LAPEER COMMUNITY SCHOOLS

EMPLOYEE BENEFIT WRAP PLAN

(Amended and Restated Effective January 1, 2018)

TABLE OF CONTENTS

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ARTICLE I – ESTABLISHMENT

1.1 THE PLAN. Lapeer Community Schools maintains the Lapeer Community Schools Employee Benefit Wrap Plan and the Lapeer Community Schools Flexible Benefit Plan. Lapeer Community Schools wishes to document the Employee Benefit Wrap Plan, and to merge the Lapeer Community Schools Employee Benefit Wrap Plan and the Lapeer Community Schools Flexible Benefit Plan into a single plan effective January 1, 2018. The merged plan will be set forth in this document and future amendments and will be known as the Lapeer Community Schools Employee Benefit Wrap Plan (the "Plan").

The Plan is maintained for the exclusive benefit of Employees of Lapeer Community Schools.

The Plan is intended to satisfy the requirements of the Internal Revenue Code of 1986, as amended ("Code"), and the Patient Protection and Affordable Care Act of 2006 ("PPACA"). The Plan provides Eligible Employees with a choice between cash and qualified benefits (as defined in Code Section 125(f)), and is intended to satisfy the requirements of Code Section 125.

The health care flexible spending account is intended to qualify as a self-insured medical reimbursement account under Code Section 105, and the dependent care flexible spending account is intended to qualify as a dependent care assistance program under Code Section 129. Although included in this document, the dependent care flexible spending account is a separate plan for purposes of Code Section 129.

The Plan is sponsored by a governmental employer and is not subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

1.2 EFFECTIVE DATE. The effective date of the merged plan is January 1, 2018.

1.3 PLAN SPONSOR INFORMATION. The Plan Sponsor is Lapeer Community Schools. Questions may be addressed to the Lapeer Community Schools, Business and Operations Department, Administration and Services Center, 250 Second Street, Lapeer, MI 48446.

1.4 INCORPORATION. The Plan provides a variety of Benefits, which are described in the policies, program booklets, and other documents for each Benefit. In addition, certain Benefits offered under the Plan are offered pursuant to an Agreement. These documents are incorporated into and made a part of this Plan and are called the "incorporated documents" in this Plan. Subject to collective bargaining, the incorporated documents may be amended at any time in accordance with Article VIII of this Plan.

ARTICLE II – DEFINITIONS AND CONSTRUCTION

2.1 DEFINITIONS. The following words or phrases, when used in this Plan, have the following meanings:

(a) Administrator or Plan Administrator: The person or entity appointed by the Plan Sponsor with authority and responsibility to manage and direct the operation of the Plan. If no such person or entity is appointed, the Plan Administrator will be the Employer.

(b) Agreement: The current Agreement between the Board of Education of Lapeer Community Schools and (1) the Lapeer Education Association; (2) Lapeer Community Schools Lapeer Educational Support Personnel (L.E.S.P.); (3) Lapeer School District Administrators' Association; (4) Lapeer Community Schools Custodial Employees Unit of Local 1421, Council 25 American Federation of State, County and Municipal Employees; (5) Lapeer Transportation Association; and (6) Service Employees International Union Local 517M (Food Service Personnel); or (7) Service Employees International Union Local 517M (Mechanics), all as amended and restated from time to time. The term Agreement shall include any successor agreement. Agreement shall also mean an Administrator Contract or Non-Union Employees Contract executed on behalf of the Lapeer Community Schools.

(c) ASA: The Plan's Administrative Services Agreement entered into between the Employer and the Third Party Administrator identified in Appendix A, or any successor Plan administrative service provider, as amended from time to time.

(d) Benefit: A Benefit provided to any Participant under the Plan.

(e) Benefit Election/Compensation Reduction Agreement: An agreement between the Participant and the Employer under which an eligible Participant elects Benefits and under which an eligible Participant may elect to make deferrals to a health savings account in compliance with Code Section 223. If the Participant elects Benefits, he or she shall agree to reduce his or her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan. The Benefit Election/Compensation Reduction Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

(f) Benefits Booklet: The current applicable Plan design, schedule of Benefits and/or Benefits addendum prepared by the applicable Third Party Administrator.

(g) Children or Child: An Employee's biological child, adopted child, child placed for adoption, stepchild, foster children, child for whom the Employee has been granted legal guardianship, or a child for whom the Employee must provide coverage pursuant to a court order, or as otherwise set forth in the applicable ASA, Benefits Booklet or Policy.

(h) COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(i) Code: The Internal Revenue Code of 1986, as amended from time to time.

(j) Compensation: The total cash remuneration received by a Participant from the Employer during a Plan Year prior to any reductions pursuant to a Benefit Election/Compensation Reduction Agreement authorized under this Plan. Compensation shall include overtime pay and bonuses.

(k) Dependent Care Center: Any facility which (i) provides care for more than 6 individuals (other than individuals who reside at the facility), and (ii) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and complies with all applicable laws and regulations of the state and city, town or village in which it is located.

(l) Dependent Care Expenses: Expenses for Dependent Care Services and related household services that (i) are incurred for the care of an Eligible Dependent of the Participant, (ii) are paid or payable to a Dependent Care Service Provider, and (iii) are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Eligible Dependents with respect to the Participant. Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

(m) Dependent Care Service Provider: A person who provides care or other services upon which Dependent Care Expenses can be expended, but shall not include: (i) a Dependent Care Center unless it complies with all applicable laws and regulations of the State or local government; (ii) an individual with respect to whom the Participant or his or her spouse is entitled to a dependent exemption under Section 151(e) of the Code; or (iii) a Child or stepchild of the Participant who is under the age of 19 at the end of the year in which the care or services are provided.

(n) Dependent Care Services: Dependent care services which may be performed either inside or outside the Participant's home. However, if the Dependent Care Services are performed outside the Participant's home, the Dependent Care Services must be provided to:

(i) A Dependent who is under the age of 13; or

(ii) A spouse or Dependent who has a Total Disability and regularly spends at least eight hours per day in the Participant's home.

(o) Earned Income: (i) With respect to a Participant, all wages, salaries, tips, and other Employee compensation derived from the Employer, and (ii) with respect to a

Participant's spouse, all wages, salaries, tips, and other employee compensation, plus the amount of net earnings from self-employment; provided, however, in the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have Earned Income of not less than $250 per month if the Participant has one Dependent and $500 per month if the Participant has two or more Dependents.

(p) Effective Date: January 1, 2018.

(q) Eligible Dependent.

(iii) For purposes of *insured Benefits*, any Dependent of an Employee, as that term is defined in the applicable Policy.

(iv) For purposes of *self-insured Benefits*, unless otherwise provided by the applicable ASA or applicable Benefits Booklet, an Eligible Employee's (A) legal spouse (unless separated by court decree); (B) Children until the end of the calendar year in which they attain age 26; and (C) disabled Children who are totally and permanently disabled prior to age 26, who are unmarried and unable to earn a living as a result of his or her disability, and who depend upon the Eligible Employee for support and maintenance.

(v) For purposes of the *pre-tax premium Benefit*, any Eligible Dependent of an Employee who qualifies for insured or self-insured Benefits will qualify for pre-tax premium payments of such Benefits, as permitted under law.

(vi) For purposes of the *health care flexible spending account*, (A) the Participant's legal spouse (unless separated by court decree), and (B) the Participant's Children until the end of the calendar year of their 26th birthday.

(vii) For purposes of the *dependent care flexible spending account*, (A) any individual who is a Child of the Participant under the age of 13, and with respect to whom the Participant is entitled to a dependent exemption under Section 151(c) of the Code, (B) the Participant's legal spouse who is mentally or physically incapable of self-care and who lives with the Participant for more than one-half of the year, or (C) another dependent relative of the Participant (such as a Child age 13 or older or any elderly parent) who is physically or mentally incapable of self-care and who lives with the Participant for more than one-half of the year.

(r) Eligible Employee: An Employee who meets the eligibility requirements of Section 3.1.

(s) Employee: Any common law employee of the Employer who is eligible to participate in this Plan pursuant to an Agreement, but excluding the following: those individuals designated by the Employer as independent contractors as evidenced by the issuance of a Form 1099, regardless of any later recharacterization; non-resident aliens (within the meaning of Code Section 7701(b)(1)(B)), who receive no earned income (within the meaning of Code Section

911(d)(2)), from the Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)), or receives earned income but it is all exempt from income tax in the United States; those individuals designated by the Employer as "contractor employees", defined as an individual employed by a third party providing goods and services, including employee services, to the Employer and whom the Employer does not regard as its common law employees as evidenced by not maintaining such individual on its payroll (regardless of any later determination to the contrary by any governmental agency or court); and any leased employee within the meaning of Code Section 414(n).

(t) Employer: Lapeer Community Schools.

(u) Health Coverage: Any medical, prescription drug, dental, vision, employee assistance plan (EAP) or wellness Benefits, and the health flexible spending account, as applicable, offered by the Employer through this Plan.

(v) HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations.

(w) Insurer: The insurance company or companies designated by the Plan Sponsor from time to time.

(x) Medicaid: A state plan for medical assistance approved under title XIX, Section 1912 of the Social Security Act.

(y) Medical Coverage: Any medical Benefits and prescription drug Benefits, as applicable, offered by the Employer through this Plan (but not including dental, vision, EAP or wellness Benefits or the health flexible spending account).

(z) Participant: An Employee who meets the participation requirements of Article III and in the case of elective Benefits, elects to participate.

(aa) Plan: Lapeer Community Schools Employee Benefit Wrap Plan, as set forth in this document and any later amendments.

(bb) Plan Sponsor: Lapeer Community Schools.

(cc) Plan Year: The short year beginning July 1, 2017 through December 31, 2017, and thereafter the twelve (12) consecutive month period ending on December 31 of every year.

(dd) Policy: The insurance Policy or policies, all as amended, and as from time to time in effect that govern the insured Benefits provided under the Plan.

(ee) Qualifying Medical Expenses: Expenses incurred by a Participant, spouse or Dependent for medical services and supplies as defined in Code Section 213, but only to the extent that the Participant, spouse or dependent incurring the expenses is not reimbursed for the expenses through insurance or any other source. Effective January 1, 2011, a reimbursement

incurred for a medicine or drug shall only be considered a reimbursement for a Qualifying Medical Expense if the drug or medicine is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. The cost of health coverage under any group health plan or individual health policy shall not constitute a Qualifying Medical Expense for purposes of the health care flexible spending account.

(ff) Third Party Administrator: An entity, appointed by the Plan Sponsor, to assist with the administration of the Plan.

2.2 CONSTRUCTION. Plural pronouns are used throughout the Plan for purposes of simplicity and will be interpreted to include the singular. Where necessary or appropriate to the context, the masculine will include the feminine, the singular will include the plural and the plural will include the singular.

ARTICLE III – ELIGIBILITY, PARTICIPATION AND ENROLLMENT

3.1 ELIGIBILITY AND PARTICIPATION.

(a) General Eligibility. Every Employee of the Employer is eligible to participate in the Plan on the date the Employee becomes eligible pursuant to the Agreement.

The Employer has adopted the look back measurement method for purposes of determining full-time status pursuant to the PPACA.

No Employee shall become a Participant unless the Employee complies with the provisions of the Plan and executes, completes and files forms required by the Administrator in a timely manner.

(b) Insured Benefits. An Employee's eligibility for Insured Benefits also will be subject to the eligibility requirements of the applicable Policy.

(c) Pre-tax Premium Benefits. An Eligible Employee will become a Participant in the pre-tax premium payment Benefits on the date he or she is eligible to participate in one or more of the insured or self-insured Benefits offered under the Plan, and, in accordance with Section 3.2 of the Plan, elects to participate in one or more of the Benefits. Coverage in the pre-tax premium Benefit is automatic unless an Employee elects not to participate in the pre-tax Benefit.

(d) Eligible Dependents. Each Eligible Dependent of an Eligible Employee will be eligible to participate in the Benefits offered under the Plan on the date the Eligible Employee becomes eligible to participate in such Plan Benefits.

(g) Dual Coverage. Subject to the applicable Agreement, special rules apply in the event that more than one family member is an Employee of the Employer and eligible for Benefits.

(i) Life, AD&D and Disability Insurance.

(A) Each eligible family member will be eligible for coverage separately under the life, AD&D and disability insurance programs offered by the Employer.

(B) An Employee and the Employee's spouse may not elect optional spouse life insurance for each other.

(C) Either the Employee or the spouse, but not both, may elect optional life insurance for eligible children.

(ii) Health Benefits.

(A) Each eligible Employee may elect single coverage, or one Employee may be the Participant and the other family members may be covered as dependents.

(B) A person may not be both a Participant and a dependent, or a dependent of more than one Participant, at the same time.

(iii) Flexible Spending Accounts.

(A) Each eligible Employee may enroll in the health flexible spending account and contribute the maximum annual amount allowed for an individual.

(B) Each eligible Employee may enroll in the dependent care flexible spending account, but the combined contributions for spouses may not exceed the maximum annual amount allowed for an individual.

(h) Verification. As part of the Employer's dependent eligibility verification process, an Employee may be required to provide documentation for each covered dependent. Examples of valid documentation may include a marriage certificate for a spouse or a child's birth certificate for a child. If an Employee fails to provide documentation, Benefits for dependents will be terminated.

3.2 ENROLLMENT.

(a) New Employees. Newly Eligible Employees must enroll in the Plan within 30 days of first becoming eligible to participate in the Plan. In order to enroll in the Plan, an Employee must complete a Benefit Election/Compensation Reduction Agreement. An Employee's contributions will be made on a pre-tax basis in the amount necessary to pay for the Benefits elected under the Plan, unless the Employee elects to contribute with after-tax dollars. The enrollment procedures are set forth in the enrollment materials. An Employee may also be required to complete and file additional enrollment forms provided by the Insurers or Third Party Administrators for some of the Benefits.

If an Eligible Employee fails to enroll when first eligible, the Employee will not participate in any elective Benefits and will not be permitted to enroll in the Plan until the following annual open enrollment period, unless an event occurs that would permit a mid-year election change as described in Section 3.3 or has a special enrollment event as described in Section 3.2(c).

(b) Open Enrollment. At such time as may be determined from time to time by the Employer in its sole discretion, there will be an annual open enrollment period during which an Eligible Employee will have the opportunity to change his or her current elections or coverage under the Plan. Unless a Participant affirmatively and timely elects otherwise during the annual open enrollment period, the elections a Participant made during the prior open enrollment period (or, if applicable, the special enrollment period) will be rolled-over to the following Plan Year, other than the flexible spending accounts. If a Participant fails to elect coverage for the flexible spending accounts during the annual open enrollment period, the Participant's election for the flexible spending accounts will default to zero for the following Plan Year.

(c) Special Enrollment.

(i) Except as otherwise expressly provided for in the applicable Policy or ASA, an Eligible Employee may enroll for Health Coverage under the Plan during a special enrollment period if the Eligible Employee previously declined Health Coverage under the Plan for himself or herself or for an Eligible Dependent and if each of the following conditions is met:

(A) The Eligible Employee or Eligible Dependent(s) was covered under a group health plan or had health insurance coverage at the time the coverage under the Plan was previously offered to the Employee or Eligible Dependent(s);

(B) The Eligible Employee's or any of his or her Eligible Dependent's coverage was under a COBRA continuation provision and the coverage under such provision was exhausted; or the coverage was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility as a result of legal separation, divorce, death, employee's termination of employment, or employee's reduction in the number of hours of employment, (but excluding, for example, loss due to failure to timely pay premiums or due to termination for gross misconduct), employer contributions toward such coverage were terminated, or a benefit option under such coverage was terminated;

(C) The Eligible Employee requests special enrollment for himself or herself and/or for his or her Eligible Dependent(s) within 30 days after such COBRA continuation coverage is exhausted; within 30 days after coverage under the other insurance or coverage is terminated, if the termination is due to loss of eligibility; or within 30 days after employer contributions to the other coverage ceased.

Coverage will be effective as soon as practical following the date the enrollment form is received by the Plan Administrator.

(ii) Except as otherwise limited by the applicable Policy or ASA, an Eligible Employee who is enrolled for Health Coverage under the Plan or an un-enrolled Eligible Employee who is eligible to enroll for Health Coverage under the Plan but who has not so enrolled, is entitled to a special enrollment period if a person becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or placement for adoption. An Eligible Employee who is not enrolled for Health Coverage under the Plan at the time a person becomes his or her Eligible Dependent may enroll himself or herself alone, or himself or herself and his or her Eligible Dependent(s) during this special enrollment period. An Eligible Employee who requests a special enrollment for an Eligible Dependent due to birth, adoption of a Child, or placement for adoption, may enroll a spouse and/or other Eligible Dependents during this special enrollment period, if otherwise eligible.

An Eligible Employee must request special enrollment for himself or herself, and/or for his or her Eligible Dependent(s), as applicable, for Health Coverage under the Plan, under this section, within 30 days of the date of the marriage, or within 30 days of the date of birth, adoption or placement for adoption. Notwithstanding anything to the contrary herein, if an Eligible Employee timely requests special enrollment for himself or herself or for an Eligible Dependent(s) during the first 30 days, the enrollment date will become effective as of the date of birth, adoption or placement for adoption, or, in the event of marriage, as soon as practical following the date in which the enrollment form is received by the Plan Administrator.

(iii) Except as otherwise limited by the applicable Policy or ASA, an Eligible Employee who is an un-enrolled Eligible Employee who is eligible to enroll for Health Coverage under the Plan but who has not so enrolled, is entitled to a special enrollment period if a person is covered under a Medicaid Plan or a State Children Health Insurance plan and coverage is terminated as a result of loss of eligibility for such coverage. An Eligible Employee must request special enrollment within 60 days of the date of termination of the other coverage. An Eligible Employee who is an un-enrolled Eligible Employee who becomes eligible for premium assistance with respect to coverage under this Plan under a Medicaid Plan or a State Children Health Insurance plan, is entitled to a special enrollment period. An Eligible Employee must request special enrollment within 60 days of the date of becoming eligible for assistance.

3.3 CHANGES IN ELECTIONS. Elections with respect to pre-tax contributions made under the Plan will be irrevocable by the Participant during the Plan Year, subject to the following and subject to acceptance of the change in election by any Insurer or Third Party Administrator. Any new election must be made within 30 days of the event and must be permitted by the Policy, ASA or Benefits Booklet. The change in election will be effective at the time prescribed by the Plan Administrator.

(a) Change in Status (applies to pre-tax premium benefits, health care flexible spending account and dependent care flexible spending account). A Participant may revoke a benefit election during a Plan Year and make a new election with respect to the remainder of the Plan Year due to a change in status event, provided that the event affects eligibility for coverage under this Plan or another employer's plan. A change in status event includes:

(i) A change in marital status due to marriage, divorce, legal separation, annulment, or death of your spouse;

(ii) A change in the number of dependents due to the death or the birth, adoption, or placement for adoption of a dependent child;

(iii) A change in employment status or the employment status of a dependent that affects eligibility under the Plan or other health and welfare benefit plan, due to termination or commencement of employment, commencement or return from an unpaid leave of absence, change in work-site, switching from full-time to part-time, salaried to hourly paid or non-union to union, reduction in hours, etc.;

(iv) A change causing a dependent to satisfy or to cease satisfying coverage requirements due to age, student status, marriage or similar circumstance; and

(v) A change in the place of residence or worksite that affects eligibility under this Plan.

(b) Court Order (applies to health coverage and health care flexible spending account). If the Plan receives an order requiring a Participant to provide health coverage for his or her Child, the Participant may change his or her election to provide health coverage to the child; if the order requires that another individual cover the child and such coverage is actually provided, a Participant may change his or her election to revoke coverage for the child.

(c) Medicaid or Medicare Coverage (applies to medical coverage). If a Participant or dependent becomes covered under Medicare or Medicaid, or loses eligibility for Medicare or Medicaid, or if Medicare becomes primary for a Participant or dependent, the Plan may permit a Participant to cancel or reduce medical coverage prospectively, to commence or increase coverage prospectively, or to change to a medical plan that coordinates with Medicare (if available).

(d) Special Enrollment Event (applies to medical coverage). A Participant is permitted to make a change in election that corresponds with a special enrollment event described below.

(e) Family and Medical Leave Act (applies to pre-tax premium benefits, health care flexible spending account). If a Participant takes an unpaid leave under the Family and Medical Leave Act and is required to make contributions during the leave, the Participant may revoke existing elections at the beginning of the leave for the duration of the leave in accordance with the Family and Medical Leave Act.

(f) Other Coverage (applies to pre-tax premium benefits). If the plan of a Participant's dependent's employer permits participants to make an election change for a period of coverage that is different from the period of coverage under this Plan, this Plan may permit a

Participant to make a prospective election change that is on account of or corresponds with a change made under the plan of the dependent's employer.

(g) Cost Changes (applies to pre-tax premium benefits). In the event the cost of a benefit increases or decreases during a Plan Year, the Plan automatically may increase or decrease, as applicable, on a reasonable and consistent basis, all affected participants' pre-tax contributions for such benefit. If the cost of a benefit increases significantly, a Participant may either (a) revoke an election and elect similar coverage on a prospective basis under another benefit package option providing similar coverage, or (b) drop coverage if no other benefit package providing similar coverage is available.

(h) Coverage Changes (applies to pre-tax premium benefits). In the event that coverage is significantly curtailed or ceases during a Plan Year, a Participant may revoke an election and elect similar coverage on a prospective basis under another benefit package option providing similar coverage. If there is no option providing similar coverage, a Participant may be permitted to drop coverage on a prospective basis. For health coverage, coverage is considered 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 generally.

(i) New Benefit Option (applies to pre-tax premium benefits). If the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option), the Plan may permit a Participant to elect the newly-added option (or elect another option if an option has been eliminated) prospectively.

(j) Coverage Purchased through Marketplace (applies to medical coverage). If a Participant is eligible for a special enrollment period to enroll in a qualified health plan through a Marketplace or wishes to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period, he/she may revoke an election for medical benefits under this Plan if the revocation corresponds to the Participant's intended enrollment of the Participant and his or her dependents in a qualified health plan for new coverage that is effective beginning no later than the day immediately following the day that coverage is revoked under this Plan.

(k) Medical Coverage During a Stability Period. An employee who has been determined to be a full-time employee for purposes of Medical Coverage during the applicable look back measurement period, is participating in the Medical Coverage during the associated stability period and whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week during the stability period, may revoke Medical Coverage for the employee and his or her dependents to enroll in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the coverage ends under this Plan.

(l) Special Rules for Dependent Care Flexible Spending Accounts. A Participant may change his or her participation or contribution amount if the fee for dependent

care increases or decreases (but only if the fee change is imposed by a dependent care provider who is not related to the Participant), if the Participant makes a provider change, if a Participant's eligible dependent enters or leaves school and it changes the need for dependent care, or if there is an employment status change of the Participant or his or her spouse that changes the need for dependent care.

(m) Administrative Determinations (applies to pre-tax premium benefit). A Participant may revoke a benefit election for the balance of the Plan Year and make a new election if the Plan Administrator determines that such other events will permit the change or revocation of an election during a Plan Year under regulations and rulings of the Internal Revenue Service issued with respect to Code Section 125. Any new election under this Subsection will be effective at such time as the Plan Administrator will prescribe, but not earlier than the first pay period beginning after an applicable benefits election form is submitted to the Plan Administrator.

(n) Premium Changes. The Plan Administrator may automatically increase or decrease the amount of a Participant's salary reduction during the Plan Year in response to an appropriate change in the premiums charged by an insurer for any of the insured benefits elected hereunder, commensurate with the time that the insurer has made such premium change effective; or the Plan Administrator may automatically increase or decrease the amount of a Participant's salary reduction during the Plan Year in response to a change by the Employer in the cost-sharing contributions to one or more of the benefits which are self-funded plans. Unless the Participant is entitled to a change of election under this section, the adjusted salary reduction amount will be in effect until the end of the Plan Year coverage period.

3.4 REDUCTION OF CERTAIN ELECTIONS TO PREVENT DISCRIMINATION. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any non-discrimination requirement imposed by the Code or any limitations on Benefits provided to "key employees" (as defined in Code Section 416(i)(1)), the Plan Administrator will take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated employees and/or "key employees" with or without consent of such Employees.

3.5 TERMINATION OF PARTICIPATION. Except as otherwise provided in the applicable Policy or ASA, and subject to any rights under COBRA or pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), or as otherwise described below, coverage under this Plan with respect to a Participant and his or her covered dependent(s) will automatically terminate as of the dates described below.

(a) Coverage under the Plan with respect to a Participant will automatically terminate as of:

(i) The date the Plan is discontinued or any Benefit offered under the Plan is discontinued;

(ii) The date a Policy ends;

(iii) The date the Participant voluntarily stops his or her coverage under the Plan;

(iv) The last day of the month in which the Participant is no longer eligible for coverage under the Plan due to termination of employment or leave of absence, except that such date shall be later if otherwise required by the Agreement or federal law;

(v) The date the Participant is no longer eligible for any reason other than termination of employment or leave of absence;

(vi) The first day of the payroll period in which the Participant fails to make any required contributions;

(vii) The date the Participant becomes covered under another group health plan sponsored by the Employer; or

(viii) The date the Participant dies.

(b) Coverage under the Plan with respect to a covered Eligible Dependent will automatically terminate as of:

(i) The date the Participant is no longer eligible for Dependent coverage under the Plan;

(ii) The first day of the payroll period in which the Participant does not make the required contribution towards the cost of Dependent coverage;

(iii) The date the Participant's coverage under the Plan ends due to any of the reasons listed is Subsection (a), above;

(iv) The date the covered dependent is no longer eligible for coverage (in this case, coverage ends on the day the covered dependent no longer meets the Plan's definition of "Eligible Dependent");

(v) The date the covered dependent becomes eligible for comparable benefits under any other plan sponsored by the Employer.

3.6 FRAUD AND MISREPRESENTATION MEDICAL COVERAGE. If a Participant commits a fraudulent act or intentionally misrepresents a material fact related to the Plan (including submission of a fraudulent act or misrepresentation of citizenship or immigration status in obtaining or maintaining employment), Medical Coverage may be terminated retroactive to the

date of the fraudulent act or misrepresentation. The Employer will provide at least 30 days advance written notice prior the retroactive termination. This paragraph does not apply if a Participant fails to timely pay any required premium or contribution towards the cost of coverage or fails to timely notify the Employer of a dependent's loss of eligibility; in these events, coverage may be terminated retroactively without advance notice.

3.7 ABSENCE DUE TO FMLA. If a Participant is absent from work due to an approved *paid* absence which is covered under the Family and Medical Leave Act of 1993 ("FMLA"), the Participant will continue to participate in the Plan's health coverage and will continue to pay the Participant cost of coverage by payroll deduction.

If a Participant is absent from work due to an approved *unpaid* absence which is covered under the FMLA, the Participant can elect to continue health coverage or to revoke health coverage during the leave. If the Participant elects to continue coverage, the Participant's share of the cost of continued coverage under the Plan will be paid as follows:

(a) On an after-tax basis at the same time as it would be made if by payroll deduction;

(b) On a pre-payment basis from any taxable compensation payable to the Participant; provided, however, that no pre-payment may be made in a manner that will permit a pre-tax payment to be made in one taxable year of the Participant that will be applied to a subsequent taxable year of the Participant; or

(c) In accordance with an alternate payment arrangement entered into between the Participant and the Employer.

If such a Participant's required payment is more than 30 days late, coverage under the Plan during an FMLA leave will cease retroactively to the date the required payment was due, provided the Employer has given the Participant at least 15 days advance written notice that if payment is not received by the 30th day, coverage will be dropped on that date retroactive to the date the required payment is due. If the notice is not timely sent, coverage will cease 15 days after the required notice is given or the date specified in the notice, if later, unless the payment has been received by that date. As an alternative, the Employer may elect to make contributions on the Participant's behalf during the leave. In this event, the Employer may collect any contributions it made on the Participant's behalf when he or she returns to work.

If coverage lapses during the FMLA leave, the Participant is entitled to be reinstated in coverage upon return from the leave.

A Participant who returns from an FMLA leave within the same Plan Year the leave commenced will continue in the Plan with no change in elections, unless he or she has a change in election event as described in Section 3.3 and is entitled to make a new election. If there is no change in election, the applicable Benefit Election/Compensation Reduction Agreement will

continue at the rate in effect on the day before the leave of absence commenced. A Participant whose FMLA spans two (2) Plan Years will be afforded the same opportunity as active Employees to make changes during the applicable open enrollment period and any change in elections will take effect at the start of the Plan Year commencing during the FMLA leave and will remain in effect for the duration of the Plan Year in accordance with Plan terms.

Special rules apply to the health care flexible spending account. If a Participant lets coverage in the health care flexible spending account lapse during an FMLA leave, coverage at the level prior to the leave will be reinstated for the remaining part of the Plan Year when the Participant returns. However, the expenses incurred during the lapse will not be reimbursable. Alternatively, a Participant may elect to resume coverage at the level in effect before the FMLA leave and make up the unpaid contributions.

3.8 CONTINUATION OF HEALTH COVERAGE UNDER "COBRA". The Plan will provide Participants and covered Dependents with continuation coverage for Health Coverage on a self-pay basis, to the extent required by the COBRA.

3.9 USERRA. Notwithstanding anything to the contrary herein, any person absent from employment by reason of service in the uniformed services will be provided Benefits under the Plan in compliance with USERRA.

3.10 ABSENCE DUE TO NON-STATUTORY LEAVE OF ABSENCE. Subject to the terms of the applicable Policy, ASA or Benefit Booklet, if a Participant is absent from work on an unpaid non-statutory leave of absence, coverage under the Plan will continue in accordance with the terms of the Agreement covering the Employee's employment.

ARTICLE IV – BENEFITS

4.1 INSURED BENEFITS. The Employer has contracted with Insurers to insure certain Benefits as set forth in the Policies. Each Policy is incorporated by reference as a part of the Plan, and coverage will be provided thereunder if properly elected.

Except to the extent specifically provided in the Plan to the contrary, the terms and provisions of the Policies, including their benefits provisions, claims information and coverage provisions, will determine the Benefit to which Participants will be entitled if coverage has been properly elected thereunder. A Participant will make application and submit such evidence of insurability or coverage as may be required by the Insurer, as applicable.

4.2 LIMIT ON LIABILITY TO MAINTAIN POLICIES. The Employer shall not be liable for any loss or obligation with respect to any insurance coverage except as expressly provided by this Plan. Such limitations shall include, but not be limited to, losses or obligations which pertain to the following:

(a) Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;

(b) To the extent premium notices are received by the Employer, the Employer's liability shall be limited to the amount of such premium; and

(c) Upon termination of employment, and/or failure of participation requirements by a Participant, the Employer shall have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan. The Employer shall not be liable for or responsible to see to the payment of any premium after termination of employment except as provided under applicable federal law.

4.3 SELF-INSURED BENEFITS. The Employer self-insures certain Benefits and has contracted with Third Party Administrators to administer the benefits. Each ASA and Benefits Booklet is incorporated by reference as a part of the Plan, and coverage will be provided thereunder if properly elected.

Except to the extent specifically provided in the Plan to the contrary, the terms and provisions of the ASA and Benefits Booklet, including eligibility provisions, Benefits provisions, and claims provisions will determine the Benefits to which Participants will be entitled under the Plan if coverage has been properly elected. A Participant will make application and submit such evidence of eligibility or coverage as may be required by the Employer or Third Party Administrator.

4.4 PRE-TAX PREMIUM PAYMENT. A Participant's Compensation for each pay period shall be reduced by the amount specified in his or her Benefit Election/Compensation Reduction Agreement. An Eligible Employee will automatically be enrolled in the pre-tax premium payment component of the Plan if the Participant elects benefits for which an Employee contribution is required. However, a Participant may elect to waive the pre-tax option for premiums and pay premiums on an after-tax basis outside of the Plan. Unless an exception applies (as described in Sections 3.2(c) and 3.3), such election is irrevocable for the duration of the Plan Year to which it relates.

4.5 HEALTH CARE FLEXIBLE SPENDING ACCOUNT.

(a) Establishment of Accounts. The Employer will establish and maintain on its books a Health Care Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Medical Expenses for the Plan Year.

(b) Crediting of Accounts. Subject to the limits of Section 4.5(c), there shall be credited to a Participant's Health Care Flexible Spending Account for each Plan Year as of each date Compensation is paid to the Participant in such Plan Year, amounts equal to the reduction to be made in such Compensation in accordance with the Participant's Benefit Election/Compensation Reduction Agreement.

All amounts credited to each such Health Care Flexible Spending Account shall be the property of the Employer until paid out pursuant to Article VII.

(c) Maximum Reimbursements. The maximum amount which the Participant may receive with regard to any Plan Year in the form of payments or reimbursements for Qualifying Medical Expenses under the Health Care Flexible Spending Account Plan shall be the amount the Participant elected as a contribution amount, in no event to exceed the amount identified in the Plan Source Enrollment Packet. For Plan Years beginning on or after January 1, 2015, the maximum amount may not exceed $2,550 per year (or such other amount established by law).

If the Participant becomes eligible during the Plan Year, the Participant may still contribute the maximum amount, as identified in the Plan Source Enrollment Packet.

(d) Debiting of Accounts. A Participant's Health Care Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any payment under Article VII to or for the benefit of the Participant for Qualifying Medical Expenses incurred during such Plan Year.

For purposes of this section, a Qualifying Medical Expense shall be incurred on the date the service or supply is provided.

(e) Forfeiture of Accounts. Except as provided in Section 4.5(f), the amount credited to a Participant's Health Care Flexible Spending Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Expenses incurred during such Plan Year, and only if the Participant applies for reimbursement no later than 45 days following the end of the grace period described in Section 4.5(f), or 90 days following the date of the Employee's termination from employment if earlier. Except as provided in Section 4.5(f), if any balance remains in the Participant's Health Care Flexible Spending Account for any Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Qualifying Medical Expenses incurred during a subsequent Plan Year, and shall not be available

to the Participant in any other form or manner, but shall remain the property of the Employer, and the Participant shall forfeit all rights with respect to such balances.

(f) Grace Period. Notwithstanding any other provision of this Plan, any amounts which remain in a Participant's Health Care Flexible Spending Account at the end of a Plan Year as they have not been used to reimburse Qualifying Medical Expenses may be used to reimburse Qualifying Medical Expenses which are incurred during the first two months and 15 days of the following Plan Year. The Plan will first apply the unused contributions from the preceding Plan Year to reimburse grace period expenses, and then, when the contributions from the prior Plan Year are exhausted, grace period expenses will be paid from current year contributions. Any amounts remaining in a Participant's Health Care Flexible Spending Account at the conclusion of the grace period which are attributable to the Plan Year immediately preceding that grace period shall be forfeited as provided in Section 4.5(e) of the Plan.

(g) Limited Purpose Health Flexible Spending Account. If a Participant or his or her spouse maintain a health savings account, or if a Participant elects to participate in a high deductible health plan, then the Participant only may elect a limited purpose health care flexible spending account. Under a limited purpose health care flexible spending account, the expenses eligible for reimbursement will be limited to services or treatments for dental care, services or treatments for vision care and qualified medical expenses that are incurred after the Participant satisfies the deducible under the high deductible health plan.

If a Participant has a balance in his or her health care flexible spending account at the end of a Plan Year, and elects to participate in a high deductible health plan option for the following Plan Year, the Participant automatically will be treated as enrolled in a limited purpose health flexible spending account for the following Plan Year.

4.6 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT.

(a) Establishment of Accounts. The Employer will establish and maintain on its books a Dependent Care Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive dependent care benefits for the Plan Year.

(b) Crediting of Accounts. Subject to the limits of Section 4.6(c), there shall be credited to a Participant's Dependent Care Flexible Spending Account for each Plan Year an amount equal to the reduction to be made in the Participant's Compensation in accordance with the Participant's Benefit Election/Compensation Reduction Agreement.

All amounts credited to each such Dependent Care Flexible Spending Account shall be the property of the Employer until paid out pursuant to Article VII.

(c) Maximum Dependent Care Flexible Spending Account. The maximum amount which the Participant may elect to contribute with respect to any Plan Year under this Dependent Care Flexible Spending Account Plan shall be:

(i) if the Participant is not married at the close of the Plan Year, the lesser of $5,000 or 100% of the Participant's Earned Income for the Plan Year (excluding any reductions in Earned Income related to dependent care assistance); or

(ii) if the Participant is married at the close of the Plan Year, the lesser of (1) $5,000 ($2,500 if the Participant files a separate income tax return) or (2) 100% of the Participant's Earned Income for the Plan Year (excluding any reductions in Earned Income related to dependent care assistance), or (3) the actual or deemed Earned Income of the Participant's spouse for the Plan Year.

If the Participant becomes eligible during the Plan Year, the Participant may still elect to contribute the maximum contribution amount.

The average benefits provided to employees who are not highly compensated employees (within the meaning of Code Section 414(q)) shall at all times equal at least 55% of the average benefits provided to highly compensated employees under this Dependent Care Flexible Spending Account Plan. For purposes of this paragraph, in the case of any benefits provided through an election, there may be disregarded any employees whose compensation (within the meaning of Code Section 414(q)(7)) is less than $25,000.

If any of the limitations on benefits to key employees or highly compensated employees under the preceding paragraphs would be exceeded but for this paragraph, the Plan Administrator may reduce or cancel the election form of one or more highly-compensated employees, to satisfy these limitations.

(d) Debiting of Accounts. A Participant's Dependent Care Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any payment under Article VII to or for the benefit of the Participant for Dependent Care Expenses incurred during such Plan Year.

(e) Forfeiture of Accounts. The amount credited to a Participant's Dependent Care Flexible Spending Account for any Plan Year shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Plan Year, and only if the Participant applies for reimbursement no later than 45 days following the close of the Plan Year, or 90 days following the date the employee terminates from employment, if earlier. If any balance remains in the Participant's Dependent Care Flexible Spending Account for any Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of the Employer, and the Participant shall forfeit all rights with respect to such balances.

(f) Statement of Expenses. On or before each January 31, the Employer shall provide each Participant with a written statement of the amounts reimbursed under the Dependent Care Assistance Plan for Dependent Care Expenses incurred during the preceding calendar year.

4.7 OPT-OUT BENEFIT. If provided by the applicable Agreement, a Participant may opt-out of certain Benefits offered under the Plan and elect to receive an opt-out Benefit. The amount of the opt-out Benefit will be announced in advance of each Plan Year and will be paid as taxable compensation throughout the Plan Year. Payment of the cash compensation is made with each payroll. For each Employee compensated on a 24 pay cycle basis, the total amount of the opt-out benefit will be divided by 12 and paid in equal installments on the second pay period of each month. No opt-out benefit shall be paid to an Employee who is no longer a Participant. If a Participant opts-out of coverage, the Participant will not be able to elect Benefits until the following open enrollment period, unless the Participant experiences an event that would allow a change in election as described in Section 3.3 or a special enrollment event as described in Section 3.2(c). An opt-out benefit will only be provided on a pro-rata basis where an Employee ceases to be a Participant under the Plan prior to the end of the Plan Year, or the Employee changes his or her election as provided in Section 3.3 prior to completion of the Plan Year.

4.8 PRE-TAX CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNT.

(a) Eligibility. One of the Benefits offered under the Plan is medical coverage through a "high deductible health plan". A Participant in the high deductible health plan that does not have other health coverage that is not a high deductible health plan may contribute to a health savings account ("HSA"). A Participant who is an "eligible individual" as defined in Code Section 223(e)(1), may make pre-tax deferrals from his or her compensation as cash contributions to a Health Savings Account as permitted by Code Section 223. In order to be deemed an "eligible individual" for any month, the Participant must (1) be covered under a high-deductible health plan as defined in Code Section 223 on the first day of that month; (2) not be covered by any other health plan which is not a high-deductible health plan, except as permitted by Code Section 223; (3) must not be enrolled in Medicare; and (4) must not be claimed as a dependent on another person's tax return.

(b) Contributions. A Participant may elect to make contributions to his or her HSA offered through HealthEquity (or any HSA provider designated by the Employer) on a pre-tax basis through this Plan. The Employer may make Employer contributions (other than pre-tax contributions) to a Participant's HSA in its discretion. Any such contribution will be announced in advance.

(c) Contribution Limits. The annual amount that a Participant may contribute to his or her HSA is limited by law, and depends on whether the Participant has elected single or family coverage under the high deductible health plan. An additional catch-up contribution may be made for Participants who are age 55 or older. The maximum annual contribution will be reduced by any Employer contributions made on a Participant's behalf.

(d) Changes to HSA Contribution Elections. A Participant's election to contribute to an HSA through this Plan can be increased, decreased, or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

(d) Status of HSA Account. HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax basis. Terms and conditions of coverage and benefits will be provided by and are set forth in the HSA documents, not this Plan.

ARTICLE V – FUNDING AND CONTRIBUTIONS

5.1 FUNDING. The Plan is funded by contributions made by the Employer and Employees, where applicable, in such amount to be determined by the Employer. Benefits are funded from the general assets of the Employer or, alternatively, through the direct payment of insurance premiums to an Insurer from the general assets of the Employer. There is no trust or other separately maintained fund for accumulation of Plan assets or from which Benefits are paid.

5.2 PARTICIPANT CONTRIBUTIONS. The Employer will establish the cost required of each Participant for each of the Benefits offered under the Plan. The cost will be determined by the Employer from time to time and communicated to Participants in enrollment materials or through any other means reasonably expected to convey the Participant contribution information to the Plan Participant. The Employer may change the contributions required of Participants at any time by notifying the Participants of the change.

5.3 EMPLOYER CONTRIBUTIONS. The Employer will make the Benefit and premium payments and pay the administrative expenses of the Plan to the extent these payments and expenses exceed Participant contributions.

ARTICLE VI – ADMINISTRATION

6.1 PLAN SPONSOR AND PLAN ADMINISTRATOR. The Employer is the Plan Sponsor and Plan Administrator.

6.2 PLAN ADMINISTRATION. The Plan Administrator has the sole and discretionary authority and responsibility to determine the status and rights of Participants, to construe and interpret Plan terms, and to make final and binding determinations as to eligibility and Benefits. The Plan Administrator may allocate and delegate any of these administrative duties among one or more persons or entities, provided that such allocation or delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibilities.

The Plan Administrator (or such person or entity as it may designate) will have such powers and duties as may be necessary to discharge its functions under the Plan, including, but not limited to the following:

(a) Rules: to promulgate uniform rules and regulations whenever in the opinion of the Plan Administrator such rules and regulations are required by the terms of the Plan or would facilitate the effective operation of the Plan;

(b) Appointments: to appoint any fiduciaries, and to fix their compensation, if any, and exercise general supervisory authority over them.

(c) Plan Benefits: to establish eligibility requirements for Employees and Dependents, to determine Employer and Participant contributions to the Plan, to establish Benefits which will be payable to any Participant or other person in accordance with the terms of the Plan and the person to whom such Benefits will be paid, and any charges, deductibles, maximum Benefits, and all other amounts payable under the Plan;

(d) Construction: to interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming Benefits under the Plan, and to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(e) Forms: to require Participants (i) to complete and file with it such forms as the Employer finds necessary or desirable for the administration of the Plan, and (ii) to furnish all pertinent information requested by the Employer;

(f) Procedures: to prescribe procedures to be followed by Participants in electing Benefits and filing claims for Benefits;

(g) Information: to prepare and distribute, in such manner as the Employer determines to be appropriate, information explaining the Plan, and to receive from Participants such information as will be necessary for the proper administration of the Plan;

(h) Insurers: to appoint and remove insurance carriers;

(i) Third Party Administrators: to appoint and remove Third Party Administrators to perform certain responsibilities of the Employer and to enter into or change any ASA or any related agreements with the Third Party Administrator; and

(j) Records: to prepare, receive, review, and keep on file (as it deems convenient and proper) records of Benefit payments and disbursements for expenses.

Notwithstanding the foregoing, the Insurers of Benefits have complete discretion to interpret and administer the provisions of the respective Policies. The Insurers are responsible for (a) determining eligibility for and the amount of any Benefits payable under the respective Policies, and (b) prescribing claims procedures to be followed and the claims forms to be used by Participants.

To the extent delegated pursuant to the ASA or any related agreement with the Third Party Administrator, the Third Party Administrator will have complete discretion to interpret and administer the provisions of the respective Benefits and will be responsible for (a) determining eligibility for and the amount of any Benefits payable under the respective Policies, and (b) prescribing claims procedures to be followed and the claims forms to be used by Participants.

6.3 FIDUCIARIES. The Plan Administrator will be a fiduciary of this Plan. The Plan Administrator has only those duties, responsibilities, and obligations (referred to collectively as

"fiduciary duties") as specifically are given it under the Plan, or as otherwise are imposed by applicable law. The Plan Administrator will be deemed to have properly exercised such fiduciary authority unless it has abused its authority by acting arbitrarily and capriciously. In the exercise of discretionary authority and discretionary responsibility in the administration of the Plan, the Plan Administrator will have the broadest possible discretion in the interpretation of the Plan, which interpretation will be binding on all persons. The Plan Administrator may delegate its fiduciary duties under the Plan to other Plan fiduciaries.

Certain Benefits are provided under Policies issued to the Employer by various Insurers. These Insurers are the fiduciaries with respect to the claims administration of their respective Benefits. The Plan Administrator has delegated to the Insurers discretionary authority to determine eligibility for Benefits and the amount of Benefits due, to construe the terms of the contract and generally to do all other things needed to administer the contracts.

Certain Benefits are provided under an ASA between the Employer and various Third Party Administrators. To the extent delegated in the ASA, these Third Party Administrators are the fiduciaries with respect to the claims administration of their respective Benefits.

6.4 DELEGATION TO OFFICERS OR EMPLOYEES. The Plan Administrator will have the power to delegate its fiduciary duties under the Plan or under any Benefit available under the Plan to officers and/or Employees of the Employer and to other persons, all of whom, if Employees of the Employer, will serve without compensation other than their regular remuneration from the Employer.

6.5 INDEMNIFICATION. The Employer will indemnify any Employees of the Employer who are deemed fiduciaries and hold them harmless, against any and all liabilities, including legal fees and expenses, arising out of any act or omission made or suffered in good faith pursuant to the provisions of the Plan, or arising out of any failure to discharge a fiduciary duty other than a willful failure to discharge an obligation of which the person was aware.

6.6 EMPLOYMENT OF ADVISERS. The Plan Administrator will have the authority to employ such legal, accounting, and financial counsel and advisers as it will deem necessary in connection with the performance of its duties under the Plan, and to act in accordance with the advice of such counsel and advisers.

6.7 FEES AND EXPENSES. All expenses incurred in the operation and administration of the Plan, including the fees and expenses of counsel and other advisors and the compensation, if any, of the fiduciaries, agents, and Administrators will be paid or reimbursed by the Employer unless the Plan Administrator determines that such fees and expenses will be paid in whole or in part by the Plan or by Participants.

6.8 STOP LOSS INSURANCE. The Plan Sponsor may enter into an excess or stop loss insurance contract to protect the general assets of the Employer from catastrophic claims under this Plan. The proceeds of any such Policy will be payable to the Plan Sponsor, not to the Plan, will not be security for payment of Benefits under the Plan and will not be assets of the Plan.

6.9 RESPONSIBILITY FOR HEALTH CARE SERVICES AND DECISIONS. The Plan Administrator and the Employer disclaim any right or responsibility to make health care treatment decisions. These decisions may only be made by health care providers in consultation with the Participant. Health care providers and the Participant may elect to continue treatments despite the Plan Administrator's, Employer's or any Insurer's or Third Party Administrator's denial of coverage for such treatments and the Participant will be responsible for the cost of such treatments. Participants may appeal any of the decisions of the Plan Administrator, Insurer or Third Party Administrator in accordance with the claim and appeal procedure.

6.10 RULES AND DECISIONS. The Plan Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator will be uniformly applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator will be entitled to rely upon its interpretation of the terms of the Plan and information furnished by a Participant or beneficiary and the legal counsel of the Plan Administrator.

6.11 APPOINTMENT OF COMMITTEE. The Plan Sponsor may appoint a committee to assist in the administration of the Plan. The committee will consist of as many persons as may be appointed by the Plan Sponsor and will serve at the pleasure of the Plan Sponsor. All usual and reasonable expenses of the committee will be paid by the Plan Sponsor.

6.12 EXAMINATION OF RECORDS. The Plan Administrator will make available to each Participant such of its records under the Plan as pertain to him or her, for examination at reasonable times during normal business hours.

6.13 FACILITY OF PAYMENT. Payment of Plan Benefits may be made on behalf of any person, including payment to an organization that has made payment to the person, when deemed expedient by the Plan Administrator to satisfy the intent of the Plan, and payment so made will discharge the liability of the Plan.

ARTICLE VII – CLAIM AND APPEAL PROCEDURES

7.1 INSURED BENEFITS. The procedures for submission of a claim with respect to a given insured Benefit under a Policy and obtaining review of a denied claim under the Policy will be governed by the Policy and any other procedures implemented from time to time by the Insurer, as applicable. Notwithstanding anything to the contrary herein, all such procedures will be in accordance with all applicable laws, including the Patient Protection and Affordable Care Act of 2006 ("PPACA").

7.2 SELF-INSURED BENEFITS. The procedures for submission of a claim with respect to a given self-insured Benefit under an ASA or Benefits Booklet and obtaining review of a denied claim under the ASA or Benefits Booklet will be governed by the ASA or Benefits Booklet and any other procedures implemented from time to time by the Third Party Administrator, as applicable. Notwithstanding anything to the contrary herein, all such procedures will be in

accordance with all applicable laws, including the Patient Protection and Affordable Care Act of 2006 ("PPACA").

7.3 HEALTH CARE FLEXIBLE SPENDING ACCOUNT.

(a) Claims for Reimbursement. A Participant may either (i) pay for a Qualifying Medical Expense by using his or her/her Section 125 Plan debit card, if available, or (ii) pay for the Qualifying Medical Expense with cash, check or credit card and submit a claim for reimbursement to the Third Party Administrator, in such form as the Employer, or Third Party Administrator, may prescribe, setting forth:

(i) the amount, date and nature of the expense with respect to which a benefit is requested;

(ii) the name of the person, organization or entity to which the expense was paid;

(iii) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant; and

(iv) the amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense.

Such application shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amounts of such expenses, together with any additional documentation which the Employer may request. Applications may be submitted by the Participant at such times, and in accordance with such rules, established by the Plan Administrator.

The Plan shall comply with IRS Proposed Regulation Section 1.125-6(c), and any subsequent IRS guidance, including final regulations, with respect to the substantiation of Qualified Medical Care Expenses with the use of the Section 125 Plan debit card.

(b) Reimbursement or Payment of Expenses. As soon as practical after the date in which the Participant shall have submitted documentation in accordance with Section 7.3(a), the Employer, through the Third Party Administrator, shall reimburse the Participant for Qualifying Medical Expense incurred by the Participant, and shall debit the appropriate account.

(c) Limitation on Coverage. Reimbursement shall be made only in the event, and to the extent, that reimbursement for amounts expended, or payment, for medical care is not provided for under any insurance policy or under any other plan of the Employer or another employer or under any Federal or State law. If there is such a policy, plan or law in effect providing for such reimbursement or payment in whole or in part, then, to the extent of the coverage under such policy, plan or law, the Employer shall be relieved of any and all liability hereunder.

In the event that a Participant ceases to be a Participant in the Health Care Flexible Spending Account for any reason, the Participant's election shall terminate. The Participant (or his or her estate) shall be entitled to reimbursement only for Qualified Medical Care Expenses incurred within the same Plan Year and prior to the date participation is terminated, and only if the Participant (or his or her estate) applies for such reimbursement in accordance with Section 7.3(a).

(d) Manner and Content of Notification. The Third Party Administrator, upon receipt of a claim, will make a determination and will provide written notification of its determination to the individual within 30 days after receipt of the individual's claim. This period may be extended one time by the Third Party Administrator, provided the Third Party Administrator both (i) determines that such an extension is necessary due to matters beyond the control of the Plan, and (ii) notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(e) Appeal of Adverse Claim Determination. A claimant may appeal an adverse determination. To do so, such claimant must submit, within 180 days following receipt of the Plan Administrator's adverse determination, a written request for review to the Plan Administrator stating the specific basis of such request, and any additional materials the claimant wishes to submit. In connection with the claimant's request for review, the claimant may request in writing copies of all documents, records, and other information upon which the Plan Administrator relied in making its determination. The Plan Administrator will provide all such documents to the claimant free of charge.

The Plan Administrator will take into account all documents, records and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial determination.

(f) Timing and Notification of Claim Determination on Review. Not later than 60 days after receipt by the Third Party Administrator of an application for review, the Third Party Administrator shall render its decision. The decision on the application for review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the claim is based. This period may be extended one time if the Third Party Administrator notifies the Claimant prior to the expiration of the 60-day period.

7.4 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT.

(a) Claims for Reimbursement. A Participant who has elected to receive dependent care benefits for a Plan Year may either (i) pay for a Dependent Care Expense by using his or her/her Section 125 Plan debit card, or (ii) pay for the Dependent Care Expense with cash,

check or credit card and submit a claim for reimbursement to the Third Party Administrator, in such form as the Employer, or Third Party Administrator, may prescribe, setting forth:

(i) the amount, date and nature of the expense with respect to which a benefit is requested;

(ii) the name of the person, organization or entity to which the expense was paid;

(iii) a statement that the expense has not been reimbursed or is not reimbursable under any other plan; and

(iv) such other information as the Employer may from time to time require.

Such application shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing that the expense has been incurred, the amounts of such expenses, together with any additional documentation which the Employer may request. Applications may be submitted by the Participant at such time and in accordance with such rules as established by the Plan Administrator.

The Plan shall comply with IRS Proposed Regulation Section 1.125-6(c), and any subsequent IRS guidance, including final regulations, with respect to the substantiation of Qualified Medical Care Expenses with the use of the Section 125 Plan debit card.

(b) Reimbursement or Payment of Expenses. As soon as practical after the date in which the Participant submits documentation in accordance with Section 7.4(a), the Employer, through the Third Party Administrator, shall reimburse the Participant for Dependent Care Expenses incurred by the Participant, and shall debit the Participant's Dependent Care Flexible Spending Account. No reimbursement or payment under this Section 7.4 of expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's Dependent Care Flexible Spending Account for the Plan Year at the time of the reimbursement or payment. If the Participant's Dependent Care Flexible Spending Account for the Plan Year exceeds the amount of reimbursements and payments made with respect to such Plan Year, the excess amount shall be forfeited and may not be carried over to any subsequent Plan Year.

(c) Manner and Content of Notification. The Third Party Administrator, upon receipt of a claim, will make a determination and will provide written notification of its determination to the individual within 90 days after receipt of the individual's claim. This period may be extended one time by the Third Party Administrator, provided the Third Party Administrator both (i) determines that such an extension is necessary due to matters beyond the control of the Plan, and (ii) notifies the claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(d) Appeal of Adverse Claim Determination. A claimant may appeal an adverse determination. To do so, such claimant must submit, within 60 days following receipt of the Plan Administrator's adverse determination, a written request for review to the Plan Administrator stating the specific basis of such request, and any additional materials the claimant wishes to submit. In connection with the claimant's request for review, the claimant may request in writing copies of all documents, records, and other information upon which the Plan Administrator relied in making its determination. The Plan Administrator will provide all such documents to the claimant free of charge.

The Plan Administrator will take into account all documents, records and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial determination.

(e) Timing and Notification of Claim Determination on Review. Not later than 60 days after receipt by the Third Party Administrator of an application for review, the Third Party Administrator shall render its decision. The decision on the application for review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the claim is based. This period may be extended one time if the Third Party Administrator notifies the Claimant prior to the expiration of the 60-day period.

7.5 NON-BENEFIT CLAIMS.

(a) Non-Benefit Claims. The Plan Administrator will determine all non-Benefit claims (i.e., eligibility, QMCSOs, etc.). An individual may submit a written non-Benefit claim to the Plan Administrator, stating the individual's name, the specific basis for their non-Benefit claim, and any other additional information they wish to submit.

The Plan Administrator, upon receipt of a non-Benefit claim, will make a determination and will provide written notification of its determination to the individual within 30 days after receipt of the individual's non-Benefit claim. This period may be extended one time by the Plan Administrator, provided the Plan Administrator both (i) determines that such an extension is necessary due to matters beyond the control of the Plan, and (ii) notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(b) Appeal of Adverse Non-Benefit Claim Determination. A claimant may appeal an adverse determination. To do so, such claimant must submit, within 60 days following receipt of the Plan Administrator's adverse determination, a written request for review to the Plan Administrator stating the specific basis of such request, and any additional materials the claimant wishes to submit.

(c) Timing and Notification of Non-Benefit Claim on Review. The Plan Administrator will notify a claimant of the Plan's non-Benefit claim determination on review

within 60 days after receipt by the Plan of the claimant's request for review. This period may be extended one time if the Plan Administrator notifies the claimant prior to the expiration of the 60-day period. This period may be extended one time if the Third Party Administrator notifies the Claimant prior to the expiration of the 60-day period.

7.6 CLAIMS FOR BENEFITS. All claims for Benefits under the Plan must be filed within the timeline specified in the applicable Policy, ASA or Benefits Booklet; if no such timeline is specified, within one year after the claim was incurred.

7.7 FINALITY OF DECISION. All determinations of the Plan Administrator, the Insurer and the Third Party Administrator, to the extent authority has been delegated to it, will be final and binding.

7.8 LIMITATION ON COURT ACTION. Any suit brought to contest or set aside a decision of the Plan Administrator must be filed in a court of competent jurisdiction within the timeline specified in the applicable Policy, ASA or Benefits Booklet; if no such timeline is specified, within one year from the date of receipt of the Insurer's, Third Party Administrator's, or Plan Administrator's final decision.

ARTICLE VIII – AMENDMENT AND TERMINATION

8.1 AMENDMENT. The Plan Sponsor may at any time amend any or all of the provisions of the Plan in a written document that expressly provides that it is an amendment to the Plan. The amendment must be approved by the Plan Sponsor's Board of Education or any committee or individual authorized by the Board of Education to approve such amendments. The amendment may apply prospectively or retroactively as permitted by law and the effective date of the amendment will be stated in the document.

8.2 TERMINATION. The Plan Sponsor may terminate the Plan at any time. Benefits incurred prior to the date of termination will be paid as soon as administratively possible after the termination date.

ARTICLE IX – NONALIENATION OF BENEFITS AND MEDICAL CHILD SUPPORT ORDERS

9.1 NONALIENATION OF BENEFITS. No interest, right, or claim in or to any part of or all of any Benefit payable from the Plan will be assignable, transferable, or subject to sale, assignment, hypothecation, anticipation, garnishment, attachment, execution, or levy of any kind and the Plan Administrator will not recognize any attempt to so transfer, assign, sell, hypothecate, or anticipate the same except to the extent required by law, and any attempt to do so in violation of this provision will be void. This provision will not apply to any "qualified medical child support order" as defined in Section 9.2, below, and will not apply to a Medicaid assignment.

9.2 QUALIFIED MEDICAL CHILD SUPPORT ORDER.

(a) A "medical child support order" is any judgment, decree, or order, including approval of a settlement agreement, issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under State law that:

(i) Provides for child support or for health benefit coverage to a child of an Employee, is made pursuant to state domestic relations law, including a community property law, and relates to Benefits under this Plan; or

(ii) Enforces a Medicaid provision relating to medical child support with respect to this Plan.

(b) A medical child support order is "qualified" if:

(i) It satisfies all of the following:

(A) It creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive Benefits for which an Employee or beneficiary is eligible under the Plan. An "alternate recipient" is any child of an Employee who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to the Employee;

(B) It clearly specifies the name and last known mailing address (if any) of the Employee and the name and mailing address of each alternate recipient covered by the order. The order may substitute the name and mailing address of a state or local official for the mailing address of an alternate recipient;

(C) It provides a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;

(D) It specifies the period to which the order applies;

(E) It does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the Medicaid provisions relating to medical child support; or

(ii) It is a "National Medical Support Notice" as described in Section 609(a)(5)(C) of ERISA with respect to the Employee and an alternate recipient (a "Notice").

9.3 PROCEDURE FOR MEDICAL CHILD SUPPORT ORDERS. Whenever the Plan Administrator is served with a child support order from a court of competent jurisdiction, the Plan Administrator will follow the procedures adopted by the Plan Administrator.

9.4 EFFECT OF ELIGIBILITY FOR MEDICAID BENEFITS. If any Employee or Dependent is also covered under Medicaid:

(a) Payment for Benefits for the Participant or Dependent will be made in accordance with an assignment of rights made by or on behalf of the Participant or Dependent as required by Medicaid;

(b) The eligibility for benefits under Medicaid will not be taken into account in enrolling the individual as a Participant or beneficiary or in determining or making any payments of Benefits for such Participant or beneficiary; and

(c) If Medicaid has paid for medical services for which the Plan would have otherwise been liable, the Plan will make payment in accordance with any state law that provides that the state has acquired the Participant's rights with respect to the payment for those medical services.

ARTICLE X – HIPAA PRIVACY AND SECURITY COMPLIANCE

10.1 DEFINITIONS.

(a) "Electronic protected health information" means protected health information that is transmitted or maintained in electronic media.

(b) "Hybrid entity" means a welfare plan whose business activities include "health plan" activities as defined in 45 CFR Section 160.103 (covered functions) and activities that are not health plan activities (non-covered functions). The term "hybrid entity" has the meaning described in 45 CFR Section 164.504(a).

(c) "Individually identifiable health information" is information that is a subset of health information, including demographic information collected from an individual, and

(i) Is created or received by this Plan; and

(ii) Relates to the past, present, or future physical or mental health or condition of an individual; 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

(A) That identifies the individual; or

(B) With respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(d) "Protected health information" means individually identifiable health information that is transmitted or maintained in any form or medium but excluding individually identifiable health information in:

(i) Education records covered by the Family Educational Rights and Privacy Act as amended, 20 United States Code ("USC") Section 1232g;

(ii) Student records described at 20 USC Section 1232g (a)(4)(B)(iv); or

(iii) Employment records held by the Employer in its role as an employer.

(e) "Summary health information" means information that summarizes claims history, expenses, or types of claims by individuals for whom the Employer provides Benefits under the Plan, as defined in 45 CFR Section 164.504, and from which individual identifying information described in 45 CFR Section 164.514(b)(2)(i) has been removed.

10.2 PLAN STATUS. The Plan provides welfare Benefits that are not health care benefits and is therefore a hybrid entity as defined in 45 CFR Section 164.103. Notwithstanding any other provision of the Plan, this Article applies only to the health care components of the Plan.

10.3 INSURED HEALTH BENEFITS. In the case of any health Benefits provided under a Policy of insurance, the Insurer will prepare and distribute a Notice of Privacy Practices describing the manner in which the Insurer will use and disclose protected health information. The Notice of Privacy Practices of the Insurer will govern the uses and disclosures of protected health information by the Insurer.

10.4 DISCLOSURE OF SUMMARY HEALTH INFORMATION. The Plan may disclose summary health information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for obtaining health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

10.5 DISCLOSURE OF ENROLLMENT/DISENROLLMENT INFORMATION. The Plan may disclose to the Employer information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health program offered under the Plan. Enrollment and disenrollment functions performed by the Employer are performed on behalf of Plan Participants and beneficiaries and are not Plan administrative functions. Enrollment and disenrollment information held by the Employer is held in its capacity as an employer and is not protected health information.

10.6 ELECTRONIC PROTECTED HEALTH INFORMATION. If the Employer creates, receives, maintains or transmits any electronic protected health information (other than enrollment, disenrollment and summary health information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information, and it will ensure that any agents (including subcontractors) to whom it provides such electronic protected health information agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

10.7 DISCLOSURES TO THE EMPLOYER FOR PLAN ADMINISTRATION PURPOSES. The Plan will disclose protected health information to the Employer only in accordance with 45 CFR

Section 164.500 et. seq. and the provisions of this Article. Unless otherwise permitted by law, the Plan may disclose protected health information to the Employer for Plan administration purposes. Plan administration purposes include but are not limited to the following:

(a) Claims processing;

(b) Quality assessment;

(c) Auditing;

(d) Eligibility and coverage determinations;

(e) Coordination of benefits adjudication and subrogation of health claims;

(f) Obtaining payment under contracts for re-insurance;

(g) Management of payment and health care operations; and

(h) Assessment of plan payment and health care operations and evaluation of proposed changes to payment and health care operations.

10.8 CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES. Other than enrollment/disenrollment information, summary health information and information disclosed pursuant to a signed authorization, the Employer will:

(a) Not use or further disclose the protected health information other than as permitted or required by the Plan documents, or as required by law;

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

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other Benefit or employee benefit wrap plan of the Employer;

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) Make available protected health information in accordance with 45 CFR Section 164.524, detailing a Participant's right of access to protected health information; make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR Section 164.526, detailing Participant's rights to amend their protected health information; and make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

(f) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of

Health and Human Services for purposes of determining compliance by the Plan with 45 CFR Section Part 164;

(g) If feasible, return or destroy all protected health information received from the Plan that the Employer continues to maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or disclosure is not feasible, the Employer will limit future use and disclosures for those purposes that make the return or destruction of the information infeasible;

(h) Ensure that adequate separation between the Plan and the Employer is maintained as follows:

(i) The Employer will limit disclosure of and access to protected health information to the individuals or classes of Employees identified in the HIPAA Policy adopted by the Employer and any other Employee who needs access to protected health information in order to perform Plan administrative functions.

(ii) The Employer will restrict the access to and use by the persons described above, to the plan administration functions that the Employee performs for the Plan.

(iii) The Employer will ensure that the provisions of this Subsection (h) are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

(iv) The Employer will provide an effective mechanism for resolving any issues of noncompliance with the provisions of this Article by persons described above.

(v) The Employer will review and where appropriate, discipline, all instances of alleged violation of the rules of this Article in accordance with the Employer's Employee discipline and separation of employment policies.

10.9 CERTIFICATION. The Plan will disclose protected health information to the Employer only upon receipt of a certification by the Employer that the Plan documents have been amended to incorporate the requirements described in Section 10.8.

10.10 ORGANIZED HEALTH CARE ARRANGEMENT. A health insurance issuer or health maintenance organization providing Benefits to Participants in the Plan may disclose protected health information to the Employer and the Plan as permitted in this Article if a Notice of Privacy Practices is maintained and provided as required by 45 CFR Section 164.506(c)(5).

10.11 GENETIC INFORMATION. The Plan will not use or disclose protected health information that is genetic information, as defined in 45 CFR Section 160.103, for determining eligibility (including enrollment and continued eligibility), the computation of premium or contribution amounts, the application of any pre-existing condition exclusion or other activities related to the creation, renewal or replacement of a contract of health insurance or health Benefits.

ARTICLE XI – COORDINATION OF BENEFITS AND OVERPAYMENTS

11.1 COORDINATION OF BENEFITS. Benefits and the coordination of benefit rules with regard to such Benefits under this Plan and other plans, including coordination of benefits relating to motor vehicle insurance and Medicare, will be governed in accordance with the terms of the applicable Policy, ASA, and Benefits Booklet.

11.2 OVERPAYMENT. In accordance with the terms of the applicable Policy, ASA, and Benefits Booklet, an overpayment occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense more than once, or if an expense or Benefit is paid by both the Plan and a third party. An expense or Benefit is considered paid if it is paid to the Participant or another party on the Participant's behalf. If an overpayment is made by the Plan, the Plan has the right to recover the overpayment from the Participant or the third party, if applicable. If the Plan is not recovered from the Participant or the third party, if applicable, the Plan will deduct the amount of overpayment from further Benefits with respect to the Participant or the Participants Eligible Dependents, or from the Participant's wages, if applicable. The Plan's right to recover an overpayment does not affect any other right of recovery the Plan may have with respect to such overpayment.

ARTICLE XII – MISCELLANEOUS

12.1 EXCLUSIVE BENEFIT. The assets of the Plan, if any, will not be diverted to or used by the Employer for purposes other than the exclusive benefit of Participants and beneficiaries, except to pay the administrative expenses of the Plan.

12.2 STATUS OF PARTICIPANTS. No Participant will have any right or claim to any Benefits under the Plan except in accordance with the provisions of the Plan. The adoption of the Plan will not be construed as creating any contract of employment between the Employer and any Participant or to otherwise confer upon any Participant or other person any legal right to continuation of employment, or as limiting or qualifying the right of the Employer to discharge any Participant without regard to any effect the discharge might have upon the Participant's rights under the Plan. Except for the right to receive a Benefit for claims incurred under the terms of the Plan, no Participant will have any right, title or interest to any Benefits or to any of the assets of the Employer because of the Plan.

12.3 NO ENLARGEMENT OF BENEFITS. This plan document describes the Benefit programs provided to Employees of the Employer. These Benefit programs are described in detail in booklets prepared by Insurers and Third Party Administrators administering claims for Benefits and booklets, certificates of insurance and insurance policies prepared by Insurers providing Benefits. This plan document will not enlarge or modify any Benefits described in these booklets, certificates or policies of insurance. In the event there is a conflict between the terms of the applicable Policy, ASA, and Benefits Booklet and the Plan, the terms of the applicable Policy, ASA, and Benefits Booklet will govern.

12.4 NO INTEREST IN EMPLOYER AFFAIRS. Nothing contained in this Plan will be construed as giving any Participant, Employee, or beneficiary an equity or other interest in the assets, business, or affairs of the Employer or the right to examine any of the books and records of the Employer. The rights of Participants are limited to the right to receive payment of Benefits when due.

12.5 GOVERNING LAW. This Plan will be interpreted and enforced in accordance with the Code, or other applicable federal law, and the laws of the State of Michigan to the extent that state law may be applicable.

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan will be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code will be deemed controlling, and any conflicting part, clause or provision of this Plan will be deemed superseded to the extent of the conflict.

12.6 TAX EFFECTS. Neither the Plan nor the Employer makes any representations or warranties regarding Federal, State, local or other tax treatment of Benefits provided pursuant to the Plan and a Participant will have no rights against the Employer or the Plan if any tax consequences contemplated by any Participant are not achieved.

12.7 SEVERABILITY OF PROVISIONS. If any provision of the Plan is declared void and unenforceable, the other provisions may be severed and will not be affected thereby, and to the extent that the Plan will ever be in conflict with, or silent with respect to, the requirements of any other law or regulation, the provisions of the law or regulation will govern. In the administration of the Plan, the Plan Administrator may avail itself of any permissive provisions of any applicable law or regulation that are not contrary to the provisions of this Plan.

12.8 CONSTRUCTION AND INTERPRETATION. The Plan will be interpreted to maintain the tax qualification and tax Benefits for the Employer and Plan Participants and to be consistent with the express purpose and intention of the Plan.

12.9 ENTIRE AGREEMENT. The Plan and the incorporated documents constitute the entire agreement.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed this 15th day of December, 2017.

Lapeer Community Schools

By: _____

Its: Mark Rajter

Asst. Supt. Business/Finance