Bloomfield Hills Schools

Flexible Benefits Plan

Restated Effective: November 1, 2012

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ARTICLE I - ESTABLISHMENT OF THE PLAN

The Bloomfield Hills Schools has established the Bloomfield Hills Schools Flexible Benefits Plan for the purpose of providing eligible Employees with a choice between cash and certain tax-free benefits. The Bloomfield Hills Schools Flexible Benefits Plan was adopted effective November 1, 1997. This Restatement is effective November 1, 2012. The Plan is intended to qualify as a cafeteria plan under Section 125 of the Code and is to be interpreted in a manner consistent with the requirements of Section 125.

ARTICLE II - DEFINITIONS

The definitions contained herein shall be applicable to the Bloomfield Hills Schools Flexible Benefits Plan only.

2.1 "Accidental Death and Dismemberment Insurance" means the employee accidental death and dismemberment insurance coverage options, as amended from time to time, offered pursuant to an Agreement.

2.2 "Accounts" means the bookkeeping accounts established to record the amount of benefits available to a Participant under the Medical Reimbursement Plan, the Dependent Care Assistance Plan and the Cafeteria Plan described in Articles V, VI and VII.

2.3 "Administrator" means the District or such other person, firm or committee, corporation, trust company or bank, as may be appointed from time to time by the District to supervise the administration of the Plan.

2.4 "Agreement" means the current Agreement between the Board of Education of Bloomfield Hills Schools and (1) the Bloomfield Hills Education Association; (2) Bloomfield Hills Association of Paraeducators; (3) Administrative Council; (4) Local 1625, Council #25, American Federation of State, county and Municipal Employees; (5) Bloomfield Hills

Association of Instructional Assistants; (6) Bloomfield Hills Association of Interpreters; (7) Bloomfield Hills Schools Office Personnel, as amended and restated from time to time. The term Agreement shall include any successor agreement. Agreement shall also mean an Individual Administrator Contract executed on behalf of the Bloomfield Hills Schools, the Supervisor & Management Support Handbook or the Conditions of Employment for Unaffiliated Staff.

2.5 "Benefit Election/Compensation Reduction Agreement" means an agreement between the Participant and the District under which an eligible Participant elects either the Cash Benefit or Qualified Benefits and under which an eligible Participant may elect to make deferrals to a health savings account in compliance with Code §223. If the Participant elects Qualified Benefits, as required by the applicable Agreement or as required by law, he/she shall agree to reduce his/her Compensation or to forego all or part of the increases in such Compensation to have such amounts contributed by the District to the Plan on the Participant's behalf pursuant to an election form established by the District. 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 §125 into account) and, subsequently does not become currently available to the Participant.

2.6 "Cafeteria Plan" means the Bloomfield Hills Schools Cafeteria Plan established in Article VII.

2.7 "Cafeteria Plan Account" means the Account established and maintained by the District under Article VII to record the amount by which a Participant reduces his compensation to make Participant contributions to premium payments and to reflect Cash Benefit payments made to eligible Participants who do not elect Qualified Benefits.

2.8 "Cash Benefit" means the amount of additional Compensation (from which applicable withholdings are made) which is paid to a Participant in lieu of Health Care Coverage in accordance with the terms of this Plan.

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

2.10 "Compensation" means the total cash remuneration received by a Participant from the District 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.

2.11 "Dental Coverage" means the group dental care options (appropriate single, employee and spouse, employee and children or family coverage) as amended from time to time offered pursuant to an Agreement.

2.12 "Dependent Care Assistance Account" means the Account established and maintained by the District under Section VI to record the amount by which a Participant reduces his/her compensation to receive reimbursement of certain dependent care expenses under the Dependent Care Assistance Plan.

2.13 "Dependent Care Assistance Plan" means the Bloomfield Hills Schools Dependent Care Assistance Plan established under Article VI.

2.14 "District" means the Bloomfield Hills Schools located within the State of Michigan.

2.15 "Effective Date" means November 1, 1997. The Effective Date of this Restatement is November 1, 2012.

2.16 "Employee" means (1) any person employed by the District who is eligible to participate in this Plan pursuant to an Individual Administrator Contract, the Supervisor &

Management Support Handbook or the Conditions of Employment for Unaffiliated Staff; and (2) any person employed by the District whose terms and conditions of employment are governed by the collective bargaining agreement between the Bloomfield Hills Schools and any of the following collective bargaining representatives: (a) the Bloomfield Hills Education Association; (b) Bloomfield Hills Association of Paraeducators; (c) Administrative Council; (d) Local 1625, Council #25, American Federation of State, county and Municipal Employees; (e) Bloomfield Hills Association of Instructional Assistants; (f) Bloomfield Hills Association of Interpreters; or (g) Bloomfield Hills Schools Office Personnel.

2.17 "Employee Life Insurance" means the employee group term life insurance coverage options (which include no permanent benefit), as amended from time to time, offered pursuant to an Agreement.

2.18 "Health Care Coverage" shall mean the group health care options (appropriate single, two-person or family coverage) as amended from time to time offered pursuant to an Agreement.

2.19 "Health Savings Account" means a tax-exempt trust or custodial account established under Code Section 223 exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to the account, is covered under a high-deductible health plan.

2.20 "Long-Term Disability Insurance" means the employee long-term disability insurance coverage options, as amended from time to time, offered pursuant to an Agreement.

2.21 "Medical Reimbursement Account" means the Account established and maintained by the District under Section V to record the amount by which a Participant reduces

his/her compensation to receive reimbursement of qualifying medical care expenses under the Medical Reimbursement Plan.

2.22 "Medical Reimbursement Plan" means the Bloomfield Hills Schools Medical Reimbursement Plan established in Article V.

2.23 "Participant" means any Employee who meets the requirements for participation as set forth in Article III.

2.24 "Plan" means the Bloomfield Hills Schools Flexible Benefits Plan as set forth herein as amended from time to time.

2.25 "Plan Administrator" means the Bloomfield Hills Schools.

2.26 "Plan Year" means the twelve-month period commencing November 1st and ending October 30th. There shall be a short Plan Year commencing November 1, 2012 and ending December 31, 2012. Effective January 1, 2013, Plan Year shall mean the twelve month period commencing January 1 and ending on December 31.

2.27 "Qualified Benefit" means a benefit which is not includable in gross income pursuant to Code §125(f). "Qualified Benefits" include health care coverage, dental coverage, vision coverage, long-term disability insurance, short-term disability coverage, and employee life insurance and accidental death and dismemberment insurance. Benefits under the Medical Reimbursement Plan and the Dependent Care Assistance Plan are also Qualified Benefits available under the Plan.

2.28 "Short-Term Disability Coverage" means the group short-term disability coverage as amended from time to time offered pursuant to an Agreement.

2.29 "Vision Coverage" means the group vision care coverage (appropriate single, employee plus one, or family coverage) as amended from time to time offered pursuant to an Agreement.

ARTICLE III - PARTICIPATION

3.1 Participation. Every Employee (as defined in Section 2.16) of the District shall be entitled to participate in the Plan and the Cafeteria Plan on the date the Employee became eligible for any Qualified Benefit pursuant to the Agreement or the Effective Date, if later. Subject to Sections 7.4 and 7.9 of the Plan, any Employee who elects coverage under the terms of the Health Care Coverage which is a "high deductible health plan" as defined in Code §223(c)(2) shall be eligible to make deferrals and receive District contributions under the Plan to a Health Savings Account. No Employee shall become a Participant unless the Employee complies with the provisions of the Plan and executes, completes and files the electronic and/or paper forms required by the Administrator with the Administrator in a timely manner as provided in Section 4.2 and 7.7 of the Plan.

3.2 Cessation of Participation. A Participant shall cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, or (b) the last day of the month in which he or she ceases to be an Employee as defined in Section 2.16 of this Plan due to termination of employment or leave of absence except that such date shall be a later date if otherwise required under the Agreement or the provisions of federal law, or (c) the date the Participant ceases to make required contributions, if any. Any person who remains employed by the District but is no longer an Employee as defined in Section 2.16 shall cease to be a Participant hereunder as of the date of reclassification. Notwithstanding the foregoing, Health Care Coverage, Dental Coverage, Vision Coverage and benefits under the Medical Reimbursement Plan shall be made available to

the Employee and covered dependents on an employee-paid basis to the extent required by federal law. A Participant who ceases to be covered by the Health Care Coverage which is a "high deductible health plan" as defined in Code §223(c)(2) shall cease to be eligible to make deferrals under the Plan to a Health Savings Account or to receive District contributions under the Plan to a Health Savings Account.

A Participant whose participation in the Plan ceases shall be ineligible to have additional amounts credited to his/her Accounts under the Medical Reimbursement Plan and the Dependent Care Assistance Plan. Amounts remaining in the Participant's Accounts under the Medical Reimbursement Plan and the Dependent Care Assistance Plan may continue to be applied toward the payment of claims for reimbursement of eligible expenses incurred before the date the individual's participation terminated. The individual shall not, however, be eligible to be reimbursed for claims incurred after the date his participation terminated, unless the individual continues to participate as described in Section 3.3.

3.3 Continuation Coverage.

A Participant whose employment terminates has the option of continuing to participate in the Health Care Coverage, Dental Coverage, Vision Coverage and/or the Medical Reimbursement Plan by making after-tax contributions in an amount equal to the amount of District contributions and Participant contributions attributable to such coverage which were credited to the individual's Cafeteria Plan Account and/or Medical Reimbursement Account prior to the date his employment terminated. Participation shall be terminated if the contributions are not made on a timely basis. Alternatively, an Employee who separates from service may revoke benefit elections and terminate receipt of benefits.

In the case of an individual's Cafeteria Plan Account with respect to Health Care Coverage, Dental Coverage, Vision Coverage and Medical Reimbursement Account, this option of continuing to participate in the Cafeteria Plan and/or Medical Reimbursement Plan is available for the period set forth in the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

If an individual does not elect to continue to participate in the Medical Reimbursement Plan under this Section or his participation is terminated for failing to timely make after-tax contributions, any amounts remaining in the individual's Medical Reimbursement Account after paying claims incurred while a Participant shall be forfeited.

If a former Participant is rehired within the Plan Year in which the separation from service occurred, such Participant shall be prohibited from making new benefit elections for the remaining portion of the Plan Year. Notwithstanding this provision, to the extent permitted under Treas. Reg. §1.125-4(c), if a Participant separates from service and is rehired within the Plan Year, but more then thirty (30) days following his/her separation from service, the Participant may either be automatically reinstated to his/her elections prior to the separation from service or permitted to make new elections under the Plan for the remainder of the Plan Year.

A former Participant will become a Participant again when he or she again becomes an Employee as defined in Section 2.16 of this Plan, complies with the provisions of this Plan and executes, completes and submits the electronic and/or paper forms required by the Administrator with the Administrator. A former Participant shall re-enter the Plan on the date he/she again becomes eligible for a Qualified Benefit.

3.4 Reinstatement of Former Participant. A former Participant will become a Participant again when he or she again becomes an Employee as defined in Section 2.16 of this

Plan, is eligible for a Qualified Benefit pursuant to the Agreement, complies with the provisions of this Plan and executes, completes and submits the electronic and/or paper forms required by the Administrator with the Administrator in a timely manner as provided in Section 4.2 and 7.7 of the Plan.

ARTICLE IV – BENEFITS

4.1 Flexible Spending Accounts.

(a) General Rule. A Participant may choose to receive his/her full Compensation for a Plan Year through the District's regular payroll system or have a specified portion of it applied by the District toward any or all of the following benefits:

(i) Benefits under the Medical Reimbursement Plan.

(ii) Benefits under the Dependent Care Assistance Plan.

(iii) Pre-tax contributions to premium payments for Health Care Coverage, Dental Coverage, Vision Coverage, Accidental Death and Dismemberment Insurance, Long-Term Disability Insurance, Short-Term Disability Coverage and/or Employee Life Insurance under the Cafeteria Plan.

(iv) Pre-tax contributions to a Health Savings Account, to the extent permitted under Section 7.9 of the Plan.

This Section merely describes the terms and conditions of the Participant's choice between Compensation received through District's regular payroll system and the generally nontaxable benefits under the above plans. The terms and condition of each specific plan, including participation and benefit requirements, are stated in Articles V, VI and VII. Eligibility for Health Care Coverage, Dental Care Coverage, Vision Coverage, Employee Life Insurance,

Accidental Death and Dismemberment Insurance, Long-Term Disability Insurance and Short-Term Disability Coverage is described in the applicable Agreement. Separate accounts shall be established for the Cafeteria Plan, the Medical Reimbursement Plan and the Dependent Care Assistance Plan.

(b) Reduction of Compensation. The amount by which a Participant's Compensation shall be reduced to obtain each of the benefits described in subsection (a) shall be stated in the Benefit Election/Compensation Reduction Agreement described in Section 4.2 and 7.7. The amount by which a Participant's Compensation is reduced shall not be changed during a Plan Year, except as described in Section 7.4 or as follows:

(i) The reduction under any of the plans described in subsection (a) may be changed on account of, and consistent with, the events described in Section 4.3.

(ii) The reduction under any of the plans described in subsection (a) may be changed to satisfy any nondiscrimination rules in the Code, as described in Sections 4.4 and 6.10.

(c) Funding of Benefits. Generally, each Participant's benefits under the Medical Reimbursement Plan and the Dependent Care Assistance Plan shall be funded through the reduction of the Participant's Compensation. Each Participant's benefits under the Cafeteria Plan shall be funded through a District contribution, a combination of a District contribution and the reduction of the Participant's Compensation or a reduction of the Participant's Compensation. For Plan Years ending prior to November 1, 2012, Participants who are eligible under an Agreement shall receive a District contribution in the amount of $750 or such other amount specified in that Agreement, which may be directed, in whole or in part to the Medical

Reimbursement Plan, the purchase of additional Employee Life Insurance or a Cash Benefit. To the extent provided in the applicable Agreement, the amount of a Participant's compensation reduction toward the purchase of Health Care Coverage shall be decreased based upon participation in a health risk assessment. Cash Benefits elected in lieu of Health Care Coverage are paid as described in Section 7.6 below. District Health Savings Account Contributions shall be paid as described in Section 7.9.

All benefits shall be paid from the general assets of District. Nothing in the Plan shall be construed to require District or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

4.2 Election Procedure

(a) During the open enrollment period prior to the commencement of each Plan Year, the Administrator shall make a Benefit Election/Compensation Reduction Agreement form available electronically to each Participant and to each Employee who is expected to become a Participant at the beginning of the Plan Year. As provided in the applicable Agreement, each eligible Participant or Employee shall specify on the Benefit Election/Compensation Reduction Agreement form either the Cash Benefit or Health Care Coverage. If so permitted under an applicable Agreement, an eligible Participant or Employee who does not elect Health Care Coverage, may elect the Dental Coverage and Vision Coverage specified in the Agreement. Employees or Participants who elect Health Care Coverage, Dental Coverage, Vision Coverage, Short-Term Disability Coverage, Long-Term Disability Insurance, Accidental Death and Dismemberment Insurance or Employee Life Insurance for which a premium copayment is required under an Agreement or by law may also elect to make such premium copayment on a pre-tax basis under the Cafeteria Plan. Effective November 1, 2012, each Participant who is

eligible to make deferrals under the Plan to a Health Savings Account shall also specify on the election form the amount, if any, of such deferrals. Each Participant who is eligible to do so under the Agreement applicable to that Participant may also elect to purchase dependent Dental Coverage, Vision Coverage, and/or additional Employee Life Insurance through pre-tax payroll deduction of the entire premium amount. Each Participant or Employee who wishes to participate in the Medical Reimbursement Plan and/or the Dependent Care Assistance Plan shall also specify the amount of his/her pay which should be deferred to the Medical Reimbursement Plan and/or the Dependent Care Assistance Plan. Participants who are eligible under an Agreement to receive a District contribution to be directed to the Medical Reimbursement Plan, additional Employee Life Insurance or a Cash Benefit, shall also specify the amount of the District contribution provided under that Agreement to be directed to the Medical Reimbursement Plan, the purchase of additional Employee Life Insurance or a Cash Benefit. An Employee who is expected to become a Participant and who does not transmit a completed Benefit Election/Compensation Reduction Agreement during the initial election period in which he/she has the opportunity to participate in the Plan shall be deemed to have elected to receive only "core" benefits (which are defined as Health Care Coverage, Dental Coverage, Vision Coverage, Accidental Death and Dismemberment Coverage, Short-Term Disability Coverage, Long-Term Disability Coverage and Employee Life Insurance) and have elected not to participate in either the Medical Reimbursement Plan or the Dependent Care Assistance Plan. All election forms must be completed and transmitted to the Administrator no later than the close of the school day on the date set each year by the Administrator. In the event that an Employee is hired after the start of the Plan Year, such Employee shall be provided with electronic election forms and paper beneficiary forms, if applicable, as soon as practicable after being employed.

Such Employee must complete and transmit the electronic election forms and execute and return all written election forms no later than thirty-one (31) calendar days after the electronic election form is made available to the Employee or after receipt of the written election form, as applicable. The election shall be effective as of the first date on which the Employee is eligible for coverage under the applicable Qualified Benefit.

(b) Subsequent Election. Each Participant must complete a new electronic Benefit Election/Compensation Reduction Agreement for each subsequent Plan Year and transmit it to the District during the annual enrollment period determined by the District. If a Participant does not complete and transmit a Benefit Election/Compensation Reduction Agreement to the District during the enrollment period, the rules described in subsection (a) and Section 7.8 shall apply.

4.3 Irrevocability of Election By the Participant During the Plan Year. Elections made under the Plan (or deemed to have been made under Section 4.2) shall be irrevocable during the Plan Year, subject to a change in family status. A Participant may revoke a benefit election for the balance of a Plan Year and file a new election only if both the revocation and the new election are on account of and consistent with a change in family status as defined under Internal Revenue Code §125 and the accompanying regulations, as the same may be amended from time to time (e.g., change in legal marital status, a change in the number of dependents, a termination or commencement of employment by the Employee, spouse or a dependent, a reduction or increase in hours of employment by the Employee, spouse or dependent (including a switch between part-time and full-time status and a commencement or return from an unpaid leave of absence), a dependent satisfying or ceasing to satisfy the requirements for coverage, a non-dependent child under age 27 satisfying the requirements for coverage, a change in residence or workplace, a significant change in the health coverage of the employee or the

employee's spouse attributable to the spouse's employment (except as provided in Treas. Reg. §1.125-4(f)) or such other events as the Administrator determines will permit a change or revocation of an election) provided that the new election is made within thirty (30) days of the qualifying event and is made as permitted under the applicable insurance policies and the plan documents governing the applicable plans. Any revocation election under this Section shall only be effective at such times as the Administrator shall prescribe but not earlier than one month after the revocation and new election. Further, no revocation and/or new election shall be allowed unless permitted under the insurance contracts, riders and plan documents governing the applicable plans. No change to a Cash Benefit shall allow the Participant to receive more than a pro-rata share of the cash payable for such Plan Year as determined by the Administrator.

In addition, the Administrator may change a Participant's election with respect to Health Care Coverage, Dental Coverage Vision Coverage and/or the Medical Reimbursement Plan to the extent that a judgment, decree, or order requires coverage under a group health plan in which the Participant is enrolled through the District and may permit the Participant to change or cancel such coverage for a dependent if the order requires the former spouse to provide coverage. Further, the Administrator may permit a Participant to make an election change relating to such coverage to the extent that the Participant, Participant's spouse, or dependent becomes entitled to coverage under Medicare or, to the extent required by Code §9801(f), based upon eligibility for employment assistance or a termination of eligibility under a Medicaid plan or a state child health program.

4.4 Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any applicable nondiscrimination requirement imposed by the Internal Revenue Code, the Administrator may take such action as the

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 the elections by highly compensated employees (as defined by the applicable Internal Revenue Code Section for purposes of the nondiscrimination requirement in question).

4.5 Automatic Termination of Election. Elections made under this Plan (or deemed to have been made under Section 4.2) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under those Plans providing qualified benefits may continue if and to the extent provided for under such Plans. Cash Benefits shall only be provided on a pro rata basis where the Employee ceases to be a Participant under the Plan prior to completion of the Plan Year, or the Employee changes his election as provided in Section 4.3 prior to completion of the Plan Year. If insurance policies form a part of any plan, the former Employee shall have all the rights under such policies, including the right to continue the policy in force by paying future premiums, if applicable. The District shall take whatever action is appropriate in the circumstances to transfer ownership of such policy to the terminated Participant upon written request of the terminated Participant.

4.6 Insufficient Participant Contributions. Nothing in this Plan shall prevent the cessation of coverage or benefits under the Plan, in accordance with the terms of each plan, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction or otherwise. Any Participant, whose available compensation for a particular payroll period is less than the amount necessary to pay for the Participant's pre-tax contribution for qualified benefits, may pay the arrearage to the Administrator ratably over twenty (20) pays after the pay day for the payroll period in which the

arrearage occurs. In the event that the Participant's employment ceases prior to full payment of the arrearage, the balance of the arrearage shall become immediately due and payable and may be deducted from any remaining compensation owed to the Participant.

4.7 Limit on Liability to Maintain Policies. The District 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 District 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 District;

(b) To the extent premium notices are received by the District, the District'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 District 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 District 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.

4.8 Receipt of Benefit By A District. Notwithstanding anything contained in the Plan to the contrary, the District's liability to the Participant shall only extend to and shall be limited to any payments actually received by the District, if any, from the insurance company. In the event that the full insurance benefit contemplated is not promptly received by the District, then the District shall notify the Participant of such facts and the District shall no longer have

any legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant and the insurer). The Participant shall be free to settle, compromise or refuse to pursue the claim as he/she, in his/her sole discretion, shall see fit. With regard to those benefits provided in this Plan not covered by insurance, the District's liability shall only extend to paying the cost of said benefits pursuant to this Plan.

ARTICLE V - MEDICAL REIMBURSEMENT PLAN

5.1 This Article Generally.

The District established the Bloomfield Hills Schools Medical Reimbursement Plan for the purpose of providing eligible Employees with the opportunity to receive reimbursement of Qualifying Medical Expenses in a manner which is excludable from gross income under Section 105(b) of the Code. The Medical Reimbursement Plan is intended to qualify as a medical reimbursement plan under Section 105(b) of the Code and is to be interpreted in a manner consistent with the requirements of Section 105(b) of the Code. The Medical Reimbursement Plan is set forth in this Article.

5.2 Establishment of Medical Reimbursement Account.

The District shall establish and maintain a Medical Reimbursement Account for each Participant who elects to receive reimbursement of Qualifying Medical Expenses under the Medical Reimbursement Plan. The Medical Reimbursement Account shall be for bookkeeping purposes only.

5.3 Crediting of Medical Reimbursement Account.

A Participant’s Compensation for each pay period shall be reduced by the amount designated by Participant in his Benefit Election/Compensation Reduction Agreement for the reimbursement of Qualifying Medical Expenses under the Plan, subject to the limitations

described in this Article. Such amounts shall be credited to the Participant's Medical Reimbursement Account. The maximum amount which may be credited to a Participant's Medical Reimbursement Account shall be $2,500 per Plan Year. The minimum amount which a Participant may credit to his/her Medical Reimbursement Account shall be $150 per Plan Year. Effective for Plan Years beginning on or after November 1, 2012, a Participant who may not receive the District Health Savings Account contribution described in Section 7.9 because he or she is not an "eligible individual" as defined in Code §223(c)(1) or because he/she elects not to receive such contribution shall be credited with a District contribution to his/her Medical Reimbursement Account equal to the amount of the District Health Savings Account contribution specified in the applicable Agreement.

5.4 Covered Expenses.

Amounts credited to a Participant's Medical Reimbursement Account shall be used to reimburse the Participant for Qualifying Medical Expenses. For purposes of the Medical Reimbursement Plan, "Qualifying Medical Expenses" means expenses incurred by a Participant, spouse or dependent for medical services and supplies as defined in Section 213 of the Code, 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. 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 Medical Reimbursement Plan.

5.5 Reimbursement of Qualifying Medical Expenses.

Benefits from a Participant's Medical Reimbursement Account for each Plan Year shall be paid only for Qualifying Medical Expenses incurred during that Plan Year. For purposes of this Section, a Qualifying Medical Expense shall be incurred on the date the service or supply is

provided. Active Participants must file all claims for reimbursement no later than 60 days following the end of the Plan Year. All claims for reimbursement by terminated Participants must be filed no later than 60 days after the last day of the month in which the Participant ceases participation in the Plan.

Participants shall be entitled to uniform coverage under their Medical Reimbursement Account throughout the Plan Year. A Participant shall be entitled to reimbursement for claims incurred at any time throughout the Plan Year, regardless of the balance in the Participant's Medical Reimbursement Account. However, claims shall not be reimbursed to the extent they exceed the pay reductions a Participant has allocated to his Medical Reimbursement account for the Plan Year. Claims shall be paid at least monthly.

At the end of a Plan Year or upon termination of the Plan or a Participant's participation in the Plan, all claims shall be paid to the extent of the balance in the Participant's Medical Reimbursement Account.

Notwithstanding any other provision of this Article, as to a Participant in this Medical Reimbursement Plan who has also elected to receive District contributions to a Health Savings Account, the Medical Reimbursement Plan shall not pay to reimburse a medical expense incurred by the Health Savings Account beneficiary other than a medical expense which is considered coverage for dental care or vision care under Code §223(c)(1)(B)(ii).

5.6 Claims for Reimbursement.

(a) A Participant shall request reimbursement, in writing, on a form provided by the Plan Administrator. The form shall include the following information:

(1) The amount, date and nature of the Qualifying Medical Expense for which reimbursement is requested;

(2) The name and address of the person or entity to which the Qualifying Medical Expense was paid;

(3) The name of the person for whom the Qualifying Medical Expense was incurred, an the person's relationship to the Participant;

(4) The amount recovered or expected to be recovered under any insurance arrangement or other source; and

(5) Any other information required by the Plan Administrator.

Any bills, invoices or receipts documenting the Qualifying Medical Expenses shall accompany the form. The Plan Administrator may establish additional procedures for the submission of claims for reimbursement.

The Plan Administrator shall verify each claim for reimbursement and determine whether the claim is for expenses covered by the he Medical Reimbursement Plan. The Medical Reimbursement Plan shall not recognize an assignment of benefits.

(b) Effective for Plan Years beginning on and after November 1, 2009, the Plan Administrator may provide Participants with debit cards which may be used to pay or reimburse Qualifying Medical Expenses. Use of the debit card shall be limited to: (i) physicians, dentists, vision care offices, hospitals, or other medical care providers; (ii) stores with the merchant category code for Drugstores and Pharmacies if, on a location by location basis, 90% of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care described in Code §213(d); and (iii) stores that have implemented an inventory information approval system which complies with Code §125 and the regulations and other applicable guidance thereunder.

Debit cards will be issued and become effective no earlier than the date when an Employee becomes a Participant in the Medical Reimbursement Plan. Each Participant who will be provided with a debit card shall agree in writing, prior to receiving the debit card, that he/she will only use the card to pay for Qualifying Medical Expenses of the Participant (or his/her spouse or dependent who is covered by the Medical Reimbursement Plan), that he/she will not use the debit card for any medical expense that has already been reimbursed, that he/she will not seek reimbursement under any other health plan for any expense paid with the debit card, and that he/she will acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the debit card. A debit card will be automatically cancelled upon the earlier of cessation of a Participant's participation in the Medical Reimbursement Plan or the Participant's cessation of employment with the Employer.

The amount available through the debit card will not exceed the amount by which the Participant elected to reduce his/her compensation to receive reimbursement of Qualifying Medical Expenses under the Medical Reimbursement Plan for the Plan Year, reduced by amounts paid or reimbursed for Qualifying Medical Expenses incurred during the Plan Year. All payments or reimbursements made with the debit card will be substantiated by the Plan Administrator using methods permitted under Code §125 and the regulations and other applicable guidance thereunder. All charges to the debit card shall be treated as conditional pending confirmation and substantiation. Any payments or reimbursements made with the debit card which do not comply with the requirements of this Plan and/or applicable Code requirements shall be corrected using any procedure permitted under Code §125 and the regulations and other applicable guidance thereunder.

5.7 Forfeiture of Medical Reimbursement Account.

If any balance remains in a Participant's Medical Reimbursement Account for a Plan Year after all reimbursements under the Medical Reimbursement Plan have been made, the balance shall be forfeited by the Participant. The balance shall not be carried over to reimburse the Participant for Qualifying Medical Expenses incurred during a subsequent Plan Year.

The total amount forfeited by all Participants at the end of a Plan Year shall be utilized by the District to pay administrative expenses and other expenses under the Plan.

ARTICLE VI - DEPENDENT CARE ASSISTANCE PLAN

6.1 This Article Generally.

The District has established the Bloomfield Hills Schools Dependent Care Assistance Plan for the purpose of providing eligible Employees with the opportunity to receive reimbursement of Dependent Care Expenses in a manner which is excludable from gross income under Section 129 of the Code. The Dependent Care Assistance Plan is intended to qualify as a dependent care assistance plan under Section 129 of the Code and is to be interpreted in a manner consistent with the requirements of Section 129 of the Code. The Dependent Care Assistance Plan is set forth in this Article.

6.2 Establishment of Dependent Care Assistance Account.

The District shall establish and maintain a Dependent Care Assistance Account for each Participant who elects to receive reimbursement for Dependent Care Expenses under the Dependent Care Assistance Plan. The Dependent Care Assistance Account shall be for bookkeeping purposes only.

6.3 Crediting of Dependent Care Assistance Account.

A Participant's Compensation for each pay period shall be reduced by the amount designated by Participant in his Benefit Election/Compensation Reduction Agreement for the reimbursement of Dependent Care Expenses under the Plan, subject to the limitations described in this Article. The amount shall be credited to the Participant's Dependent Care Assistance Accounts.

The maximum amount which may be credited to a Participant's Dependent Care Assistance Account during a calendar year shall be the lesser of the following amounts:

(a) $5,000 ($2,500 in the case of a married Participant filing a separate income tax return); or

(b) An amount equal to the Participant's Earned Income for the calendar year, or, if the Participant is married on the last day of the calendar year, the lesser of the Earned Income of the Participant or his spouse. For purposes of this subsection, a spouse who is a Student or has a Total Disability during any month in which the Participant incurs Dependent Care Expenses shall be deemed to have the following Earned Income for the month:

(i) $200, if there is one Qualified Individual for whom the Participant incurs Dependent Care Expenses; or

(ii) $400, if there is more than one Qualifying Individual for whom the Participant incurs Dependent Care Expenses.

6.4 Covered Expenses.

Amounts credited to a Participant's Dependent Care Assistance Account shall be used to reimburse the Participant for Dependent Care Expenses.

6.5 Reimbursement of Dependent Care Expenses.

Benefits from a Participant's Dependent Care Assistance Account for each Plan Year shall be paid only for Dependent Care Expenses incurred during that Plan Year. For purposes of this Section, a Dependent Care Expense shall be incurred on the date the service is provided. All claims for reimbursement by active Participants must be filed no later than 60 days after the end of the Plan Year. Claims for reimbursement by terminated Participants must be filed no later than 60 days after the end of the end of the month in which the Participant ceases participation in the Plan. Claims shall be paid at least monthly.

Claims shall be paid only to the extent of the balance in the Participant's Dependent Care Assistance Account at the time the claim is filed. If the balance in the Dependent Care Assistance Account is insufficient to pay a claim in full, the unpaid balance of the claim shall be carried over and paid when and if a sufficient amount is credited to the Dependent Care Assistance Account later in the Plan Year.

However, all claims shall be paid to the extent of the balance in the Participant's Dependent Care Assistance Account in any of the following situations:

(a) At the end of a Plan Year;

(b) A Participant terminates participation in the Plan; or

(c) Termination of the Plan.

6.6 No Reimbursement for Amounts Paid to Related Individuals.

The Dependent Care Assistance Plan shall not reimburse a Participant for a Dependent Care Expense owed to the following individuals:

(a) A Dependent of the Participant;

(b) The spouse of the Participant; or

(c) A child of the Participant if the child was under the age of 19 on the last day of the Participant's taxable year during which the Dependent Care Expense was incurred.

6.7 Claims for Reimbursement.

A Participant shall request reimbursement, in writing, on a form provided by the Plan Administrator. The form shall include the following information:

(a) The amount, date and nature of the Dependent Care Expense for which reimbursement is requested;

(b) The name, address and taxpayer identification number of the person or entity to which the Dependent Care Expense was paid;

(c) The name of the person for whom the Dependent Care Expense was incurred, and the person's relationship to the Participant;

(d) The amount recovered or expected to be recovered under any other source; and

(e) Any other information required by the Plan Administrator.

Any bills, invoices or receipts documenting the Dependent Care Expenses shall accompany the form. The Plan Administrator may establish additional procedures for the submission for reimbursement.

The Plan Administrator shall verify each claim for reimbursement and determine whether the claim is for expenses covered by the Dependent Care Assistance Plan. All reimbursement checks shall be made payable to the Participant. The Dependent Care Assistance Plan shall not pay benefits to the dependent care provider and shall not recognize an assignment of benefits.

6.8 Forfeiture of Dependent Care Assistance Account.

If any balance remains in a Participant's Dependent Care Assistance Account for a Plan Year after all reimbursements under the Dependent Care Assistance Plan have been made, the balance shall be forfeited by the Participant. The balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year.

Similarly, if a Participant terminates employment and elects not to continue participation in the Plan, any amount remaining in his Dependent Care Assistance Account after reimbursing all claims incurred while employed by the District shall be forfeited.

The total amount forfeited by all Participants at the end of a Plan Year shall be utilized by the District to pay administrative expenses and other expenses of the Plan.

6.9 Statement of Expenses.

On or before each January 31, the District 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.

6.10 55% Average Benefits Test.

In addition to the nondiscrimination rules described in Section 4.3, the Dependent Care Assistance Plan shall also be subject to the 55% average benefits test described in this Section effective for all Plan Years beginning on or after January 1, 1990.

The average benefits provided to the Participants who are not highly compensated Employees, as defined in Section 414(q) of the Code, under all of the District's dependent care assistance plans must be at least 55% of the average benefits provided to all Participants who are highly compensated Employees under all of the District's dependent care assistance plans, as provided under Section 129(d)(8) of the Code. For purposes of performing such average benefits test, there shall be excluded from consideration those employees described in Code Section 129(d)(8)(B) and in Section 129(d)(9).

The District shall conduct periodic testing immediately before and/or during each Plan Year to determine if the 55% average benefits test is being satisfied. As of the first date during a Plan Year the District's testing indicates that the 55% average benefits test shall not be satisfied, the Benefit Dollars allocated to the Dependent Care Assistance Plan on behalf of Participants who are highly compensated employees shall be reduced on a pro rata basis to the extent necessary to satisfy the 55% average benefits test.

6.11 Definitions.

The following terms used in the Dependent Care Assistance Plan and other documents relating to the Dependent Care Assistance Plan shall have the meanings described in this Section.

(a) **"Dependent"** means an individual who is a dependent of a Participant within the meaning of Section 151(c) or Section 21(e)(5) of the Code.

(b) **"Dependent Care Expenses"** means expenses for Dependent Care Services and Household Services which are necessary for the Participant to be gainfully employed.

(c) **"Dependent Care Services"** means 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.

The Dependent Care Service may be provided by a day care center. For purposes of this Section, "day care center" means an establishment which satisfies the following requirements:

(i) Complies with all applicable laws and regulations of the state and city, town or village in which it is located;

(ii) Provides care for more than six individuals (other than individuals who reside at the day care center); and

(iii) Receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether the facility is operated or a profit).

(d) **"Earned Income"** means all income derived from wages, salaries and other Compensation (such as disability benefits). Earned Income does not include any amounts received:

(i) Under the Dependent Care Assistance Plan or any other dependent care assistance program under Section 129 of the Code;

(ii) As a pension or annuity; or

(iii) As unemployment or workers' compensation.

(e) **"Household Services"** means household services performed in and about the Participant's home which are ordinary and necessary to the

maintenance of a household and which are attributable in part to the care of a Qualifying Individual. For example, amounts paid for the services of a domestic maid or cook are expenses for Household Services if part of the services are provided to the Qualifying Individual.

(f) **"Qualifying Individual"** means:

(i) A Dependent who is under the age of 13 or has a Total Disability; or

(ii) A spouse who has a Total Disability.

The status of a person as a Qualifying Individual is determined on a day-to-day basis.

(g) **"Student"** means an individual who, during each of five calendar months during a Plan Year, is a full-time student at an educational institution. For purposes of the Dependent Care Assistance Plan, "educational institution" means a college or university which satisfies the following requirements:

(i) Its primary function is to present formal instruction;

(ii) It normally maintains a regular faculty and curriculum; and

(iii) It normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly conducted.

(h) **"Total Disability"** means a physical or mental condition which makes a person incapable of caring for his hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his personal safety or the safety of others.

ARTICLE VII - CAFETERIA PLAN

7.1 This Article Generally.

The District established the Bloomfield Hills Schools Cafeteria Plan for the purpose of providing eligible Employees with the opportunity to make premium co-payments on a pre-tax basis, make and receive pre-tax Health Savings Account contributions and to receive cash in lieu of Qualified Benefits under Section 125 of the Code. The Cafeteria Plan is intended to qualify as a cafeteria plan under Section 125 of the Code and is to be interpreted in a manner consistent with the requirements of Section 125 of the Code. The Cafeteria Plan is set forth in this Article.

7.2 Establishment of Cafeteria Plan Account.

The District has established and maintained a Cafeteria Plan Account for each Participant who is eligible under an Agreement to elect to receive cash in lieu of a Qualified Benefit and who elects to do so or who is required by an Agreement or by law to make Participant contributions to the Plan in the form of premium co-payments. The Cafeteria Plan Account shall be for bookkeeping purposes only.

7.3 Crediting of Cafeteria Plan Account.

A Participant's Compensation for each pay period shall be reduced by the amount specified in his/her Benefit Election/Compensation Reduction Agreement for his/her Participant contribution to premium payments under the Cafeteria Plan. The amount shall be credited to the Participant's Cafeteria Plan Account.

7.4 District Contributions and Participant Contributions. The District shall make such contributions and premium payments as are required in order to provide the Cash Benefits or the benefits payable under an Agreement as described herein. In addition, the District shall make Health Savings Account contributions on behalf of Participants as provided in Section 7.9

of the Plan. Participants shall make contributions to premium payments as required by the applicable Agreement or as required by the District on a nondiscriminatory basis by means of compensation reduction agreements set forth in the applicable Benefit Election/Compensation Reduction Agreement. Any eligible Employee or Participant who elects coverage under Health Care Coverage which is a "high deductible health plan" as defined in Code §223(c)(2) may designate the amount of his/her deferrals under the Plan to a Health Savings Account, provided that the beneficiary of the Health Savings Account is an "eligible individual" as defined in Code Section 223(c)(1) and the requirements of Section 7.9 of the Plan are satisfied.

In the event that the amount of a Participant's share of the cost changes, the amount of such Participant's pre-tax compensation reduction shall be adjusted to reflect the new cost. The amount of each Cash Benefit distribution is disclosed in the applicable Agreement. The amount of premium cost for each benefit plan is disclosed in the applicable insurer's premium schedule which is provided to the District each year. Each Participant is responsible for co-payments and deductibles applicable to the Participant and/or Participant's covered dependents under the terms of the various Qualified Benefit plans.

7.5 Health Care Coverage. Based on the election of each Employee pursuant to the provisions of Section 7.7 and subject to the provisions of the applicable Agreement, cash or benefits shall be provided under the applicable Agreement. Cash Benefits shall be paid directly from the District pursuant to the provisions of Section 7.6. All other benefits shall be paid from the various Health Care Coverage plans described in the Agreements.

The types and amounts of benefits available, the requirements for participating in such benefits and the other terms and conditions of coverage and benefits are set forth from time to time in the various benefit plan documents which govern the Health Care Coverage, and in the

group insurance contracts and riders that constitute (or are incorporated by reference in) such plans. The benefit provisions in such plans, contracts and riders, as in effect from time to time, are hereby incorporated by reference into this Plan.

At the time any Employee is eligible to participate in an elected benefit which is fully or partially insured, it shall be the responsibility of such Employee to apply to any insurance carrier for the insurance provided for under this Plan, and to otherwise satisfy the health and other requirements for such insurance.

7.6 Cash Benefits.

Based on the election of each Employee or Participant pursuant to the provisions of Section 7.7, Cash Benefits are only available for those who are eligible under an Agreement to elect a Cash Benefit, and who elect the specific Cash Benefit options available under an Agreement. Subject to the provisions of Section 4.4, payment of the cash compensation available under the Cash Benefit option is made in equal installments with the first payroll of each month from November through June and September through October. Cash Benefits for the short Plan Year from November 1, 2012 – December 31, 2012 shall be paid as described in the Agreement providing for such Cash Benefits. No Cash Benefit shall be paid to an Employee who is no longer a Participant as defined in Section 2.22.

7.7 Election Procedure.

During the open enrollment period prior to the commencement of each Plan Year, the Administrator shall make available electronic Benefit Election/Compensation Reduction Agreement forms to each Participant and to each Employee who is expected to become a Participant at the beginning of the Plan Year. Each Participant who is eligible under an Agreement to elect a Cash Benefit in lieu of Health Care Coverage (and the associated District

Health Savings Account contribution, if applicable) shall specify on the appropriate electronic election form either the Cash Benefit or Health Care Coverage. Each Participant who is eligible to make deferrals under the Plan to a Health Savings Account shall also specify on the election form the amount, if any, of such deferrals. All election forms must be transmitted to the Administrator no later than the close of the school day on the date set each year by the Administrator.

In the event that an Employee is hired after the start of the school year, such Employee shall be provided with electronic election forms and paper beneficiary designation forms, if applicable, as soon as practicable after being employed. Such Employee must complete and transmit all electronic election forms and execute and return all paper beneficiary designation forms no later than thirty (30) calendar days after the electronic election form is made available or receipt of the paper beneficiary designation form, as applicable.

Subject to applicable federal law, benefit coverages shall only apply during the period of actual employment based on the election of each such Employee.

7.8 Failure to Elect. Any Participant who fails to complete and transmit a new election form by the specified due date set forth in the preceding sections shall be deemed to have elected to receive only the Cash Benefit in lieu of Health Care Coverage and to have declined to participate in the Medical Reimbursement Plan and the Dependent Care Assistance Plan. A Participant who has elected to make pre-tax deferrals to a Health Savings Account and who fails to complete a Benefit Election/Compensation Reduction Agreement Form modifying his/her election to make such deferrals, shall be deemed to have elected to cease Health Savings Account deferrals, provided however, that a Participant may prospectively modify an election to

make pre-tax deferrals to a Health Savings Account during any calendar month prior to the calendar month in which the modification is to take effect.

7.9 Health Savings Accounts

(a) A Participant who is an "eligible individual" as defined in Code Section 223(c)(1), may make pre-tax deferrals from his/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 entitled to benefits under Medicare; and (4) must not be claimed as a dependent on another person's tax return.

(b) Pursuant to an Agreement, the Employer may offer as a Health Care Coverage option a high deductible health plan. Participants who select a benefit option other than the high deductible health plan for any month shall not be eligible to make deferrals to a Health Savings Account for that month.

(c) If a Participant elects to make deferrals to a Health Savings Account under this Plan and also elects to participate in a medical reimbursement plan sponsored by the Employer, such medical reimbursement plan shall not pay or reimburse a medical expense incurred by the Health Savings Account beneficiary other than a medical expense which is considered coverage for dental care or vision care under Code Sec. 223(c)(1)(B)(ii).

(d) Deferrals to a Health Savings Account must be made in cash and shall not exceed the sum of the monthly limits provided in Code Section 223(b) as modified by the Secretary of Treasury from time-to-time. For 2012, those limits are defined as:

(i) Self-only: $3,100

(ii) Family Coverage: $6,250.

A Participant who is 55 or older before the close of the taxable year may make additional "catch-up" contributions as provided in Code Section 223(b)(3). The maximum catch-up contribution amount for 2012 is $1,000. These limitations shall be reduced by the amount of any Employer HSA contributions made on behalf of an individual for a tax year.

(e) To the extent provided in an Agreement, the District shall make contributions to the HSA of a Participant who is an "eligible individual" as defined in Code Section 223(c)(1). Such contributions shall comply with the non-discrimination requirements of Code Section 125 and shall not exceed the maximum amount permitted by Code Section 223.

ARTICLE VIII - FUNDING

8.1 Funding of Reimbursement Accounts.

A Participant's benefits under the Medical Reimbursement Plan and the Dependent Care Assistance Plan shall be funded through the pay reductions a Participant has allocated to his Medical Reimbursement Account and Dependent Care Assistance Account. As to Participants covered by the Administrative Council Agreement, a Participant's benefits under the Medical Reimbursement Plan may also be funded by District contributions as specified in that Agreement. A Participant's benefits under the Cafeteria Plan shall be funded through a combination of District contributions and the pay reductions a Participant has allocated to his/her Cafeteria Plan Account. The Accounts shall be for bookkeeping purposes only. All benefits shall be paid from District's general assets. Nothing in the Plan shall be construed to require District or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

ARTICLE IX - ADMINISTRATION OF THE PLAN

9.1 Plan Administrator. The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan subject to the terms of the applicable Agreement. The Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) To interpret the Plan, its interpretations thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any persons to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan, and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities

under the Plan, any such allocation, delegation or designation to be in writing.

Notwithstanding the foregoing, any claim which arises under the various Health Care Coverage, Dental Coverage, Vision Coverage, Employee Life Insurance, Accidental Death and Dismemberment Insurance, Long-Term Disability Insurance or Short-Term Disability Coverage plans described in the Agreements shall not be subject to review under this Plan, and the Administrator's authority under this Section 9.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan.

9.2 Examination of Records. The Administrator will make available to each Participant such of his records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

9.3 Reliance on Opinions. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the Health Care Coverage, Dental Coverage, Vision Coverage, Accidental Death and Dismemberment Insurance, Employee Life Insurance, Long-Term Disability Insurance and Short-Term Disability Coverage plans, or by accountants, counsel or other experts employed by the Administrator.

9.4 Discretionary Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in its sole and absolute discretion.

9.5 Indemnification of Administrator. The District agrees to indemnify and to defend to the fullest extent permitted by law any employee of the District serving as the

Administrator or as a member of the committee designated as Administrator (including any employee or former employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the District) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

9.6 Claims Procedure. Any claim which arises under any plan providing medical, dental or other benefits hereunder shall be subject to the claims procedure applicable to such plan.

ARTICLE X - AMENDMENT AND TERMINATION OF THE PLAN

10.1 Right to Amend and Terminate Subject to the applicable Agreement, the Plan may be amended or terminated at any time from time to time by a written instrument executed by a duly authorized officer of the District, providing such amendment or termination is communicated to those employees participating in this Plan by posting a notice on the District bulletin board or a mailing to their last known address. Termination of the Plan shall not eliminate a Participant's right to claim reimbursement in accordance with the provisions of the Plan to the extent that there are amounts credited to the Participant's Accounts sufficient to provide such reimbursement.

ARTICLE XI - MISCELLANEOUS PROVISIONS

11.1 Information to be Furnished. Participants shall provide the District and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

11.2 Limitation of Rights. Neither the establishment of the Plan or any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other

person any legal or equitable right against the District or Administrator, except as provided herein.

11.3 Governing Law. This Plan shall be construed, administered and enforced according to the laws of Michigan.

11.4 Nonassignability of Rights. The rights of any Participant to receive any benefits under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

11.5 No Guarantee of Tax Consequences. Neither the Administrator nor the District 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 or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant.

11.6 Employment. Participation in this Plan shall not give any employee the right to be retained in the District's employ, or any right or interest in this Plan other than as provided herein.

11.7 Release of School District. Any payment to or for any Participant, or his or her legal representative or beneficiary in accordance with the provisions of this Plan or any other plan incorporated herein by reference, shall to the extent thereof be in full satisfaction of all claims hereunder against the District.

11.8 Insurance Contracts. No insurance company which may issue any contract upon the application of the Administrator shall be required to take or permit any action contrary

to the provisions of such contract; or be bound to allow a benefit or privilege to any person interested in any contract it has issued which is not provided in such contract; or be deemed to be a part of this Plan for any purpose; or be responsible for the validity of this Plan; or be required to look into the terms of this Plan or question any act of the District or Administrator hereunder; or be required to see that any action of the District or Administrator is authorized by this Plan. Any such issuing company shall be fully discharged from any and all liability for any amount paid pursuant to its contract; and no issuing company shall be obligated to see to the application of any monies so paid by it. Any such issuing company shall be fully protected in taking or permitting any action on the faith of any instrument executed by the Administrator and shall incur no liability for doing so.

11.9 Incapacity of Participant. If any Participant entitled to receive benefits hereunder shall be physically or mentally incapable of receiving or acknowledging receipt thereof, but no legal representatives have been appointed for him, the Administrator may cause any benefit otherwise payable to him to be made to one or more persons as chosen by the Administrator, and any payment so made shall be a complete discharge of all liability under the plan in respect to such payment.

11.10 HIPAA Privacy and Security Compliance. The Plan will disclose Protected Health Information (PHI) to the Employer (herein the Plan Sponsor) only for the purposes permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the HIPAA privacy regulations. As a condition of receiving PHI, the Plan Sponsor will:

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

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

(c) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

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

(e) Make available PHI in accordance with 45 CFR §164.524 and make electronic PHI available as required by 42 USC §17935(e);

(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;

(g) Comply with an individual's request that his/her PHI not be disclosed if the disclosure is for payment or health care operations and the PHI pertains solely to an item for which the individual has paid the health care provider out of pocket and in full as required by 42 USC §17935(a);

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528 and an accounting of disclosures via electronic health record of PHI for

payment, treatment or health care operations as required by 42 USC §17935(c);

(i) Notify affected individuals of a privacy or security breach involving their unsecured protected health information as required by 42 USC §17932(a);

(j) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy regulations;

(k) If feasible, return or destroy all PHI received from the Plan that the plan sponsor 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;

(l) Ensure that there is adequate separation between the Plan and the Plan Sponsor as required by 45 CFR §164.504(f)(2)(iii); and

(m) Certify to the Plan that the plan documents have been amended to incorporate the requirements of 45 CFR §164.504(f)(2).

No employees or classes of employees of the plan sponsor will be given access to protected health information as the Plan does not receive, maintain, use or disclose PHI. In the event that the Plan does receive, maintain, use or disclose PHI in the future, the classes of

employees of the plan sponsor who will be given access to PHI will be identified. The access of these employees or classes of employees shall be restricted to plan administration functions that the plan sponsor performs for the group health plan. In the event that any of the employees described in this section fail to comply with this Section 11.10 of the Plan, they shall be subject to sanctions consistent with the Plan Sponsor's employment policies, up to and including termination from employment.

Effective April 20, 2006, where Electronic Protected Health Information will be created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that the Plan sponsor creates, receives, maintains or transmits on behalf of the Plan;
2. The Plan Sponsor shall ensure that the adequate separation that is required by 45 CFR §164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
4. The Plan Sponsor shall report to the Plan any Security Incidents, as defined in 45 CFR §164.304, of which it becomes aware; and

5. Upon request by the Plan, the Plan Sponsor will report to the Plan any Security Incident of which it becomes aware.

These provisions concerning Electronic Protected Health Information shall not apply when the only Electronic Protected Health Information disclosed to the Plan Sponsor is disclosed pursuant to 45 CFR §164.504(f)(1)(ii) or (iii), or as authorized under 45 CFR §164.508.

IN WITNESS WHEREOF, the District has caused this Plan to be executed in its name and behalf this____ day of December, 2012, by its officer thereunto duly authorized.

Bloomfield Hills Schools

By:_____

Its:_____