eligible Employee becomes eligible for HSA contributions on July 1st and remains eligible through December 1st. The Eligible Employee may begin making contributions to his or her HSA through this Plan on July 1st at a rate pursuant to which the full annual contribution will have been made by the end of the taxable year.

(e) **Employer Contributions.** The applicable limit on Participant contributions, as determined in accordance with the above-described rules, shall be reduced by the amount of contributions made by the Employer to the Participant's HSA.

15.7 **Investment of HSA Funds.** The Employer shall have no control or responsibility for how a Participant's HSA funds are invested. A Participant may invest his/her HSA funds as allowed by the HSA trustee/custodian.

15.8 **Tax Consequences**. It is intended that the HSA contributions made under this Plan shall, in general, be excluded from the Participant's gross income under Section 223 of the Code. Such HSA contributions shall not be subject to income and employment tax withholding provided that it is reasonable for the Employer to believe, at the time the contribution is made, that the contribution will, in fact, be excluded from the Participant's income.

15.9 **Distribution of HSA Funds.** The Employer shall have no responsibility or control over distributions made from a Participant's HSA. The Employer shall have no responsibility to substantiate expenses for which such distributions are made. Sections 6.7 and 6.8 of this Plan shall not apply to distributions from a Participant's HSA. A Participant need not be a Participant in this Plan, be covered by a High Deductible Health Plan of this Employer, nor be covered by any other high deductible health plan in order to receive a distribution from the Participant's HSA.

15.10 **Reporting.** The Employer shall be responsible for reporting contributions made to a Participant's HSA through this Plan on the Participant's Form W-2. Participants shall be responsible for reporting contributions to their HSAs and distributions from their HSAs on appropriate forms. Participants shall also be responsible for determining whether an HSA distribution is taxable.

15.11 **Continuation of Coverage**. This HSA Contribution Feature and the underlying HSAs are not group health plans for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, ("COBRA"), as amended, and reflected in the Public Health Services Act ("PHSA"), as amended, the Family and Medical Leave Act ("FMLA"), and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature and the underlying HSAs.

ARTICLE XVI.
INDIVIDUAL PREMIUM FEATURE

16.1 **Separate Written Plan**. For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of Insurance Premiums. To the extent necessary, other provisions of the Plan are incorporated by reference.

16.2 **Purpose**. The purpose of this Article is to provide Participants the opportunity to make pre-tax payments for the cost of certain individual Insurance Contracts through this Plan.

16.3 **Definitions**.

(a) **Dependent** means a person eligible for dependent coverage under the Insurance Contract.

(b) **Individual Premium Feature** means this Article of the Plan that permits pre-tax payment of the cost of certain Insurance Contracts.

(c) **Insurance Contract** means an insurance contract secured from Aflac that provides "specialty" coverage (e.g., cancer, hospital indemnity, transplant, etc. coverage) other than disability coverage. For purposes of this Article, Insurance Contract includes only policies issued on a non-group, individual basis to a Participant. Notwithstanding anything herein to the contrary, Medicare Part B, Medicare Part D, and Medicare supplement coverage, long-term care policies, major medical policies, and individual insurance policies purchased through a public exchange are specifically excluded.

(d) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract.

16.4 **Terms, Conditions, and Limitations.** The Participant shall secure the necessary Insurance Contract. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contract. The Insurance Contract may provide coverage to the Participant's Spouse and Dependents. To the extent a person covered through the Participant is not a Spouse or Tax Dependent of the Participant, the value of the coverage provided to such person(s) shall be included in the Participant's income as the coverage is provided. The Insurance Contract may not by its terms violate the provisions of a cafeteria plan within the meaning of Section 125 of the Code, including but not limited to operating to defer compensation.

16.5 **Payments**. Benefits under the Individual Premium Feature shall be provided in the form of direct payments of Insurance Premiums to the Insurer. The Insurer shall submit a bill to the Employer with respect to such Insurance Premiums. In the event an Insurance Premium is not paid, Participants may submit a claim in accordance with Section 6.7. Claims determination and appeals shall be handled in accordance with Article VI. Payments shall be made from contributions made in accordance with the salary reduction arrangement and other arrangements. Under no circumstances will Insurance Premium payments be made with contributions from one Plan Year for coverage actually received in a different Plan Year.

16.6 **Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan during a Plan Year, no further contributions will be made to the Individual Premium Feature. Nevertheless, any contributions made prior to the termination of participation will be used to pay Insurance Premiums.

16.7 **Forfeitures**. Amounts contributed to this Individual Premium Feature for any Plan Year that cannot be used to pay Insurance Premiums incurred during that Plan Year shall be forfeited in accordance with Section 5.7. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.

16.8 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Individual Premium Feature shall recognize child support orders to the extent required by applicable law.

16.9 **Tax Consequences of the Individual Premium Feature**. Except as otherwise provided below, the Insurance Premiums (including pre-tax payments paid by the Participant through this portion of the Plan) for a Participant's Insurance Contract shall be excluded from the Participant's gross income under Section 106 of the Code. Any benefits received as a result of the Insurance Contract under this portion of the Plan shall be excluded from the recipient's gross income to the extent permitted under Section 105(b) of the Code. With respect to coverage that covers a Dependent other than the Participant's Spouse or Tax Dependent, it is intended that (a) value of the coverage be imputed as taxable income to the Participant as provided in Section 4.2, and (b) the value of any benefits received as a result of such coverage under the Individual Premium Feature be excluded from the recipient's gross income to the extent permitted under Section 104(a)(3) of the Code.

16.10 **HIPAA.** The Insurance Contracts shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract and/or the HIPAA policies established by the "covered entity" (as that term is defined in HIPAA).

ARTICLE XVII.
HIPAA PROVISIONS

The Privacy Rules and Security Rules under HIPAA apply to the Medical Expense Reimbursement Plan and Limited Scope Medical Expense Reimbursement Plan as further described in this Article XVII. The Group Medical Plan, Group Dental Plan, and Group Vision Plan are also subject to HIPAA. The HIPAA responsibilities for the Group Medical Plan, Group Dental Plan, and Group Vision Plan are reflected in the documentation for those plans.

17.1 **Use and Disclosure of PHI**. The Plan will use PHI to the extent allowed by, and in accordance with the uses and disclosures permitted by, HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. The Plan will also use and disclose PHI as required by law and as permitted by authorization of the subject of PHI. If the Plan discloses PHI to the Employer in accordance with this Article, the Employer may use and further disclosure PHI for the same purposes and in the same situations as the Plan may use and disclose PHI, provided that such use or disclosure is for Plan administration functions performed by the Employer for the Plan or is required by law or permitted by authorization. All uses and disclosures of PHI, whether by the Plan or by Employer, shall be limited to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure in accordance with HIPAA. Notwithstanding the foregoing, neither the Plan nor the Employer shall use PHI that is genetic information in a manner that is prohibited by the Genetic Information Nondiscrimination Act of 2008.

(a) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

(2) coordination of benefits;

(3) adjudication of health benefits claims (including appeals and other payment disputes);

(4) subrogation of health benefit claims;

(5) establishing employee contributions;

(6) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) billing, collection activities, and related health care data processing;

(8) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(9) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(12) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health Plan); and

(13) reimbursement to the Plan.

(b) **Health care operations** include, but are not limited to, the following activities:

(1) quality assessment;

(2) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

(6) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) business management and general administration activities of the Plan, including, but not limited to:

(i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(ii) customer service, including data analyses for policyholders.

(8) resolution of internal grievances; and

(9) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

17.2 **Employer's Obligations under the Privacy Rules**. Under the Privacy Rules, the Plan may not disclose PHI to the Employer unless the Employer certifies that the Plan document has been amended to provide that the Plan will make such disclosures only upon receipt of a certification from the Employer that the Plan has been amended to include certain conditions to the Employer's receipt of PHI and that Employer agrees to those conditions. By adopting this Plan document, the Employer certifies that the Plan has been amended as required by the Privacy Rules and that it agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Employer. The Employer agrees to:

(a) not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(c) not use or disclose PHI for employment related actions and decisions unless authorized by an individual;

(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(e) report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the uses or disclosures permitted hereunder and/or may constitute a "breach" as that term is defined in HIPAA;

(f) make PHI available for access by the individual who is the subject of the PHI in accordance with HIPAA;

(g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(i) make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

(j) if feasible, return or destroy all PHI received for the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

17.3 **Employer's Obligations under Security Rules**. If the Employer creates, receives, maintains, or transmits ePHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer will:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI;

(b) ensure that any agents, including subcontractors, who create, receive, maintain, or transmit ePHI on behalf of the Plan implement reasonable and appropriate security measures to protect the ePHI;

(c) report to the Plan any Security Incident of which it becomes aware; and

(d) implement reasonable and appropriate security measures to ensure that only those persons identified below have access to ePHI and that such access is limited to the purposes identified below.

17.4 **Adequate separation between the Plan and the Employer must be maintained.** In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(a) the person employed in the position that is given primary responsibility for performing the Employer's duties as the Plan Administrator of the Optional Benefits; and

(b) staff designated by the person described in (a) above.

17.5 **Limitation of PHI Access and Disclosure.** The person(s) described above may only have access to and use and disclose PHI for Plan administration functions that the Employer performs for the Plan.

17.6 **Noncompliance Issues.** If the person(s) described above does not comply with this Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including, but not limited to, disciplinary sanctions.

IN WITNESS WHEREOF, the parties hereto have executed this Plan as of the effective date set forth above.

Dated: _____

SOUTHWEST HEALTH AND HUMAN SERVICES

By: _____

_____

Its: _____

EXHIBIT A
THIRD PARTY ADMINISTRATOR AND INSURER INFORMATION
(as of January 1, 2018)

Southwest Health and Human Services Flexible Benefits Plan *(including the Medical Expense Reimbursement Plan and Dependent Care Reimbursement Plan)*	Coverage offered through Southwest Health and Human Services and administered by: Secure Benefits Systems PO Box 469 Okoboji, IA 51355 Phone: 800-562-8454 / 712-336-0203 Fax: 800-421-6737 / 712-336-0209 www.sbsc.info
Southwest Health and Human Services Group Medical Benefits Plan	Coverage offered through Southwest Health and Human Services and administered by: PreferredOne 6105 Golden Hills Drive Golden Valley, MN 55416 Phone: 763-847-4000 www.preferredone.com
Southwest Health and Human Services Group Dental Benefits Plan	Coverage offered through Southwest Health and Human Services and insured by:
Southwest Health and Human Services Group Vision Benefits Plan	Coverage offered through Southwest Health and Human Services and administered by:

MEMORANDUM OF AGREEMENT
BETWEEN
AFSCME LOCAL 2398-MINNESOTA COUNCIL 65
AND
SOUTHWEST HEALTH & HUMAN SERVICES
HEALTH INSURANCE/EMPLOYEES ELIGIBLE AS DEPENDENTS

IT IS HEREBY AGREED by and between Southwest Health & Human Services (Employer) and AFSCME Local 2398 Southwest Health & Human Services (Union) and that the following shall constitute the understanding reached between the parties with respect to health insurance and employees' eligible as dependents.

WHEREAS, the Employer and the Union are parties to a collective bargaining agreement; and

NOW, THEREFORE, Southwest Health & Human Services (SWHHS) and the Union agree to the following:

1. The Employer will contribute up to a maximum of six hundred sixteen dollars ($616.00) per month per employee for the cafeteria plan for employees taking single coverage. The Employer will contribute up to a maximum of nine hundred ninety one dollars ($991.00) per month per employee to the cafeteria plan for employees taking dependent coverage. Employees are required to carry single or dependent health care coverage using the maximum employer contributions stated above.
2. However, when a current SWHHS employee is eligible to be a dependent on another current SWHHS employee's insurance, the provision requiring coverage will be waived.
3. If this is exercised, only the SWHHS employee who is primary for health insurance will receive the employer contribution.
4. The Agreement shall be effective immediately through December 31, 2019.

IN WITNESS WHEREOF, the parties have caused this Memorandum of Agreement to be executed this _____ day of _____, 2018

Southwest Health & Human Services

_____
Beth Wilms Date
Director

_____
Gerald Magnus Date
SWHHS Governing Board Chairman

AFSCME Council 65, Local 2398

_____
Nicole Longtin Date
President, Local 2398

_____
Eric Austin Date
Business Agent

MEMORANDUM OF AGREEMENT
BETWEEN
AFSCME LOCAL 1687-MINNESOTA COUNCIL 65
AND
SOUTHWEST HEALTH & HUMAN SERVICES
HEALTH INSURANCE/EMPLOYEES ELIGIBLE AS DEPENDENTS

IT IS HEREBY AGREED by and between Southwest Health & Human Services (Employer) and AFSCME Local 2398 Southwest Health & Human Services (Union) and that the following shall constitute the understanding reached between the parties with respect to health insurance and employees' eligible as dependents.

WHEREAS, the Employer and the Union are parties to a collective bargaining agreement; and

NOW, THEREFORE, Southwest Health & Human Services (SWHHS) and the Union agree to the following:

1. The Employer will contribute up to a maximum of six hundred sixteen dollars ($616.00) per month per employee for the cafeteria plan for employees taking single coverage. The Employer will contribute up to a maximum of nine hundred ninety one dollars ($991.00) per month per employee to the cafeteria plan for employees taking dependent coverage. Employees are required to carry single or dependent health care coverage using the maximum employer contributions stated above.
2. However, when a current SWHHS employee is eligible to be a dependent on another current SWHHS employee's insurance, the provision requiring coverage will be waived.
3. If this is exercised only the SWHHS employee who is primary for health insurance will receive the employer contribution.
4. The Agreement shall be effective immediately through December 31, 2019.

IN WITNESS WHEREOF, the parties have caused this Memorandum of Agreement to be executed this _____ day of _____, 2018

Southwest Health & Human Services

_____
Beth Wilms Date
Director

_____
Gerald Magnus Date
SWHHS Governing Board Chairman

AFSCME Council 65, Local 1687

_____
Jennifer Nelson Date
President, Local 2398

_____
Eric Austin Date
Business Agent

--PERSONNEL COMMITTEE--

Section 1 - Purpose

The Southwest Health and Human Services Governing Board shall establish a committee known as the Personnel Committee. This committee shall be in charge of making recommendations to the Board on matters including but not limited to the review of the agency's personnel policies, collective bargaining and administering a comprehensive human resources program that is consistent with federal, state, and local laws/regulations. The Personnel Committee will make recommendations to the Southwest Health and Human Services Governing Board who have the final authority.

Section 2 - Composition

The Personnel Committee will be made up the Director, Deputy Director, HR Specialist and the Chairpersons from each of the Southwest Health and Human Services' Boards.

Section 3 – Policy Guideline

Any personnel issues shall be presented to the Personnel Committee before being taken to the Southwest Health and Human Services Governing Board for their final action. The Committee shall make recommendations to the Governing Board or carry out other activities assigned to it by the Governing Board. Nothing in this Policy shall diminish the final authority that is vested in the Southwest Health and Human Services Governing Board.

The Personnel Committee shall meet upon the call by the Director, Deputy Director, or the Southwest Health and Human Services Governing Board.

SOUTHWEST HEALTH AND HUMAN SERVICES
PERSONNEL POLICY NUMBER 3

EFFECTIVE DATE: 01/01/11
REVISION DATE: 10/21/15; 02/17/16; 01/18/17; 04/18/18; 11/21/18
AUTHORITY: Southwest Health and Human Services Joint Governing Board

- - -LEAVES AND HOLIDAYS- - -

Section 1 – Vacation Leave

a. Each permanent , trainee, parttime or probationary employee shall earn vacation on the last working day of each payroll period, but this vacation cannot be used until the first working day of the following payroll period.

- At initial hire, staff will earn 3.7 hours of vacation bi-weekly.
- At 5 years of service, staff will earn 5.55 hours of vacation bi-weekly.
- At 10 years of service, staff will earn 6.45 hours of vacation bi-weekly.
- At 15 years of service, staff will earn 7.35 hours of vacation bi-weekly.

b. Vacation leave will be prorated for part-time employees. Part-time employees, or employees whose status has changed from part-time to full-time (or vice-versa), are not eligible for automatic increases based upon years of service. Any increase in vacation leave is based upon total months of service.

c. Vacation leave can accumulate to a maximum of 224 hours. No time is accumulated after reaching the maximum. Vacation leave cannot be used during the first three months of full-time equivalency service. When taking vacation leave, the minimum increment that can be used is one-half hour. Vacation leave cannot be used until it is earned.

d. Requests for vacation leave must be made to the employee's supervisor in writing and must be authorized in advance by the supervisor in writing. In the absence of the employee's supervisor, the request may be made to another supervisor in the agency.

e. Upon voluntary separation of employment, any employee who has six (6) months of satisfactory service will be paid for any accrued vacation leave that has not been used. Employees may not use more than three (3) days during the last two weeks of employment. Employees terminated for misconduct shall not be entitled to be paid accrued unused vacation leave. This shall not apply to employees terminated for poor work performance.

f. Employees who were previously employed by Lincoln, Lyon, and Murray Human Services and Lincoln, Lyon, Murray, and Pipestone Public Health or a County that becomes a member of Southwest Health and Human Services, shall maintain their seniority dates from their initial employment, so long as there was no interruption in

continuous employment from their prior employer and Southwest Health and Human Services.

Section 2 – Medical Leave

a. Each permanent, trainee, parttime or probationary employee shall earn medical leave at the end of the payroll period at the rate of 3.7 hours. Medical leave will be prorated for part-time employees. Medical leave can accumulate to a maximum of 450 hours. No time is accumulated after reaching this maximum. Medical leave may not be used in the payroll period it is earned.

b. When taking medical leave, the minimum increment that can be used is one-half hour. In addition, the agency may designate any qualifying leave for employee or family medical purposes, paid or unpaid, as counting toward an employee's FMLA entitlement (FMLA § 825.208).

c. Medical leave may be used for illness (self and immediate family), injury, medical and dental appointments. (Immediate family shall be spouse, children, parents, grandparents and legal wards of the employee or as allowed by state statute). Medical leave may be used for reasons of prenatal and postnatal care for the length of time prescribed, and verified in writing, by a physician.

d. When an employee cannot report to work due to an illness the employee shall notify the receptionist so the employee's calendar can be updated. The receptionist should then notify the supervisor so that unit coverage is ensured.

e. When illness occurs within a period of vacation leave, the period of illness may be charged as medical leave and the charge against vacation leave reduced accordingly.

f. No employee will be paid for accrued medical leave at the time of separation, except those employees in the Public Health Collective Bargaining Unit. Payment of unused medical leave will be paid out to the Public Health Collective Bargaining Unit as per the Collective Bargaining Agreement.

g. The employer may require medical documentation when three days of leave are used within a thirty (30) day period. Such documentation may consist of verification of doctor's or dental appointments without disclosure of diagnosis. The employer reserves the right to request additional information, including medical information, in the event that there is a pattern indicating the possible abuse of sick leave.

h. Medical leave due to preplanned medical appointments must be approved by the employee's supervisor in the same manner as vacation.

i. If any employee receives a compensable injury and has benefits accrued under sick leave, the employee may at his/her option, request and receive sick leave to supplement the difference between his/her regular pay and Worker's Compensation. The total amount paid to the employee will not exceed his/her regular earnings.

Section 3 – FMLA Leave

a. An "eligible employee" is an employee of a covered employer who:

1. Has been employed by the employer for at least 12 months, and

2. Has been employed for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave,

b. Eligible employees may take leave for:

1. The birth of a child;

2. The placement of a child for adoption or foster care;

3. To care for the employee's spouse, son, daughter or parent with a serious health condition;

4. A serious health condition that renders the employee unable to perform the functions of his/her job;

5. To care for the employee's spouse, son, daughter, parent, or next of kin with a serious injury or illness incurred during active duty military service;

6. For the purposes of FMLA leave, "child" is defined as a biological, adopted or foster son or daughter, stepchild, legal ward, or a child of a person standing in loco parentis who is: (a) under the age of 18 years; or (b) 18 years of age or older and incapable of self-care because of mental or physical disability.

c. Requesting Leave

Eligible employees seeking to use FMLA leave shall be required to provide written notice to the Human Resources, except in emergency circumstances, when oral notice may be given:

1. 30-day advance notice the need to take FMLA leave when the need is foreseeable;

2. notice "as soon as practicable" when the need to take FMLA leave is not foreseeable ("as soon as practicable" generally means at least verbal notice to the employer within one or two business days of learning of the need to take

FMLA leave);

3. sufficient information for the employer to understand that the employee needs leave for FMLA-qualifying reasons (the employee need not mention FMLA when requesting leave to meet this requirement, but may only explain why the leave is needed); and

4. where the employer was not made aware that an employee was absent for FMLA reasons and the employee wants the leave counted as FMLA leave, timely notice (generally within two business days of returning to work) that leave was taken for an FMLA-qualifying reason.

d. Designation

1. The agency may designate an employee's absence from work FMLA leave if the circumstances giving rise to the leave is FMLA qualifying. The Agency will notify the employee that the leave is being designated FMLA leave. The Human Resources shall complete the appropriate FMLA designation forms in a timely manner (within five days of the leave commencing whenever possible) and forward them to the employee. The Supervisor is responsible for notifying the Human Resource of leaves of three days or more or intermittent leaves which may be FMLA qualifying.

2. The Human Resources is responsible for completing the "Employer Response to Employee Request for FMLA Leave" form and related forms in all circumstances in which an employee qualifies for leave under the FMLA, whether or not the employee specifically requests such a FMLA leave. (e.g. when an employee is on medical leave which also qualifies under FMLA, when an employee is unable to request a leave due to a medical condition, etc.). The original shall be provided to the employee and a copy retained by the Human Resources in a "confidential medical file" for the employee, which shall be separate from the employee's personnel file. All medical certifications shall also be retained in that file.

e. Child leave shall begin at a time requested by the employee, but may begin not more than twelve months after the birth or adoption, except in the case where the child must remain in the hospital longer than the mother, the leave may not begin more than six weeks after the child leaves the hospital.

f. During FMLA leave, the employee will be required to use any available earned, accumulated leave. However, staff may hold up to 37.5 hours of medical and/or vacation leave to be available upon return from leave. Employees will provide written notification to their supervisor and Human Resources of their intent to bank medical and/or vacation leave prior to FMLA leave. When the reason for the FMLA leave qualifies under the "Medical Leave" section of this policy for either the employee or an

eligible family member, then earned, accumulated medical leave must be used. If the reason for FMLA leave does not qualify for use of medical leave, then any accumulated vacation leave must be used before leave without pay will be authorized. An employee shall continue to be eligible for paid holidays while on approved FMLA.

g. For as long as an employee is on FMLA leave the agency will make its cafeteria contribution towards health insurance.

h. The agency will require that an employee's FMLA leave be supported by appropriate documentation.

1. For the employee's serious health conditions, the leave must be supported by a certification issued by the health care provider of the employee. The agency will notify the employee, in writing, that such certification is required. The certification shall contain all of the information permitted by law. Failure of the employee to submit complete Certification of Health Care Provider forms, with all information, may result in a denial of FMLA leave.

2. The employee must provide the medical certification within fifteen (15) days of a request for certification.

3. The agency will also require medical certification from the eligible family member's health care provider to support a leave request for a leave to care for an eligible family member. In cases where the employee's use of FMLA leave to care for an immediate family member is of an intermittent nature, a medical certification will be required verifying this fact during each 12-month period in which the employee uses FMLA leave for this purpose.

4. Other appropriate documentation, including military records, verification of adoption and similar records, may be required by the employer.

i. Second Opinion

1. In General - In any case in which the employer has reason to doubt the validity of the certification provided by the health care provider, the employer may require, at the expense of the employer, that the eligible employee obtain the opinion of a second health care provider designated or approved by the employer concerning any information certified by the employee's health care provider.

2. Limitation - Health care provider designated or approved under paragraph (1) shall not be employed on a regular basis by the employer.

3. Resolution of Conflicting Opinions

- In General – In any case in which the second opinion differs from the opinion in the original certification provided, the employer may require, at the expense of the employer, that the employee obtain the opinion of a third health care provider designated or approved jointly by the employer and the employee concerning the information certified.

- Finality – The opinion of the third health care provider concerning the information certified shall be considered to be final and shall be binding on the employer and the employee.

4. Subsequent Recertification - The employer may require that the eligible employee obtain subsequent re-certifications on a reasonable basis.

5. In cases where the employee's use of FMLA leave is of an intermittent nature, a medical certification will be required verifying this fact during each 12-month period in which the employee uses FMLA leave.

j. As a condition of restoring an employee whose FMLA leave was occasioned by the employee's own serious health condition that made the employee unable to perform the employee's job, Southwest Health and Human Services will require all employees who are certified for FMLA leave obtain and present certification from the employee's health care provider that the employee is able to resume work.

k. For additional information refer to "Family and Medical Leave Act" (FMLA) U.S. Department of Labor website.

Section 4 Parenting Leave

a. A parental leave of up to 12 weeks shall be granted to a natural parent or adoptive parent, who requests such leave in conjunction with the birth or adoption of a child. To be eligible, the employee must have been employed for at least 1 year at half time. The 12 weeks of leave shall include any period of paid leave already provided. The employee shall be required to use all eligible paid leave during the parental leave period. This policy is provided for those employees who do not meet eligibility requirements under the Family Medical Leave Act and shall not be construed as being in addition to FMLA rights.
   - The leave must begin no later than 6 weeks following the birth or adoption.
   - The employee may continue all group insurance during the leave at the employee's expense.

Section 5 – Statutory Leaves

a. Employees are entitled to certain statutory leaves under state and federal law. In order to request such leaves, the employee must make a written request to their immediate

supervisor and the Deputy Director/Human Resources Director. Leaves may be granted or denied based upon whether the employee qualifies for the statutory leave(s); the employee has made the request for leave in a timely manner and provided the appropriate documentation.

b. Such statutory leaves include such leaves as military leaves, voting leave, bone marrow donation leave and school conference leave.

Section 6 – Educational Leave

a. An employee may request an educational leave without pay or benefits, not to exceed 2 years, by presenting the following written documents to their supervisor who will submit it to the Board for approval:
   - Letter of request
   - Any other material felt necessary to support the request

b. The Southwest Health and Human Services Governing Board has the sole discretion to approve or deny such leave as it sees fit.

Section 7 – Jury or Witness Duty

a. After notice to his/her supervisor, any employee shall be granted leave with pay for service upon a jury or appearance before a court, legislative committee, or other judicial or quas-judicial body as a witness in an action involving the federal government, State of Minnesota, or a political subdivision thereof, in response to a subpoena or other direction by proper authority.

b. The employee will be required to turn over to the agency any per diem payment received as a result of serving on a jury or as a witness. Monies received as expenses shall be kept by the employee.

Section 8 – Bereavement Leave

a. Each employee shall have up to 22.5 hours non-cumulative annual bereavement leave. Each employee shall have an additional 5 days (37.5 hours) noncumulative bereavement leave for immediate family (parent/child/spouse). Such days shall be with pay and shall not be deducted from medical leave or vacation balances. Such leave must be taken in a minimum of 1/2 hour (.5) hour increments.

b. Upon exhaustion of the non-cumulative bereavement leave and approval of their supervisor, an employee may use up to three (3) days of medical leave for bereavement of parents, children, spouse, siblings, legal wards, grandparents, grandchildren, aunts,

uncles nieces, nephews, cousins, spouse's parents and in-law relatives.

c. Reasonable agency time without loss of pay will be allowed to attend a funeral of current staff members or former staff members who left the agency within the last two years.

d. In the event of a death in the family the employee shall inform the supervisor in the same manner as for medical leave.

Section 9 – Holidays

a. An employee must be in pay status the day preceding and the day following a holiday to earn holiday pay. Holiday pay for part-time employees or employees who are in leave without pay status will be prorated.

If a holiday falls on a Saturday the holiday will be observed on Friday, if a holiday falls on a Sunday the holiday will be observed on Monday.

b. New Year's Day
Martin Luther King Day
President's Day
Memorial Day
Independence Day
Labor Day
Veteran's Day
Thanksgiving Day
Day after Thanksgiving
Christmas Eve Day at noon if December 24th falls on Tuesday, Wednesday, or Thursday
If Christmas Eve falls on a Monday, then the full day holiday is observed
Christmas Day

Section 10 – Leave Without Pay

a. Up to 37.5 hours of leave without pay per calendar year can be approved by ~~administration~~ the employee's direct supervisor. The supervisor in his/her discretion has the authority and responsibility to deny a leave request when such a request could have negative effect on the service delivery of the agency.

b. Whenever an employee requests leave without pay under the total of 37.5 hours per calendar year, the Leave Without Pay/Overtime Authorization (AG#006) must be completed and given to the supervisor. The supervisor will then give it to the Director for final approval. ~~At the end of the payroll period the Leave/Overtime Authorization~~

~~should be attached to the employee's time sheet and routed to their supervisor.~~ Salary, vacation, holiday, and medical leave (earned) will be prorated in the same manner as for part-time employees. Health insurance coverage will not be affected unless the employee takes leave without pay in excess of 37.5 hours per calendar year.

c. Leave without pay of more than 37.5 hours per calendar year will be reviewed and approved/denied by a sub committee made up of the Director, Deputy Director/HR, employee's immediate supervisor, and Division Director ~~require Southwest Health and Human Services Governing Board approval~~ except when the leave is FMLA qualifying. An employee must make written application to ~~the Governing Board~~ Human Resources setting forth the request for the leave, the requested duration of the leave and the circumstances necessitating the leave. The request must be received prior to the commencement of the leave. ~~The~~ Southwest Health and Human Services ~~Governing Board~~ ha~~s~~ve the sole discretion to approve or deny such leave as it sees fit.

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d. Leave without pay will only be considered if all eligible accrued leave has been exhausted.

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~~d.~~e Any unauthorized absence from work shall be considered absence without leave and be subject to disciplinary action and time without pay. Three days of absence without authorization may be deemed as a resignation, but such leave may be covered by subsequent approval of leave if conditions warrant.

Agency Forms Regarding This Policy
AG#006 - Leave Without Pay/Overtime Authorization

Child and Teen Check Up Outreach Supplies

Authorization Summary

November 21, 2018 SWHHS Board Meeting

Vendor	Description	Quantity	Quote
Cubik	Magnets	3000	$1,539.65
Channing Bete	Brochures	6,500 various titles	$8,387.93
Nutrition Matters	Brochures	1,750 various titles	$318.00
Fresh Baby	Training Cups	1,000	$2,381.75

- Specific brochures have been used in the past, are not offered by any other vendor, and the cost has been deemed reasonable.

- **ALL COSTS** will be covered by the Child & Teen Check Up Grant and have been approved in our work plan.

- The particular vendors have been checked on the SAM System and have no active exclusion records.

CUBIK

DATE: 10/29/2018
Quotation # 14112

600 W Park Rd
Redwood Falls, Mn 56283
800-554-2706
yourfriends@cubikpromo.com

Quotation For:
Name: Michelle Schuelke
Company: SWHHS
Street
Address

Comments or Special Instructions

n/a

SALESPERSON	P.O. NUMBER	In Hands / Event Date	Valid For	TERMS
MSP		TBD	30 days	Net30

QUANTITY	DESCRIPTION	Unit Cost	AMOUNT
3000	Picture Frame Magnet w/ Oval Punch Out - 30 mil	$0.47	$1,410.00
1	Estimated Shipping	$129.65	$129.65

SUBTOTAL	$	1,539.65
TOTAL	$	1,539.65

If you have any questions concerning this quotation please do not hesitate to call me! 800-554-2706

If you are tax exempt please remit an exemption certificate when placing your order. Prices subject to change.

Review Order Payment Submit Order

Print

Review Your Order:

This page shows items currently in your shopping cart.
To continue the checkout process, please click on the **Payment Information** button below.

Confirm Order Information

Please review the information below. Use the links provided to make any necessary changes or corrections.

Contact Information:

Tanlee
Noomen
Health & Human Services Aid
Public Health
Southwest Health & Human Services
607 West Main St, Suite 200
Marshall
MN
US
56258
507-836-6144 Ext. 2100
tanlee.noomen@swmhhs.com
Customer #: H912X
Sales/Use Tax Exemption Number:
1684076
Change contact information

Shipped via:

UPS Ground
Change shipping option

Shipped to:

Tanlee
Noomen
Health & Human Services Aid
Southwest Health & Human Services
607 West Main St. Suite 200
Marshall
MN
US
56258
Change shipping address

Additional Information:

Key Code:
Change additional information

Billed to:

Tanlee
Noomen
Health & Human Services Aid
Southwest Health & Human Services
607 West Main St. Suite 200
Marshall
MN
US
56258
Change billing address

To change the number of items in your order, type in the desired quantity, then click on the "Update" button.
To delete an item from your order, click on the "Remove" button.

Items Chosen from Price List B

Title	Item No.	Price Ea.	Qty.	Total Price
A Healthy Home -- Keeping Tabs® On Household Hazards	PS81427	1.02	4000 Update Remove	$ 4,080.00
We Wonder® -- We Love Healthy Food!	PS90874	1.02	500 Update Remove	$ 510.00
Distracted Driving -- Keeping Tabs® On Driving Safely	PS83672	1.02	500 Update Remove	$ 510.00
Interview Skills -- Keeping Tabs® On Getting Your Next Job	PS83590	1.02	500 Update Remove	$ 510.00
Managing Your Money -- Keeping Tabs® On Your Finances	83337	1.02	500 Update Remove	$ 510.00

Price List B

Qty	1-99	100-499	500-999	1,000-2,499	2,500-4,999	5,000-9,999
$	2.11 ea.	2.05 ea.	1.98 ea.	1.71 ea.	1.35 ea.	1.02 ea.

Prices apply to **total quantity** ordered within this price group.

Total qty. 6000 x Price ea. 1.02 = Subtotal: **$ 6,120.00**

Items Chosen from Price List S

Title	Item No.	Price Ea.	Qty.	Total Price
Your Guide To Your Baby's First Year	PS83926	4.30	500 Update Remove	$ 2,150.00

Price List S

Qty	1-99	100-499	500-999	1,000-2,499	2,500-4,999	5,000-9,999
$	4.42 ea.	4.38 ea.	4.30 ea	4.14 ea.	3.95 ea	3.32 ea

Prices apply to **total quantity** ordered within this price group.

Total qty. 500 x Price ea. 4.30 = Subtotal: **$ 2,150.00**

Subtotal: **$ 8,270.00**
Estimated Shipping & Handling: **$ 117.93**
Notification regarding sales/use taxes.
Grand Total: **$ 8,387.93**

Payment Information ▶

ABOUT SSL CERTIFICATES

Site Map | Terms of Use | Privacy For customer service, call 1-800-477-4776.

Wish Lists My Account Sign out (24 items)

CALL US 888-356-5575 Search for a product

HOME OUR SERVICES INFANTS & TODDLERS CHILDREN MARKET NUTRITION PG, BF, PP WOMEN FAMILY NUTRITION

SECURE CHECKOUT

STEP 1: BILLING DETAILS	Tanlee Noomen, Southwest Health & Human Service 607 West	MODIFY »
STEP 2: SHIPPING DETAILS	Tanlee Noomen, Southwest Health & Human Service, 607 West	MODIFY »
STEP 3: SHIPPING METHOD	Ship by Order Total for $0 00	MODIFY »
STEP 4: ORDER CONFIRMATION		

Please review the contents of your order below and then choose how you'd like to pay for your order.

CART ITEMS	QTY	ITEM PRICE	ITEM TOTAL
TODDLER MEALS (LANGUAGE: ENGLISH)	10	$12 00	$120.00
BYE BYE BOTTLE (LANGUAGE: ENGLISH)	3	$12 00	$36 00
BABY TEETH (LANGUAGE: ENGLISH)	3	$12.00	$36 00
TWELVE STEPS TO A HEALTHY FAMILY (LANGUAGE: ENGLISH)	3	$12 00	$36 00
MYPLATE - ENJOY FAMILY MEALS (LANGUAGE: ENGLISH)	5	$12 00	$60 00
		SUBTOTAL:	**$288.00**
		SHIPPING (SHIP BY ORDER TOTAL):	**$30.00**
		GRAND TOTAL:	**$318.00**

HOW WOULD YOU LIKE TO PAY?

REDEEM A GIFT CERTIFICATE OR COUPON

To apply a gift certificate or coupon code to this order, please enter the code below and click 'Apply'

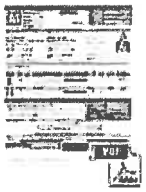
www.FreshBaby.com
231-348-2706
523 East Mitchell St., Petoskey, MI 49770

Quote AAAQ4555

Valid through December 8, 2018

Prepared For:
Southwest Health & Human Services
Michelle Schuelke
Phone: (507) 537-6713
michelle.schuelke@swmhhs.com

Prepared By:
Tracy Barr
Account Manager
Phone: 231-348-2706 x19
Fax: 888-747-3247
Email: tracy@FreshBaby.com



For a PDF version of this quote, click here. You can sign and fax (888-747-3247) or email it to us at accountservice@freshbaby.com or you can save time by simply electronically accepting this quote below.

Line Item Detail

QTY	Description	Picture	Unit Price	Ext Price
900	4- to 6- oz. Kid's MyPlate Dairy Training Cup (w/ lid) - English		$2.14	$1,926.00
100	4- to 6- oz. Kid's MyPlate Dairy Cup - English		$2.00	$200.00

SubTotal:	**$2,126.00**
Shipping:	**$255.75**
Sales Tax:	**$0.00**
Total:	**$2,381.75**

Deposit Required: $2,381.75

Payment Options

○ **Purchase (Credit Card)**
Credit Card
$2,381.75
full payment

◉ **Purchase (CustomPaymentType1)**
CustomPaymentType1
$2,381.75
full payment

Ready to Accept?

Order Confirmation

Please check your billing and shipping address. If there is change needed, please send us the information using the question section below. We will update the quote and resend it.

Bill To:
Southwest Health & Human Services
Michelle Schuelke
Phone: (507) 537-6713
607 West Main Street
Suite 200
Marshall MN 56258-3099
michelle.schuelke@swmhhs.com

Ship To:
Southwest Health & Human Services
Michelle Schuelke
Phone: (507) 537-6713
607 West Main Street
Suite 200
Marshall MN 56258-3099
michelle.schuelke@swmhhs.com

☐ I agree to the terms and conditions of the above document and PDF attachment with an electronic signature below.

IP Address 136.234.57.253

PO Number
(Optional: Enter PO Number as your reference only.)

Comments

Email Address michelle.schuelke@swmhhs.com

Printed Name

Signature

Click to Accept
(Note: After accepting you will have the opportunity to provide payment.)

Have Questions?

Not Ready To Accept? Have Questions?

Submit
(Note, you will receive a copy of your message by email.)

No questions posted yet.

Time expressed in Eastern Standard Time UTC-05:00

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NOVEMBER 2018

GRANTS ~ AGREEMENTS ~ CONTRACTS

Board review and approval

☐ **Brown County Evaluation Center Inc. (New Ulm, MN)** – 01/01/19 to 12/31/19; Detoxification and evaluation services, $411/day (4% increase or $19/day) or according to client's insurance plan plus a 12% service fee of total per diem cost for insurance processing (renewal).
Fiscal Note: 2018 $57,314

☐ **Woodland Centers (various locations)** – 01/01/19 to 12/31/19; Crisis stabilization services, adult per diem at $375 (no increase), youth per diem at $525 (no increase), and detoxification $550 (14.5% increase) (renewal).
Fiscal Note: 2018 $16,491

☐ **DHS Mental Health Crisis Response Services Grant for Adult & Children's (Lincoln, Lyon, Murray, Redwood and Yellow Medicine Counties)** – 01/01/18 to 12/31/20; Amendment to extend mental health crisis response services an additional two years, which will be provided through Western Mental Health Center, $600,000 amended amount + $394,369 original allocation (extension of grant).
Fiscal Note: pass through grant monies to WMHC for crisis services

☐ **New Horizons Crisis Center (Marshall, Slayton; Redwood locations)** – 01/01/19 to 12/31/19; Block grant payment for supervised parenting time services, $100,000 (renewal).
Fiscal Note: 2018 $82,122

☐ **Lyon County (Marshall, MN)** - 07/01/17 – 12/31/24; Amendment to the office lease beginning 2019 to reduce the square footage from 31,737 to 29,777 square feet of space thus reducing incremental payments to $22,333/mo ($9.00/ft/yr) for 2019, $23,573/mo ($9.50/ft/yr) for 2020, and $24,814/mo ($10.00/ft/yr) for 2021. (amendment).
Fiscal Note: 2018 $269,760 ($22,480/mo)

☐ **New Life Treatment Center (Woodstock, MN)** - 01/01/19 – 12/31/19; CCDTF services, $375/day plus $.61 Detox mileage (39% increase) (renewal).
Fiscal Note: 2018 $41,430