CLINTON COUNTY

POST RETIREMENT HEALTH CARE PLAN

SUMMARY PLAN DESCRIPTION

September 1, 2016

INTRODUCTION

Clinton County (the "Employer") maintains the Clinton County Post Retirement Health Care Plan (the "Plan"). The Plan is a tax-qualified employee benefit plan that provides medical benefits to eligible retirees, their spouses and their dependents. The Plan has been restated effective as of September 1, 2016.

The Plan may be amended from time to time by action of the Board of Commissioners to keep it in compliance with federal laws affecting employee benefit plans and to keep the Plan current with developments related to Clinton County (the "Employer") and its benefit program. Your rights and benefits as a participant are generally governed by the terms of the Plan as in effect when you last worked for the Employer.

This Summary Plan Description is intended to serve as an easy-to-read explanation of the Plan. It summarizes, in a very condensed form, the Plan's important provisions as they apply to participants who are employees of the Employer on or after that date. **Although the Employer has made a sincere effort to make this Summary as complete and accurate as possible, this Summary is not a substitute for the Plan document itself.** The detailed provisions of the Plan document, not this Summary, govern the actual rights and benefits to which you may be or become entitled. The Plan document is available for your inspection during regular business hours at the Employer's offices.

Nothing in the Plan or in this Summary Plan Description confers on you any rights of continued employment with the Employer. Moreover, your participation in the Plan does not prohibit changes in the terms of, or the termination of, your employment with the Employer.

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1. WHAT IS THE EFFECTIVE DATE?

The effective date of the restated Plan is September 1, 2016.

2. WHO IS ELIGIBLE TO PARTICIPATE?

All employees of the Employer who (a) customarily perform services for the Employer on a regular full-time basis (as described in the Employer's personnel manual) and (b) have completed at least ninety (90) days of continuous service with the Employer are eligible to participate in the Plan.

3. WHEN WILL I BE ELIGIBLE TO PARTICIPATE?

You will become a Plan participant on the first day of the month immediately following the date on which you satisfy each of the requirements that is listed below.

a. You are retired from the Employer.

b. You have attained age sixty (60) as of the date health insurance coverage begins under this Plan, even if your retirement from the Employer precedes your benefit commencement date.

c. You have completed twenty (20) consecutive years of service (fourteen (14) consecutive years of service if you retired before January 1, 2002) with the Employer (as described in paragraph 4 below) as of your retirement date.

d. You are receiving Employer funded pension retirement benefits.

e. You certify that you (and if applicable, your spouse and/or dependent(s)) are eligible to receive retiree health coverage under the Plan and that no other major medical coverage is available to you (or if applicable, your spouse and/or dependent(s)) from another health insurance plan or source. Health insurance coverage under Medicare is not considered "another health insurance plan or source" for purposes of this rule.

You (or your surviving spouse and/or dependent(s)) will be required to file an annual statement with the Employer certifying your continued eligibility for health insurance coverage under the Plan. The eligibility requirements for specific health benefits, the amount and type of benefits, the circumstances under which benefits will not be provided and other provisions affecting eligibility and benefits are described in this Summary Plan Description and in your group health insurance contract.

4. HOW ARE YEARS OF SERVICE COMPUTED?

You will earn a year of service credit for each consecutive twelve (12) month period (based on the twelve (12) month anniversary of your date of hire) for which you are credited with two-thousand and eighty (2,080) hours of service with the Employer. You will be credited with one hour of service for each hour that you are paid or entitled to be paid for services performed for the Employer.

Service will be credited from the date you first perform an hour of service for the Employer (including hours of service completed before the Plan's effective date) until you separate from service. You will also receive credit for each partial year of service based on a fraction, the numerator of which is your hours of service completed during the twelve (12) month computation period and the denominator of which is two-thousand and eighty (2,080).

5. WHAT IS THE PLAN YEAR?

The Plan Year is the consecutive twelve (12) month period beginning on January 1 and ending on December 31.

6. WHAT BENEFIT WILL I RECEIVE FROM THE PLAN?

The Plan provides you with (i) post-retirement health insurance coverage (the "Retiree Health Benefit"); and (ii) supplemental reimbursement benefits for certain post-retirement medical expenses (the "Supplemental Benefit"). Each benefit is further explained below.

a. Retiree Health Benefit. The Retiree Health Benefit provides you, and if applicable, your spouse and/or eligible dependent, with coverage under the group health insurance policy described in the Schedule of Retiree Health Benefits that is attached to this Summary Plan Description, as amended from time to time. The Employer's sole obligation under the Plan with regard to the Retiree Health Benefit is to deposit your (and if applicable, your spouse's and/or dependent's(s)) contribution in the Trust Fund and to mail periodic premium payments directly to the insurance company.

b. Supplemental Benefit. The Supplemental Benefit provides you with the reimbursement of certain medical expenses as described in the Schedule of Supplemental Benefits that is attached to this Summary Plan Description, if you are enrolled in the Retiree Health Benefit that is described in Section 6.a. above. Reimbursable medical expenses do not include any medical expenses, reimbursements or payments that are provided under (i) any insurance policy, whether owned by the Employer, you or your spouse and/or dependent; (ii) any federal or state health and accident plan; or (iii) any other health plan maintained by the Employer or any other employer.

If you are eligible for the Supplemental Benefit, you will receive reimbursement for eligible medical expenses that are incurred while you are a Plan participant. Medical expenses are deemed to have been incurred when the services giving rise to the claim for benefits are provided, regardless of when you are formally billed, charged or pay for the related expense. Medical expenses that you incur before the date on which you became a Plan participant, or that

are incurred after you cease to be a Plan participant, are not eligible for reimbursement. You must submit claims for the reimbursement of eligible medical expenses in accordance with Section 12. of this Summary Plan Description.

7. DOES THE PLAN PROVIDE A HEALTH BENEFIT TO MY SPOUSE AND/OR MY DEPENDENTS?

Yes. The Plan provides a health benefit to your spouse only if you were legally married to your spouse on your participation date. The Plan also provides a health benefit to your eligible dependent child(ren) (if the child is classified as a dependent under the relevant health insurance policy). The Plan does not provide a health benefit to any individual who is (or becomes) divorced or legally separated from you.

8. DOES THE PLAN REQUIRE ANY CONTRIBUTIONS FROM YOU, YOUR SPOUSE, AND/OR YOUR DEPENDENT(S)?

Yes. Contributions payable by you (and if applicable, your spouse and/or your dependent(s)) may be required as described in the attached Schedule of Retiree Health Benefits, as amended from time to time. You are required to pay one hundred percent (100%) of the premium costs associated with the health insurance coverage of your spouse and/or eligible dependent, whichever is applicable, unless otherwise specified in a collective bargaining unit agreement that is applicable to your employment with the Employer.

9. WHEN DOES COVERAGE END?

Your Retiree Health Benefit and Supplement Benefit will terminate as described below.

a. Participant coverage, and if applicable spouse and/or dependent coverage, terminates on the last day of the month in which any of the events below occur.

(i) You (or your surviving spouse and/or dependent(s)) fail to file an annual statement with the Employer certifying your continued eligibility for retiree health coverage under the Plan.

(ii) You (or your spouse and/or your dependent(s)) fail to remit any health insurance premium contributions to the Employer by the tenth (10^{th}) day of the month preceding the month of coverage, with a thirty (30) day grace period for late payments. Any check that is returned for insufficient funds (NSF) will be treated as a nonpayment. The participant, spouse, or dependent will be assessed a Twenty-Five Dollar ($25) returned check fee and will be required to forward a replacement check to the Employer within fourteen (14) days after being notified of the return check. Any subsequent NSF payments will be treated as nonpayments and will result in immediate termination of coverage.

(iii) Major medical coverage becomes available to you (or if applicable, your spouse and/or your dependent(s)) from another health insurance plan or source unless a pre-existing condition exclusion prevents the coverage of a condition. To the extent such other coverage is Medicare, this Plan will provide a policy of Medicare supplemental coverage. To the

extent such other coverage is not comparable to the coverage provided under this Plan, the availability of health insurance coverage under this Plan will be secondary to such other coverage. In the event the other health plan provides for similar coordination of benefits, coverage under this Plan shall be provided as required by applicable law. You (and if applicable, your spouse and/or eligible dependent) must provide the Employer with an annual statement, in the form specified by the Employer, certifying whether any other health coverage is available to you, your spouse and/or eligible dependent.

b. Subject to applicable continuation health coverage rules, your spouse's coverage under this Plan will terminate on the last day of the month in which you divorce or legally separate from your spouse.

c. Subject to applicable continuation health coverage rules, your eligible dependent's coverage under this Plan shall terminate on the date on which the dependent no longer qualifies as an eligible dependent under the terms of the relevant health insurance policy.

d. Subject to any collective bargaining agreement, the Employer may amend or terminate coverage under the Plan at any time, in its sole discretion, by action of the Board of Commissioners.

10. WILL I BECOME VESTED IN MY RETIREE HEALTH BENEFIT?

No. Neither you, your spouse, your dependent(s), nor any other person shall have any right, title or interest in the Retiree Health Benefit or in the Supplement Benefit that is offered under the Plan or in the assets of the related Trust fund, or in any Employer contributions to the fund. Such contributions will be held in the Trust for the sole purpose of paying (i) health insurance premiums; and (ii) medical reimbursement benefits under the Plan for retirees (and, if applicable, their spouses and/or eligible dependents) and for defraying any Plan expenses. The sole liability of the Employer and the Trustee for the payment of such benefits under the Plan is limited to paying premiums to the insurer and/or medical reimbursement benefits that are due as of the date in question, subject to the availability of assets then held in the Trust fund for the benefit of Plan participants and beneficiaries. Any forfeited, nonvested amounts held in the Plan shall be applied to reduce Employer contributions for the following Plan Year.

11. WHAT IS THE PROCEDURE FOR RETIREE HEALTH BENEFIT CLAIMS?

Claims to participate in the Plan must be submitted to the Employer, who has discretionary authority to construe and interpret the Plan and make all determinations as to the right of any employee (or if applicable, any spouse or dependent) to participate in the Plan. Any denial by the Employer of a claim to participate in the Plan will be stated in writing and must set forth the specific reasons for the denial, written in a manner calculated to be understood by you without legal or actuarial counsel.

Approval or denial of a claim will be delivered or mailed to you within thirty (30) days after the time such claim is made. Claims for health insurance benefits must be made directly to the insurer in the format determined by the insurer.

If your claim to participate in the Plan is denied in whole or in part, you will be afforded a reasonable opportunity for a review of the Employer's decision denying the claim. Review must be applied for by written request to the Employer within one-hundred and eighty (180) days after denial of the claim. The Employer will advise you of the decision within sixty (60) days after such request is made.

12. WHAT IS THE PROCEDURE FOR SUBMITTING SUPPLEMENTAL BENEFIT CLAIMS?

Claims for reimbursement will be accepted by the Employer (or, if applicable, the claims administrator) until March 31 of the Plan Year following the Plan Year in which the eligible expense was incurred. The reimbursement of claims submitted after that date are subject to approval by the Employer (or, if applicable, the claims administrator). Reimbursement benefits will be paid only if the Employer (or, if applicable, the claims administrator) determines in its sole discretion that you are entitled to them. Claims must be submitted to the Employer (or if applicable, the claims administrator) in the manner described in this Summary Plan Description. The Employer (or if applicable, the claims administrator) has sole and exclusive discretionary authority to construe and interpret the terms of the Plan, make factual determinations, and to decide all questions of eligibility and the amount, manner and time of any benefit payment as described below. Please contact the Employer if you have any questions about filing a claim for Supplemental Benefits under the Plan. Supplement benefits, for which you are eligible, will be paid on a monthly basis.

Reimbursement claims under the Plan are considered to be post-service claims. A post-service claim is a claim that does not require pre-approval as a condition of coverage. Approval or denial of an initial post-service claim will be sent to you within 30 calendar days after receipt of the claim, unless an extension is required. The 30-day period may be extended once up to 15 calendar days. If the extension is required due to your failure to provide the necessary information, the claims administrator will describe the required information. You will have at least 45 calendar days from receipt of the notice to provide the information.

If your claim is denied in whole or in part, you will be afforded a reasonable opportunity for a review of the Employer's decision denying the claim. Review must be applied for by written request to the Employer within one-hundred and eighty (180) days after denial of the claim. The Employer will advise you of his decision within sixty (60) days after such request is made.

13. HOW IS THE PLAN FUNDED?

The Employer has established a Trust fund under the Clinton County Post Retirement Health Care Trust Agreement. The Employer expects to make contributions to this Trust for the purpose of accumulating a fund to pay health insurance premiums and medical reimbursement benefits. An individual account will be maintained for each group of bargaining unit employees as well as an individual account for all non-bargaining unit employees. Trust assets will be segregated in connection with the maintenance of such individual accounts and the Employer and participant (or spouse or dependent) contributions to the Trust. Thereafter: (i) health insurance premiums will be paid from the Trust to the insurer; and (ii) medical reimbursement

benefits will be paid from the Trust to you (if eligible), only to the extent funded under the individual account established for each group of designated participants. If no assets remain allocated to the individual account of a designated group of participants, no such insurance premiums or medical reimbursement benefits will be payable from the Trust fund on behalf of the affected participants, spouses and dependents.

The Trust fund is invested by the Trustee in stocks, bonds and other investments permitted by PA 314 of 1965 and PA 149 of 1999, as amended. No adjustments will be made to any amount payable from the Plan based on any actual earnings or losses experienced by the investments. Any income generated by actual investments will be retained in the fund and used to offset future Employer contributions to the fund. The Employer is not required to fund the Trust at any particular rate, although it uses actuarially sound funding policies regarding its funding options.

14. WHAT HAPPENS IF THE EMPLOYER TERMINATES THE PLAN?

Subject to the terms of any bargaining unit agreement, the Employer may terminate the Plan at any time by action of the Board of Commissioners, in its sole discretion. If the Employer decides to terminate the Plan, all assets held in the Trust will be used to fund your retiree health insurance, pay medical reimbursement benefits, and/or to purchase other fringe benefits for you. The Employer is not obligated to make additional contributions on Plan termination in order to fund any particular insurance or medical reimbursement benefit. Your benefit on Plan termination will be based solely on the assets in the Trust when the Plan terminates. These decisions will be made by the Trustee in its sole discretion, subject to applicable law.

15. CAN THE EMPLOYER AMEND THE PLAN AND TRUST?

Yes. Subject to the terms of any collective bargaining unit agreement, Clinton County may amend all or any portion of the Plan and the Trust at any time by action of the Board of Commissioners, in its sole discretion. Plan provisions which could be amended include the eligibility provisions and the level of benefits, as well as any other Plan provision.

16. WILL I HAVE TO PAY TAXES ON MY SHARE OF THE FUND?

No. As of the effective date of this restated Plan, relevant law provides that the Retiree Health Benefit and the Supplement Benefit will be paid tax free. The tax treatment of those benefits in the future will depend on the tax laws that are in effect when the premiums and reimbursement benefits are paid, and the health benefits are provided.

17. DOES THE PLAN PROVIDE COVERAGE AFTER MY DEATH?

No benefit will be paid from the Plan for any reason after your death (or if applicable, the death of your covered spouse or dependent(s)) based on your Plan participation. However, claims for reimbursement of eligible medical expenses incurred before the date of death will be accepted by the Employer (or, if applicable, the claims administrator) until March 31 following the last day of the Plan year during which the expense was incurred.

18. WHAT ARE MY RIGHTS UNDER HIPAA?

If the Plan is subject to the HIPAA privacy rules, the Plan will incorporate the HIPAA administrative provisions regarding your privacy rights. The HIPAA rules describe the permitted and required uses and disclosures of your protected health information (PHI). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. There will be separation between the Employer and the Plan to limit the Employer's access to your PHI. Procedures will be implemented to ensure that PHI is not improperly used or disclosed and for resolving issues of non-compliance.

19. WHERE CAN I GET FURTHER INFORMATION ABOUT THE PLAN?

Copies of the Plan and the Trust Agreement are available at the office of the Employer.

20. WHAT OTHER INFORMATION SHOULD I KNOW?

Certain information regarding the administration of the Plan is as follows:

The Plan Administrator is:

Clinton County
100 East State Street
St. Johns, MI 48879
Telephone: (989) 224-5156
Attention: Ryan Wood

The Employer's Taxpayer Identification Number is: 38-6004844

The agent for service of legal process is:

Ryan Wood
c/o Clinton County
100 East State Street
St. Johns, MI 48879
Telephone: (989) 224-5156

Legal process may also be served upon any Plan Trustee or the Plan Administrator.

The Co-Trustees' names and addresses are:

Craig Longnecker, 5387 Wild Oak, East Lansing, MI 48823
Sara Clark Pierson, 13450 S. Bauer Rd., Eagle, MI 48822
Robert Showers, 120 E. Washington Street, DeWitt, MI 48820