ELKTON-PIGEON-BAY PORT LAKERS SCHOOLS CAFETERIA PLAN

With Premium Payment and HSA Components

Effective: July 1, 2013

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TABLE OF CONTENTS

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ARTICLE I

Introduction

1.1 Amendment and Restatement of Plan
Elkton-Pigeon-Bay Port Lakers Schools, ("the Employer") hereby amends and restates the provisions of the Elkton-Pigeon-Bay Port Lakers Schools Cafeteria Plan ("the Plan"), as amended, effective as of July 1, 2013. The Plan was originally effective September 6, 2011. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II, Definitions.

This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions on a pre-tax salary reduction basis under the Premium Component, and contribute to the reimbursement benefit(s) on a pre-tax salary reduction basis.

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

The HSA funding feature described in the HSA Component is not intended to establish an ERISA plan.

ARTICLE II

Definitions

"Benefits" mean cash, flex credits and the various qualified benefits under Section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan, including, but not limited to, premium insurance benefits as described in Section 6.1.

"Benefit Package Option" means a qualified benefit under Code section 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan.

"Change in Status" has the meaning described in Section 8.3.

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

"Compensation" means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under sections 125, 132(f)(4), 401(k), 403(b), 408(k) or 457(b) of the Code.

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

"Dependent" means for purposes of accident or health coverage, to the extent funded under the Premium Payment Component, (1) a dependent as defined as in Code section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year).

For purposes of the new income exclusions under Code sections 105(b) and 106, the term "child" includes adult children under the age of 27 that is the employee's son, daughter, stepson, stepdaughter, legally adopted individual (or an individual placed with the employee for adoption), and eligible foster child. Under Notice 2010-38, such a child does not have to satisfy the age limits, residency, support and other tests described in Section 152 of the Code in order to be considered an employee's child for purposes of these new income exclusions.

"Effective Date" of this Plan has the meaning described in Section 1.1.

"Election Form/Salary Reduction Agreement" means the agreement by an Employee authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of obtaining Benefits under the Plan.

"Electronic Protected Health Information" has the meaning described in 45 C.F.R. Section 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"Eligible Employee" means any Employee who is employed by a participating Employer other than:

(a) Employees who are self-employed individuals as defined in section 401(c) of the Internal Revenue Code (including sole proprietors and partners in a partnership);

(b) Employees who own (or are considered to own within the meaning of section 318 of the Internal

Revenue Code) more than two percent (2%) of the outstanding stock of an S corporation or stock possessing more than two percent (2%) of the total combined voting power of all stock of such corporation.

In the event an individual who is not characterized or treated by the Participating Employer as a common law employee of a Participating Employer is reclassified as a common law employee of a Participating Employer who meets the definition of an Eligible Employee, the individual shall continue to be excluded from the Plan until the Plan is amended to classify such individual as an Eligible Employee (to the extent such individual otherwise qualifies as an Eligible Employee hereunder). In no event shall such individual be eligible to participate in the Plan prior to the effective date of such Amendment.

The Plan Administrator shall have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member.) The Plan Administrator's decision shall be final, binding, and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude, and the Plan Administrator is authorized to exclude, all individuals who are not considered Employees for purposes of the Employer's payroll system.

"Employee" means a person who is currently or hereafter employed by the Employer and any Related Employers that have adopted the Plan. Former Employees are also considered "Employees" of the Employer strictly for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means Elkton-Pigeon-Bay Port Lakers Schools.

"Employment Commencement Date" means the first regularly-scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

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

"Entry Date" means the date that an Eligible Employee actually becomes a Participant in the Plan. Eligibility requirements are defined in Section 3.1 and the specific Entry Dates for the Plan are listed in Section 3.1, unless a Component Plan has different eligibility requirements.

"Flex Credits" mean an amount made available to a Participant by the Employer in a Plan Year for use in purchasing Benefits available under the Plan.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Health Savings Account" or "HSA" means a health savings account established under Code section 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

"High Deductible Health Plan" means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code section 223(c)(2), as described in materials provided separately by the Employer. The High Deductible Health Plan may or may not be the sole Medical Insurance Plan eligible for pre-tax salary reduction funding hereunder.

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

"HITECH" means the Health Information Technology for Economic and Clinical Health Act.

"HSA-Eligible Individual" means an individual who is eligible to contribute to an HSA under Code section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

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

"Open Enrollment Period" means with respect to a Plan Year the month preceding the Plan Year, or such other period as may be prescribed by the Plan Administrator.

"Participant" means a person who is an Eligible Employee and who enters the Plan after meeting the eligibility requirements of Section 3.1. Participants include those who elect any benefit(s) offered under the Plan.

"Participating Employer" means Elkton-Pigeon-Bay Port Lakers Schools and any Related Employer that adopts the Plan.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

"PHSA" means the federal Public Health Service Act, which contains the provisions of COBRA that govern continuation coverage under government-sponsored Group Health Plans, as well as certain provisions of HIPAA and other federal group health plan mandates that are part of health care reform.

"Plan" means the Elkton-Pigeon-Bay Port Lakers Schools Cafeteria Plan as set forth herein and as amended from time to time.

"Plan Administrator" means Elkton-Pigeon-Bay Port Lakers Schools or such other person or committee as may be appointed by the Employer to administer the Plan.

"Plan Year" means the 12-month period commencing September 6th and ending on June 30th.

"Premium Payment Component" means the benefits of this Plan described in Article VI.

"Protected Health Information" (PHI) shall have the meaning described in 45 C.F.R. Section 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

"Related Employer" means any employer affiliated with Elkton-Pigeon-Bay Port Lakers Schools that, under Code Sections 414(b), (c), or (m), is treated as a single employer with Elkton-Pigeon-Bay Port Lakers Schools for purposes of Code section 125(g)(4).

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

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

"Timely Submitted" means, unless the Plan Administrator has specific and special cause to alter the definition of this phrase, within 30 calendar days of event that has triggered the Change in Status as described in Section 8.2(a).

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as

amended.

ARTICLE III

Eligibility and Participation

3.1 Eligibility to Participate
An individual is eligible to participate in this Plan, including the Premium Payment Component, and the HSA Component, if the individual satisfies all of the following:

(a) is an Eligible Employee; and

(b) is eligible to participate in the Employer's group medical insurance.

To participate in the HSA Component, the individual must be an HSA-Eligible Individual and shall also be subject to the additional requirements, if any, specified in the High Deductible Health Plan.

Once an Employee has met the Plan's eligibility requirements, the Eligible Employee may commence participation on the date the eligibility requirements have been met or for any subsequent Plan Year, in accordance with the procedures described in Article IV, Method and Timing of Elections.

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

- the date on which the Plan terminates;
- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee;
- the date on which the Employee fails to make a contribution required under the terms of the Plan; or
- the end of the Plan Year for Eligible Employees;

Termination of participation in this Plan will automatically revoke the Participant's elections.

The Premium Insurance Benefits will terminate as of the date specified in the Premium Plan.

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

3.3 Participation Following Termination of Employment or Loss of Eligibility
If a Participant terminates his or her employment for any reason, including, but not limited to, disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of termination of employment, and is otherwise eligible to participate in the Plan, the Employee will immediately rejoin the Plan and be reinstated with the same elections that the individual had before termination.

If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the Employee will be treated as a new hire and must resatisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan.

Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Premium Insurance Benefits is reinstated.

Likewise, an HSA Benefit election will only be reinstated if an individual is an HSA-Eligible Individual.

If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including, but not limited to, a reduction of hours, and then becomes an Eligible Employee again, the Employee may rejoin the Plan without having to re-satisfy (complete the waiting period) Plan eligibility requirements as described in Section 3.1.

3.4 FMLA Leaves of Absence
Under FMLA, the provisions of this section shall not be available to Eligible Employees for such Plan Years in which the Employer has 50 or fewer Employees. For Plan Years in which the Employer has more than 50 Employees, the Employer must make FMLA leave available to Eligible Employees for up to 12 weeks in connection with the birth or adoption of a child, or to care for a close relative, or because of a serious health condition of the Employee. An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember is entitled to take up to 26 workweeks of leave during a 12 month period to care for the servicemember.

3.5 Non-FMLA Leaves of Absence
If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid in one of the following ways:

- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);

- with their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations; or

- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 8.3 will apply.

ARTICLE IV

Method and Timing of Elections

4.1 Elections When First Eligible
Once an Employee has met the Plan's eligibility requirements, the Employee may enter the plan on the date the eligibility requirements have been met provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence.

Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, as specified by the insurance benefits provider(s). The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified by the insurance benefits provider(s).

4.2 Elections During Open Enrollment Period
During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Eligible Employee. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary salary reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement
If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement (or waiver of pre-tax premiums) within the time period described in Method and Timing of Elections for the first plan year, then the Employee is considered to have elected not to participate for the initial Plan Year and may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 8.3 or 8.4

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement for subsequent Plan Years, then the Employee shall continue with same elections as prior year for insured/premium benefits.

If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Premium Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described under Section 8.3), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

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

ARTICLE V

Benefits Offered and Method of Funding

5.1 Benefits Offered
When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect specific Benefits offered under this Plan:

(a) Premium Payment Benefits, as described in Article VI;

(b) HSA Benefits, as described in Article VII;

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Employer Contributions

(a) Employer Contributions.
The Employer shall contribute amounts deemed necessary to meet its obligations under the Plan. Contributions to the Plan for the Plan Year shall be limited to the amounts determined by the Election Form/Salary Reduction Agreement entered into by Participants for the Plan Year.

(b) Flex Credits Formula

(c) Unused Flex Credits
Employee□s waiving employer sponsored group medical, dental or vision coverage will receive cash-in-lieu of the benefit

5.3 Participant Contributions
Participants who elect Benefits under the Plan may pay for the cost of that coverage on a pre-tax salary reduction basis by completing an Election Form/Salary Reduction Agreement.

(a) Salary Reductions. The salary reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (elected under the Plan as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which salary reductions are applied may fluctuate). If a Participant increases his or her election under the benefits elected under the Plan to the extent permitted under Section 8.4, the salary reductions per pay period will be, for the Benefits affected, an amount equal to: (1) the new reimbursement limit elected pursuant to Section 8.4, less the salary reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which salary reductions are applied may fluctuate).

(b) Considered Employer Contributions for Certain Purposes. Salary reductions are applied by the Employer to pay for the Participant's share of the Contributions for the benefits elected under the Plan and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) After-Tax Contributions for Premium Payment Benefits. For those Participants who elect to pay their share of the Contributions for any of the Premium Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.4 Funding This Plan

All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

5.5 Maximum Contribution

The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions, as described under each Component.

ARTICLE VI

Premium Payment Component

6.1 Benefits
The premium insurance benefits that may be offered under the Premium Payment Component for premium-type benefits pursuant to an insurance policy issued by an insurance company, or a contract with a point of service organization are medical, dental, vision, or other qualified benefits under Section 125.

Notwithstanding any other provision in this Plan, the premium insurance benefits are subject to the terms and conditions of the respective insurance policy. No changes can be made with respect to such premium insurance benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable insurance policy. Unless an exception applies, as described in Article VIII, such election is irrevocable for the duration of the Period of Coverage to which it relates.

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

6.3 Events Permitting Exception to Irrevocability Rule
A Participant may make a new election upon the occurrence of certain events, including a Change in Status as described in Section 8.3, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

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

A Participant may change an election under the regulations for the Premium Component of this Plan as described below upon the occurrence of the stated events:

- **(a)** Open Enrollment Period
- **(b)** Change in Status:
  - **(b.1)** Change in Employee's Legal Marital Status
  - **(b.2)** Change in the Number of Employee's Dependents
  - **(b.3)** Change in Employment Status of Employee, Spouse or Dependent that Affects Eligibility
  - **(b.4)** Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements
  - **(b.5)** Change in Place of Residence
- **(c)** Cost Changes with Automatic Increase/Decrease in Elective Contributions
- **(d)** Significant Cost Increase or Significant Cost Decrease
- **(e)** Significant Curtailment of Coverage (With or Without Loss of Coverage)
- **(f)** Addition or Significant Improvement of a Benefit Package Option
- **(g)** Change in Coverage Under Another Employer Cafeteria Plan or Qualified Benefits Plan
- **(h)** Loss of Coverage Under Other Group Health Coverage
- **(i)** HIPAA Special Enrollment Rights
- **(j)** Certain Judgments, Decrees and Orders (QMCSO)
- **(k)** Medicare and Medicaid Eligibility
- **(l)** FMLA Leaves of Absence

6.4 Insurance Benefits Provided Under the Plan
Insurance benefits will be provided by the insurance provider(s), not this Plan. The types and amounts of insurance benefits, the requirements for participating in each insurance plan, and the other terms and conditions of coverage and benefits of the insurance plan(s) are set forth by the insurance provider. All claims to receive benefits under the insurance plan shall be subject to and governed by the terms and conditions of the insurance plan and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.5 Premium Insurance Benefits Grace Period
No grace period applies to the Premium Component of this Plan.

ARTICLE VII

HSA Component

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

7.2 Contributions for Cost of Coverage for HSA; Maximum Limits
In no event shall the annual Contribution for a Participant's HSA Benefits of:

(a) an individual with self-only coverage under a high deductible health plan exceed the inflation-indexed statutory amount as governed under Code section 223(b)(2)(A);

(b)an individual with family coverage under a high deductible health plan exceed the inflation-indexed statutory amount as governed under Code section 223(b)(2)(B);

An additional catch-up Contribution may be made for Participants who are age 55 or older.

In addition, the maximum annual contribution shall be reduced by any matching (or other) Contribution made on the Participant's behalf (other than pre-tax salary reductions) made under the Plan.

7.3 Recording Contributions for HSA
The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in a HSA as specified in the HSA Plan Document.

7.4 Tax Treatment of HSA Contributions and Distributions
The tax treatment of the HSA (including contributions and distributions) is governed by Code section 223.

7.5 Trust/Custodial Agreement, HSA Not Intended to Be an ERISA Plan
HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax salary reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan. The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code section 223(d)(2). The Employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow pre-tax salary reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

ARTICLE VII

HIPAA Provisions

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

> Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased. The Employer shall have access to PHI from the Premium only as permitted under this Article or as otherwise required or permitted by HIPAA.
>
> The Health Information Technology for Economic and Clinical Health Act passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff."

7.2 Permitted Disclosure of Enrollment/Disenrollment Information
The Premium may disclose to the Employer information on whether the individual is participating in the Plan.

7.3 Permitted Uses and Disclosure of Summary Health Information
The Premium may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Premium.

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

7.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes
Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 7.5 and obtaining written certification pursuant to Section 7.7, the Premium may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Premium, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

7.5 Conditions of Disclosure for Plan Administration Purposes
The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Premium, the

Employer shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Premium agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Premium available to the Secretary of Health and Human Services for purposes of determining compliance by the Premium with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Premium that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Premium and the Employer (i.e., the "firewall"), required in 45 CFR Section 504(f)(2)(iii), is satisfied.

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

7.6 Adequate Separation Between Plan and Employer

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

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

7.7 Certification of Plan Sponsor

The Premium shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 7.5.

ARTICLE VIII

Irrevocability of Elections; Exceptions

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

- participation in this Plan;
- salary reduction amounts; or
- election of particular Benefit Package Options.

However, as described further in Section 8.4, an election to make a Contribution to an HSA can be changed at any time on a prospective basis.

8.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) Timeframe for Making New Election. A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 4.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 8.3, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period. Notwithstanding the foregoing, a Change in Status (e.g., a divorce) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) Effective Date of New Election. Elections made pursuant to this Section shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 8.3 for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective the date the election is made.

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

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

(a) Open Enrollment Period. A Participant may change an election during the Open Enrollment Period in accordance with Section 4.2.

(b) Termination of Employment. A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

(c) Legal Marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(d) Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(e) Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(f) Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, or any similar circumstance; and

(g) Change in Residence. A change in the place of residence of the Participant or his or her Spouse or Dependents that causes the gain or loss of eligibility for coverage option.

(h) Leaves of Absence. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(h.1) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(i) HIPAA Special Enrollment Rights. If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(i.1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

(i.2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

An election change on account of a HIPAA special enrollment attributable to an employee or dependent becoming eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP may, subject to the provisions of the underlying group health plan be effective retroactively (up to 60 days).

(j) Certain Judgments, Decrees and Orders. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(k) Medicare and Medicaid. If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid.

(l) Change in Cost. For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(m) Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing salary reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(n) Significant Cost Increases. If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing salary reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage.

(o) Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit Package Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option (such as an HMO, but not the Health FSA) other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package

Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option.

(p) Change in Coverage. For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(q) Significant Curtailment. If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer.

(q.1) Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(q.2) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(q.3) Definition of Loss of Coverage. For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(r) Addition or Significant Improvement of a Benefit Package Option. If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved

Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option.

(s) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(t) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the Plan Year under the other cafeteria plan or qualified benefits plan.

8.4 Election Modifications for HSA Benefits May Be Changed Prospectively at Any Time
As set forth in Section 7.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Package Option election changes can occur as a result of a change in HSA election except as otherwise described in this Article.

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

ARTICLE IX

Recordkeeping and Administration

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

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

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to provide the Employer with such tax or other information it may require in connection with the Plan;

(g) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(h) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(i) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(j) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(k) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(l) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

(m) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might ensure the efficient administration of the Plan.

However, nothing in this Section is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he or she sees fit to assure that the Plan complies with the nondiscrimination requirements of Section 125 of the Code.

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

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

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

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

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

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

9.10 Effect of Mistake
In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such

Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE X

General Provisions

10.1 Plan Expenses
All reasonable expenses incurred in administering the Plan are currently paid by the Employer. The Employer has the discretion to decide upon an appropriate expense amount to offset experience gains.

For HSA Benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian.

10.2 No Contract of Employment
Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

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

10.4 Governing Law
This Plan shall be construed, administered, and enforced according to the laws of the State of Michigan, to the extent not superseded by the Code.

10.5 No Guarantee of Tax Consequences
Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

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

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

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

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

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

*** * ***

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Elkton-Pigeon-Bay Port Lakers Schools Cafeteria Plan, Elkton-Pigeon-Bay Port Lakers Schools has caused this Plan to be executed in its name and on its behalf, on this _____ day of _____, ____.

Employer:
Elkton-Pigeon-Bay Port Lakers Schools

_____
Robert Smith