BALDWIN COMMUNITY SCHOOLS

SECTION 125 PLAN

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BALDWIN COMMUNITY SCHOOLS

SECTION 125 PLAN

Baldwin Community Schools, a Michigan Public School District, amends and restates the Baldwin Community Schools Section 125 Plan.

ARTICLE 1

ESTABLISHMENT

1.1 Establishment of Plan.

This flexible benefits plan ("Plan") is established by the Employer to permit eligible Employees to choose among benefits offered by the Plan in amounts that meet the particular needs of the Employee. Each Qualified Benefit together with the provisions for its eligibility, contributions and the other provisions of this Plan shall constitute a separate written Plan under the Code.

(a) Employer. "Employer" means Baldwin Community Schools.

(b) Plan History. A schedule that states the effective date of this Plan and certain amendments is attached as Schedule A.

(c) Collective Bargaining. This plan is maintained in part to implement the terms of a Collective Bargaining Agreement between the Employer and the Michigan Education Association (MEA).

1.2 Exclusive Benefit.

The Plan is established and shall be operated for the exclusive benefit of Participants and their eligible Dependents.

1.3 Compliance With Law.

This document is intended to establish a qualified cafeteria plan under Section 125 of the Internal Revenue Code of 1986 ("Code"), as amended, and all Regulations issued under the Code.

1.4 Effective Dates of Plan Provisions.

"Effective Date" of this Amendment and Restatement is July 1, 2008. Each Plan provision applies from its effective date until the effective date of an amendment.

ARTICLE 2

DEFINITIONS

A table showing the location of definitions for defined terms appears immediately after the table of contents.

2.1 Compensation.

"Compensation" means an Employee's W-2 earnings without reduction for contributions under this Plan or any qualified retirement program under Code Sections 402(a)(8) (401(k) plan), 402(h) (SEP), 403(b) (tax sheltered annuity) or 457 (deferred compensation government or tax exempt).

2.2 Highly Compensated Employee.

A "Highly Compensated Employee" is:

(a) Cafeteria. For purposes other than medical or dependent care benefit nondiscrimination requirements, any Employee who during the Plan Year was an officer; a 5% owner; highly compensated; or the spouse or a dependent of that Employee. For this purpose, Employees who have not completed one year of service and have not attained age 21 within the meaning of Code Section 410(b) may be excluded.

(b) Medical. For purposes of a medical pre-tax premium payment benefit nondiscrimination requirements, any Employee who during the Plan Year was a 10% owner of the Employer; was one of the top 5 officers ranked on the basis of compensation; or was in the top 25% of all Employees ranked on the basis of compensation. An Employee for this purpose excludes one with less than 3 years of service before the beginning of the Plan Year, one who has not attained age 25, one who is customarily employed less than 25 hours per week or less than 7 months per year, one who is covered by a collective bargaining agreement if accident and health benefits were the subject of good faith bargaining, and one who is a nonresident alien who receive no earned income from sources within the United States.

2.3 Key Employee.

"Key Employee" means an Employee who is or was at any time during the Plan Year a corporate officer who earns more than $150,000 (as adjusted under Code section 416(i)(1)).

2.4 Plan Year.

"Plan Year" means the 12-month period beginning each July 1.

2.5 Related Employer.

"Related Employer" means (i) each corporation other than the Employer that is a member of a controlled group of corporations, as defined in Code Section 414(b), of which the Employer is a member; (ii) each trade or business other than the Employer whether or not incorporated, under common control of or with the Employer under Code Section 414(c); (iii) each member other than the Employer of an affiliated service group, as defined in Code Section 414(m), of which the Employer is a member; and (iv) any other entity required to be aggregated with the Employer by Regulations under Code Section 414(o).

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

(a) Requirements. An Employee in Covered Employment shall be eligible to become a Participant in the Plan:

(i) Pre-Tax Premium Payment. For Pre-Tax Premium Payment benefits (if approved by Employer), on the entry date of the plan to which premium payments are applied.

(ii) Other Benefits. For all other Qualified Benefits, on the first Entry Date following the Employee's completion of one (1) hour of service in Covered Employment and filing of an Election Form with the Administrator.

(b) Employee. "Employee" means an individual receiving Compensation from the Employer.

(i) Exclusions. Employee excludes a Self-Employed Individual and a 2% or more shareholder of the Employer if the Employer is an S Corporation. A Self-Employed Individual is an individual who has earned income from self-employment with the Employer for the Plan Year (including an individual who would have had earned income if the Employer had had net profits for the Plan Year).

(ii) Employee Classifications. The employer may create different classes of employees that will be subject to different eligibility requirements and have different benefits available. These include: Administrative/Clerical, MEA Teachers and MEA Support Staff.

(c) Entry Date. "Entry Date" means the first day of the first payroll period following a Participant's completion of the Eligibility requirements.

(d) Continuous Employment. "Continuous Employment" means covered employment with the Employer since the Employee's most recent date of hire without a Break in Continuous Employment.

(e) Nondiscriminatory Classification. The Plan must be available to a group of Employees that does not discriminate in favor of Highly Compensated Employees - Cafeteria. The group of Employees eligible for:

(i) Medical Care. Pre-Tax Premium Payment - Medical must be available to 70% or more of all Employees; 80% or more of all Employees eligible if 70% or more of all Employees are eligible; or a classification of employees which does not discriminate in favor of Highly Compensated Employees.

(ii) Group Term Life. Group Term Life Benefits must be 70% or more of all qualifying Employees; a group of Participants at least 85% of which are not Key Employees; or a classification of Employees which does not discriminate in favor of Key Employees.

3.2 Covered Employment.

"Covered Employment" means all employment with the Employer excluding any employment by: students, part-time MEA support staff employees, MEA teacher employees and administrative and clerical employees regularly scheduled to work less than 20 hours per week, leased employees, self-employed individuals, employees covered by a Collective Bargaining Agreement under which this Plan is not adopted and the Employer has engaged in good faith negotiations regarding Qualified Benefits, employees covered by a Collective Bargaining Agreement which excludes them from Covered Employment, and employees of a Related Employer.

3.3 Election Form.

Each eligible Employee shall, during the Initial and each Annual Enrollment Period, complete an Election Form that specifies the amount of each type of benefit desired and that authorizes reduction in compensation in an amount equal to the amount of Contributions required to provide the benefits elected.

(a) Enrollment Period. The Initial Enrollment Period for a newly hired employee shall be until the end of the month which includes the completion of eligibility requirements. The Annual Enrollment Period shall be the period from July 1 though September 15.

(b) Failure to Enroll.

(i) Full Time Employees. A Full-Time Participant who fails to return a completed Election Form during the Initial Enrollment Period shall be deemed to have elected to receive the least level of benefits provided to similarly situated Employees in the Participant's employment classification that do not require Participant contributions. A Full-Time Participant who fails to return a completed Election Form during an Annual Enrollment Period for any Plan Year shall be deemed to have elected to receive the same level of benefits as previously elected on the most recent election form. Except as permitted below, an Election may not be made after the end of the applicable Enrollment Period.

(ii) Part Time Employees. A Part-Time Participant who fails to return a completed Election Form during the Initial Enrollment Period shall be deemed to have elected to receive the least level of benefits provided to similarly situated Employees in the Participant's employment classification that do not require Participant contributions. A Part-Time Participant who fails to return a completed Election Form during an Annual Enrollment Period for any Plan Year shall be deemed to have elected to receive the same level of benefits as previously elected on the most recent election form. Except as permitted below, an Election may not be made after the end of the applicable Enrollment Period.

(c) Modifications by Administrator. The Administrator may, without a Participant's consent, modify a Participant's Election Form:

(i) Premium Change. Under the Pre-Tax Premium Payment program (if adopted by Employer), to conform to a change in the Participant's medical benefits plan premium subject to the provisions under Section 3.5(a).

(ii) Nondiscrimination. To permit the Plan to satisfy any non-discrimination requirement or limitation on benefits imposed by the Code.

(iii) Medical Child Support Orders. To adhere to the terms of a Qualified Medical Child Support Order (AQMCSO@).

(A) QMCSO. A "QMSCO" is any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) that:

(1) Relates to Child Support. Relates to the provision of child support related to health benefits for a child of a Participant of a group health plan;

(2) Valid under State Law. Is authorized by state domestic relations law; and

(3) Right of Alternate Recipient. Creates or recognizes the right of an Alternate Recipient, or assigns to an Alternate Recipient, the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits. An "Alternate Recipient" is the Participant's child or a foster child who is a dependent of the Participant.

(4) Other Requirements. Specifies the name and last known mailing address of the Participant and the name and address of each Alternate Recipient covered by the order; describes the coverage to be provided by the group health plan or the manner in which the coverage is to be determined; and specifies the period of coverage that must be provided and each plan to which the order applies.

(B) QMCSO Plan Procedures. The Plan Administrator shall promptly notify the Participant and each Alternate Recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and each Alternate Recipient of its determination. If the Participant or any affected Alternate Recipient objects to the determination of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

(C) QMCSO Limitations. A QMCSO shall not require the Plan to provide any type or form of benefit, or any option, that it is not already providing except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act.

(D) Plan Must Recognize QMCSO. Upon determination of an order as a QMCSO, the Plan shall provide benefits for the Participant's child as required by the order and must permit the parent to enroll any child who is otherwise eligible for coverage without regard to any enrollment period restrictions.

3.4 Irrevocability of Election.

A Participant may not revoke or otherwise change an Election made for a Plan Year unless, after the Plan Year begins, the Participant experiences one of the changes specified in this Section or Section 3.5.

(a) Special Election Changes for Health Coverage. A Participant may make a mid-year change to health care coverage under the following circumstances:

(i) HIPAA Enrollment Rights for Loss of Other Coverage or New Dependent. To conform with any special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

(ii) COBRA Eligibility. To increase an Election under this Plan in order to pay for the Continuation Coverage if a Participant or Dependent becomes eligible for and elects COBRA Continuation Coverage under a group health plan of the Employer.

(iii) QMCSO. To provide coverage for a Participant's child if a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody requires health coverage for the Participant's child. If a judgment, decree, or order requires the former spouse of the Participant, or the Participant's spouse, to provide coverage for the child and the coverage is actually provided, the Participant may make an Election change to cancel coverage for the child covered by the order. For purposes of this paragraph, a foster child that is a Dependent of the Participant shall be considered the Participant's child.

(iv) Entitlement to Medicare or Medicaid. To cancel coverage for a Participant or Dependent if the Participant or Dependent becomes entitled to coverage under Medicare or Medicaid. Likewise, if a Participant or Dependent entitled to coverage under Medicare or Medicaid loses such coverage, the Participant may elect to commence or increase accident or health coverage of that individual under this Plan.

(v) HIPAA Enrollment Rights for Medicaid/Children's Health Insurance Program Coverage. To elect coverage in this Plan if the Participant or Dependent were eligible for, but not enrolled in this Plan, and the Participant's or Dependent's coverage under a Medicaid plan or state's Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility or, if the Participant or Dependent becomes eligible for a premium assistance subsidy to this Plan under a Medicaid plan or state CHIP.

(b) Mid-Year Change in Status. A Participant may change an Election of any coverage under this Plan during the Plan Year, if the Participant experiences any of the following changes in status:

(i) Marital Status. Events that change the Participant's legal marital status including marriage, divorce, legal separation, annulment of marriage, or death of a spouse of the Participant.

(ii) Number of Dependents. Events that change a Participant's number of dependents, including birth, adoption, placement for adoption or death of a child of the Participant.

(iii) Employment Status. Any of the following changes of employment status of the Participant, the spouse, or other Dependent of the Participant that affect benefits eligibility: termination or commencement of employment; a strike or lock out; commencement of, or return from, an unpaid leave of absence; change of work site, or any other change in employment status that results in the affected individual becoming, or ceasing to be, eligible for a cafeteria plan or other employee benefit plan of the affected individual's employer (e.g., switching from hourly-paid status to salaried when the applicable coverage requires status as a salaried employee for eligibility).

(iv) Dependent Status. A Dependent satisfying or ceasing to satisfy the requirements for Dependent status under this Plan or any benefit offered under this Plan on account of age, student status or any similar circumstance.

(v) Residence. A change in the residence of the Participant, spouse, or other Dependent.

(vi) Internal Revenue Service Guidance. Any other event that permits a change or revocation of a Participant's Election for this Plan under any provision of the Internal Revenue Code or under any regulation or ruling.

(c) Change in Status Election. Except with respect to group-term life insurance, long-term disability coverage, and accidental death and dismemberment coverage, any Change in Status mid-year Election change permitted by Section 3.4(b), must meet the following requirements of this subsection:

(i) General Consistency Rule. The Change in Status must result in the Participant, spouse, or other dependent gaining or losing coverage under this Plan or under a plan of the spouse's or dependent's employer. If the Change in Status is due to a Participant, spouse, or Dependent, gaining coverage under the plan of a spouse or Dependent, the Participant must certify that the Participant, spouse, or Dependent, has or will obtain coverage under the other plan. In addition, the Participant's Election change must correspond to the gain or loss of coverage caused by the status change.

(ii) Special Consistency Rule - Dependent Care Reimbursement. For purposes of Dependent Care Reimbursement benefits, an Election change must be on account of and correspond with a Change in Status that affects eligibility of the expenses for the tax exclusion available under Code Section 129.

(iii) Filed Within Time Limit. A Participant who experiences a Change in Status may revoke an existing Election and file a new Election for the balance of the Plan Year. The new Election must be filed within 30 days of the Change in Status event. A new Election in the case of a HIPAA special enrollment right under a Medicaid plan or CHIP must be filed no later than 60 days after the date the Medicaid or CHIP coverage terminates or the date the Participant is determined to be eligible for such assistance. A new Election shall be effective no earlier than the date that the completed Election Form is returned to the Plan Administrator, except that, if the new Election is made due to HIPAA special enrollment rights on account of gaining a new dependent, the Election will be effective from the date of the birth, adoption, or placement for adoption of a child or, in the case of marriage, no later than the first day of the month following the marriage.

(d) FMLA Election Rights. A Participant on leave under the Family and Medical Leave Act (FMLA), may revoke an Election for group health coverage for the duration of FMLA leave or for the remainder of the Plan Year. Following a Participant's return from FMLA leave, the Participant may elect to reinstate group health coverage for the remainder of the Plan Year. The reinstated group health coverage will be on the same terms as prior to the Participant's FMLA leave, unless the Participant is eligible to change his or her Election.

(e) USERRA Election Rights. A Participant on leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), may revoke an Election for group health coverage for the duration of USERRA leave or for the remainder of the Plan Year. Following a Participant's return from USERRA leave, the Participant may elect to reinstate group health care coverage for the remainder of the Plan Year. The reinstated group health coverage will be on the same terms as prior to the Participant's USERRA leave, unless the Participant is eligible to change his or her Election.

(f) Reemployment. An Employee who has incurred a Break in Continuous Employment (other than one returning to Covered Employment from noncovered employment) shall be required to complete the eligibility requirements after the rehire (or return to Covered Employment).

3.5 Cost or Coverage Changes – Pre-Tax Premium Payments.

Mid-Year Election changes are permitted under this section for Pre-Tax Premium Payments (if adopted by Employer) if any of the following events occur:

(a) Significant Cost Change. If the cost of coverage significantly increases, an affected Participant may either make a corresponding change in an Election or revoke the Election and elect, on a prospective basis, coverage under another benefit option with similar coverage. If there is no similar coverage, an affected Participant may drop the coverage. If there is a significant mid-year decrease in the cost of a benefit, an eligible Employee (including an employee who has not previously participated in the Plan) may change his or her Election in order to elect that less expensive option.

(b) Cessation or Curtailment of Coverage. If coverage ceases or is significantly curtailed during the Plan Year, an affected Participant may revoke an Election under the Plan, and may prospectively elect coverage under another benefit option with similar coverage. If the significant curtailment constitutes a loss of coverage, the Participant may drop the coverage if no similar coverage is available under this Plan.

(i) Significant Curtailment. Coverage under an accident or health plan is significantly curtailed only if there is an overall general reduction in coverage provided to Participants under the Plan.

(ii) Loss of Coverage. A loss of coverage means a complete loss of coverage under the benefit package option including the elimination of a benefits package option, an HMO ceasing to be available in the area where the Participant resides, the Participant reaching an overall annual or lifetime limit; a substantial decrease in the number of medical care providers available under the option; a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or Dependent is currently in a course of treatment; or any other similar, fundamental loss of coverage.

(c) Addition or Elimination of Coverage. If a new insurance coverage option is added or significantly improved, an affected Participant may prospectively revoke an Election and elect to receive coverage under the new option and make corresponding changes to other options with similar coverage. If an insurance coverage option is eliminated, an affected Participant may make a new Election for an option with similar coverage.

(d) Changes in Coverage Under Another Employer's Plan. A Participant may prospectively change an Election if it corresponds to a change made under a cafeteria or qualified benefits plan of the employer of a spouse, former spouse, or other Dependent if the other employer's plan permits its participants to make an Election change that would be permitted under this Plan, or if the other plan permits its participants to make an Election for a period of coverage different from the Plan Year.

(e) Other Loss of Group Health Coverage. A Participant may prospectively change an Election to add coverage under the Plan for the Participant, spouse, or Dependent if the Participant, spouse or Dependent loses coverage under any group health program sponsored by a governmental or educational institution.

(f) Similar Coverage. Coverage for the same category of benefits for the same individuals is considered to be similar coverage for purposes of this section. Coverage provided by another employer's plan may constitute similar coverage.

3.6 Cessation of Participation.

Except as provided in Section 3.7, a Participant's participation and benefits shall cease when a Participant incurs a Break in Continuous Employment. A Break in Continuous Employment shall occur (and a new date of hire shall be established) by an Employee's: resignation, involuntary termination, death, total and permanent disability, failure to return to work upon expiration of an approved leave of absence, FMLA leave or USERRA leave, layoff without recall for a period of one month or more, or transfer to employment other than Covered Employment (a Break in Continuous Employment).

3.7 Extension of Participation - COBRA Continuation Coverage.

If the Employer is subject to the Comprehensive Omnibus Budget Reconciliation Act of 1985, as amended, a Qualified Beneficiary who has elected Pre-Tax Premium Payments (if adopted by Employer) benefits may elect to continue participation until the end of the Plan Year by returning a modified Election Form to the Plan Administrator and by making after-tax contributions, if applicable, as provided under Paragraph 4.3(a) (Continuation Coverage).

(a) Employer COBRA Obligation. An Employer is subject to COBRA if:

(i) 20 Employees. During any calendar year following a calendar year in which the Employer had 20 or more Employees (including part-time employees on a pro-rata basis) for more than half the working days during the year; and

(ii) Code, or Public Health Service Act. If it is a State which receives funds under the Public Health Service Act, political subdivision of that State, or agency or instrumentality of that State or political subdivision of that State.

(b) Qualified Beneficiary. A "Qualified Beneficiary" is an individual who, as of the date before a Qualifying Event because of a Participant's Election, was covered under the Pre-Tax Premium Program.

(i) Participant Termination Restriction. A Participant can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) a reduction of hours of the Participant's employment or the Participant's receipt of Medicare Benefits under Title XVIII of the Social Security Act.

(ii) Exclusions. A Qualified Beneficiary excludes: an individual that receives medical benefits only by virtue of the Election of continuation coverage by another individual, an individual who is entitled to Medicare coverage, an individual who fails to elect continuation coverage within the Election Period, or an individual who fails to properly notify the Administrator (as required in Paragraph 3.8(b)) of divorce, ceasing to be a dependent, or disability.

(c) Qualifying Event. A "Qualifying Event" means an event that would otherwise cause participation to cease under this Plan and is on account of the:

(i) Death. Death of a Participant;

(ii) Termination. Termination (other than by reason of gross misconduct) of the Participant's employment or reduction of hours of employment below any minimum level of hours required for Covered Employment;

(iii) Divorce. Divorce or legal separation of a Participant from the Participant's spouse;

(iv) Medicare. A Participant receiving Medicare benefits under Title XVIII of the Social Security Act; or

(v) Dependent. A dependent child of a Participant ceasing to be a Dependent-Medical under this Plan or the plan to which pre-tax premium payments are made.

(d) Election Period. The Election Period means a period of 60 days from the date of the Qualifying Event or, if later, the date of the notice required by Section 3.8.

(e) Cessation. Continuation coverage shall cease at the earliest of the date that:

(i) No Health. The Employer no longer offers group health coverage to any of its employees,

(ii) Premium Nonpayment. The required contribution for continuation coverage is not paid within 30 days of the date due,

(iii) Alternative Coverage. After the date of electing continuation coverage, a Qualified Beneficiary becomes covered under another group health plan which does not contain any exclusion or limitation with regard to any preexisting condition of the Qualified Beneficiary, or

(iv) Medicare. After the date of electing continuation coverage, a Qualified Beneficiary becomes entitled to receive benefits under Medicare.

3.8 Notice Requirements.

When an Employee becomes a Participant, the Administrator shall inform the Participant (and spouse, if any) in writing of the right to Continuation Coverage.

(a) Notice of Qualifying Event. The Employer shall notify the Administrator within 30 days of a Qualifying Event other than those events listed in Paragraph (b) below.

(b) Divorce, Not Dependent, or Disability. A Participant or a Qualified Beneficiary who is a spouse or dependent of a Participant must notify the Administrator within 60 days of the occurrence of a Qualifying Event under Subparagraph 3.7(c) or 3.7(c)(iii) and (v) (divorce or ceasing to be a Dependent - Medical). A Participant who is disabled at the time of a Qualifying Event or becomes disabled within 60 days after a Qualifying Event under Subparagraph 3.7(c)(ii) (termination or reduction in hours) must notify the Administrator of the Disability within 18 months from the date of the Qualifying Event.

(c) Notice of Termination of Participation. Within 14 days of receipt of a notice, the Administrator shall furnish each Qualified Beneficiary with written notice of the right to continue participation.

(d) Spousal Notice. Notification to a Qualified Beneficiary who is the spouse of a Participant is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

(e) FMLA Notice. Within a reasonable amount of time after notification that a Participant needs FMLA leave, the Administrator shall provide the Participant with written notice detailing the specific expectations and obligations of the Participant and explaining any consequences of a failure to meet those obligations. The notice shall state that the leave will be counted against the Participant's annual FMLA leave entitlement; any requirements for the Participant to furnish medical certification of a serious health condition and the consequences of failing to do so; the Participant’s right to substitute paid leave and whether the Employer will require the substitution of paid leave, and the conditions related to any substitution; the requirement for the Participant to make premium payments to maintain health benefits and the arrangements for making payments and the possible consequences of failure to make payments on a timely basis; any requirement for the Participant to present a fitness-for-duty certificate to be restored to employment; the Participant’s status as a "Key Employee" and the potential consequence that restoration may be denied following FMLA leave, explaining the conditions required for such denial; the Participant's right to restoration to the same or an equivalent job upon return from leave; and the Participant's liability for payment of health insurance premiums paid by the Employer during the Participant’s unpaid FMLA leave if the Participant fails to return to work after taking FMLA leave.

ARTICLE 4

CONTRIBUTIONS

4.1 Participant Election.

A Participant may elect to receive cash or Qualified Benefits.

(a) Qualified Benefits. Qualified Benefits include Employee Insurance Coverage under Code Sections 104 - 106; and, if authorized by Employer, Pre-Tax Premium Payments under Code Sections 104 – 106 (for medical, dental, vision or disability benefits) and Code Section 79 (for Group Term Life Insurance Benefits).

(b) Excluded Benefits. A Participant may not elect: Deferred compensation; Code Section 117 scholarship; Code Section 119 Meals or Lodging; Code Section 124 qualified transportation; Code Section 127 Educational Assistance; or Code Section 132 Fringe benefits (including spousal and dependent group term life insurance).

4.2 Employer.

The Employer, shall make a contribution for each Participant in addition to any contributions by the Participant. The amount of the contribution shall be reflected on each Participant's Election Form. The Employer Contribution will be determined monthly.

4.3 Limits on Contributions.

If Employer has adopted the Pre-Tax Premium Payment benefit, a Participant may elect to reduce Compensation in order to make pre-tax contributions to the plan which shall be “Deferral Contributions.”

(a) Pre-Tax Premium Payment. Deferral Contributions for Pre-Tax Premium Payment Benefits (including medical, dental and vision) shall not exceed the applicable premium for coverage during the Plan Year. The contribution shall be adjusted if the applicable premium changes during the Plan Year or upon a change in a Participant's Election.

(b) Extension of Participation - Medical. A Participant who has elected a Medical extension of Participation may make after-tax contributions to the Plan. A Participant's contributions for Medical Pre-Tax Payment Continuation coverage shall be equal to 102% of the applicable premium amount.

(c) Continuation of Participation - FMLA Leave. A Participant who shared in the cost of group health plan coverage prior to FMLA leave must continue to pay that share, including any increases in plan rates, if an Election is made to continue coverage during FMLA leave. If a Participant's FMLA leave is unpaid, the Employer will notify the Participant of the terms for payment of the Participant's share of premiums. The Employer shall select the terms for payment, on a nondiscriminatory basis, from the options specified in regulations (pre-pay, pay-as-you-go, or catch-up).

(d) Continuation of Participation - USERRA Leave. A Participant who shared in the cost of group health plan coverage prior to USERRA leave must continue to pay that share, including any increases in plan rates, if an Election is made to continue coverage during USERRA leave. If a Participant's USERRA leave is unpaid, the Employer will notify the Participant of the terms for payment of the Participant's share of premiums. The Employer shall select the terms for payment, on a nondiscriminary basis, from the options specified in regulations (pre-pay, pay-as-you-go, or catch-up).

4.4 Timing.

Employer Contributions and employee contributions or Deferral Contributions (if available) to a plan funded by insurance or prepaid contracts shall be transmitted to the insurer or plan administrator as of the earliest date on which the amount can reasonably be segregated from the Employer's general assets but not later than 90 days from the date on which amounts are received by the Employer or would have otherwise been payable to the Participant in cash. Employer Contributions will be prorated and transmitted on a monthly basis.

(a) Continuation Coverage. Payment of Continuation Coverage shall be made:

(i) Initially. Within 45 days of the end of Election Period (retroactive to the date of the Qualifying Event requiring the coverage).

(ii) Subsequently. On the first day of each month following the due date of the initial payment.

(b) Deductible. Employer and Participant Contributions shall be paid to the Plan within the time required to qualify for a deduction under the Code.

ARTICLE 5

ALLOCATIONS AND BENEFITS

5.1 Accounts.

The Employer shall establish and maintain a separate account for each type of benefit elected by each Participant. The account shall be for bookkeeping purposes and shall not require segregated investment of contributions credited to the account.

5.2 Allocations.

The account shall be credited with any Employer contributions and employee contributions or Deferral Contributions (if available) elected and paid by the Participant. The account shall be debited with premium payments and benefit payments.

5.3 Pre-Tax Premium Payments.

"Pre-Tax Premium Payments" mean amounts used to pay premiums for Participant and Dependent coverage under a nondiscriminatory Medical Benefits plan, Dental Benefits plan, Vision Benefits plan or premium payments for Participant coverage under a nondiscriminatory Group Term Life or Disability Plan. It includes after-tax payments for Continuation Coverage and for Group Term Life Insurance coverage in excess of $50,000.

5.4 Group Term Life Insurance.

"Group Term Life Insurance" means providing a general death benefit (under a formula which precludes individual selection) to a group of employees under an insurance policy carried directly or indirectly by the Employer which satisfies the nondiscriminatory, eligibility and benefit requirements of Code Section 79.

The Plan must make benefits available to Key Employees available to all other Participants. This may consist of a flat amount of benefits or benefits that bear a uniform relationship to the total, basic, or regular rate of compensation of Participants.

5.5 Nondiscrimination.

All medical benefits available to Highly Compensated Employees under a self insured plan must be available to all other Participants and benefits may not discriminate in favor of Highly Compensated Employees except for diagnostic benefits as described in Regulations under Code Section 105(h).

5.6 Cafeteria Plan Concentration Test.

The plan shall not provide Key Employees with more than 25% of the aggregate of Qualified Benefits under the plan.

5.7 Expenses Incurred After Termination of Employment.

If participation is terminated or suspended (including for a failure to make required COBRA, FMLA or USERRA contributions), a Participant shall not receive benefits or reimbursements for claims incurred during the period after participation ceased or while participation was suspended.

5.8 Insurance Contract/Other Plan Limitation.

Benefits may be provided by insurance contracts or other plans. The insurance contract or other plan shall control the eligibility for, requirements for, and exclusion of benefits provided. The Employer does not guarantee benefits under any insurance contract or other plan. Those benefits shall be the exclusive responsibility of the insurer or other plan.

ARTICLE 6

VESTING

6.1 No Vested Rights.

A Participant does not have any vested right to current or future benefits under the plan. A Participant's right to benefits is limited to the assets held under the Plan and to claims for benefits incurred while a Participant and submitted before the earliest of amendment of the Plan, termination of the Plan, expiration of the applicable limitations period, or termination of participation (including any extension for which the Participant properly elected and paid).

ARTICLE 7

PAYMENT OF BENEFITS

7.1 Incurred During Plan Year.

Payments may be made only for expenses incurred during the Plan Year for Plan benefits. Expenses for services are incurred when rendered, not when billed or paid.

7.2 Time.

Payment of benefits shall be made as soon as administratively practicable following approval of a claim for benefits.

7.3 Claim.

In order to receive payment or reimbursement under a benefit program, a Participant (for purposes of this Article called a Claimant) must submit the information required by the Plan Administrator. A claim for payment or reimbursement shall be submitted to the claims administrator, and the Claimant shall be notified of the decision or the claim in accordance with the provisions of the applicable benefit program.

(a) Claims Evaluation. A decision shall be made on all claims in accordance with the guidelines established by the Plan Administrator for the applicable benefit program. Within a reasonable time of the determination, the Claimant shall be given a written notification as to whether the claim is granted or denied, in whole or in part.

(i) Approval of Claim. If a claim is approved, payment of benefits shall be made as soon as practicable.

(ii) Denial of Claim. The notice of claim denial shall be written in a manner calculated to be understood by the Claimant.

(b) Review of Claim Denial. If a claim for payment or reimbursement is denied, in whole or in part, or a Participant is denied a benefit under this Plan due to an issue related to the Participant's coverage under the Plan, the Claimant shall have the right to request that the Plan Administrator review the denial according to guidelines established by the Plan Administrator for the applicable benefit program.

7.4 Facility of Payment.

A payment made under this Section shall fully discharge the Employer, the claims administrator, the Plan Administrator, and the trustee, if any, from all future liability with respect to the payment.

(a) Incapacity. If a person entitled to payment is legally, physically, or mentally incapable of receiving or acknowledging payment, the claims administrator may direct payment in any one or more of the following ways: directly to the person; to the person's legal representative; to a spouse, child, or relative by blood or marriage of the person; to the person with whom the person resides; or by expending the payment directly for the benefit of the person. A payment made other than to the person shall be used for the person's exclusive benefit.

(b) Legal Representative. The claims administrator or the Plan Administrator shall not be required to commence probate proceedings or secure the appointment of a legal representative.

(c) Determinations. The claims administrator in making any determination may act upon affidavits. The claims administrator, in relying upon affidavits or having made a reasonable effort to locate any person entitled to payment, shall be authorized to direct payment to a successor beneficiary or another person, and a person omitted from payment thereby shall have no rights on account of payments so made.

(d) Anti-Escheat. If the claims administrator cannot locate a person entitled to payment, the amount shall be a forfeiture.

7.5 Participant Indemnification.

The Participant will indemnify and reimburse the Employer and the Plan for any expense or cost incurred (including attorney fees) due to the payment of a Benefit which should not have been paid. The indemnification shall include reimbursement for any liability incurred for failure to withhold federal or state income, social security, unemployment tax, or other tax incurred as the result of the payment offset by any tax paid by the Participant.

ARTICLE 8

ADMINISTRATION OF THE PLAN

8.1 Duties, Powers, and Responsibilities of the Employer.

(a) Required. The Employer shall be responsible for:

(i) Employer Contributions.

(A) Amount. Determining the amount of Employer Contributions;

(B) Payment. Paying, ceasing, or suspending Employer Contributions and transmitting Participant Contributions; and

(C) Compliance. Determining that the amount and time of Employer Contributions comply with this plan;

(ii) Agent for Service of Process. Serving as the agent for service of process;

(iii) Amendment. Amending this plan;

(iv) Plan Termination. Revoking this instrument and terminating this plan; and

(v) Mergers; Spin-Offs. Merging this plan with another qualified cafeteria plan maintained by the Employer or dividing this plan into multiple plans.

(b) Discretionary. The Employer may exercise or delegate to the Administrator the following responsibilities:

(i) Claims Administrator. To appoint, compensate and remove a Claims Administrator for the Plan or certain benefits provided by the Plan. The Claims Administrator shall be qualified as a Third Party Administrator if required by Governing Law.

(ii) Custodian. Appointing one or more agents to act as custodians of a portion of the Plan assets to each such custodian;

(iii) Alternate Administrator. Designating a Person other than the Employer as the Administrator;

(iv) Payment of Administrative Expenses Paying administrative expenses incurred in the operation, administration, management, and control of this plan, unless the Employer directs payment from the plan; and

8.2 Employer Action.

An action required to be taken by the Employer shall be taken by its board of directors unless the board has delegated the power or responsibility to one or more Persons identified by its resolution.

8.3 Plan Administrator.

"Administrator" means the Employer or an individual or entity designated by the Employer.

8.4 Administrative Committee.

The Employer may, but shall not be required to, appoint an Administrative Committee to perform the duties involved in the daily operation of this Plan.

(a) Agent; Powers and Duties. The administrative committee is an agent of the Employer. The administrative committee shall have the powers and duties delegated to it by the Administrator.

(b) Not Administrator. The administrative committee will be responsible to the Employer for its actions and will not be the Administrator for operation and management of this plan.

(c) Membership. The number of members of the administrative committee shall be determined by the Employer. The Employer shall appoint the members of the administrative committee and may remove or replace them at any time.

(d) Records. The administrative committee shall keep records of its proceedings.

(e) Actions. The administrative committee shall act by a majority of its members then in office. Action may be taken either by a vote at a meeting or in writing without a meeting. Action may be evidenced by a resolution certified by the Secretary, a writing signed by all committee members, or by individuals authorized by its resolution to so act.

(f) Report to Administrator. The administrative committee shall report to the Administrator when requested with respect to the administration, operation, and management of this Plan.

(g) Compensation. Any member of the administrative committee who is an Employee shall serve without compensation.

(h) Conflict of Interest. Any member of the administrative committee who is a Participant shall not vote or act on a matter that relates solely to that Participant. If that Participant is the only member of the administrative committee, the necessary action shall be exercised by the Administrator.

8.5 HIPAA Administration.

As of April 14, 2004, the Plan Administrator may use or disclose an individual's PHI only as HIPAA, the Privacy Rules, or the Plan permits or under an individual's Valid Authorization.

(a) Hybrid Entity. Under the Privacy Rules, the Plan is a "Hybrid Entity," meaning that some functions of the plan are covered by the privacy rules, while other functions are not.

(b) Permitted Uses/Disclosures. HIPAA limits the uses and disclosures of PHI. Unless the individual has authorized the disclosure, PHI created or received by the Plan may be used or disclosed only as follows:

(i) Individual/Family. An individual's PHI to that individual; an unemancipated minor's PHI to the child's parent, guardian or other person acting in loco parentis, unless there is a court order prohibiting the disclosure; to a legal guardian or other personal representative who is legally authorized to receive the information; or to family members or friends in an emergency, for disaster relief or if they are involved in the individual's healthcare;

(ii) Plan Administration. For determining eligibility, enrollment and disenrollment activities, verification of coverage, obtaining premiums, maintaining accounts, determining benefits, coordinating benefits, adjudicating of claims and appeals, exercising rights of reimbursement and subrogation, assisting Participants with respect to eligibility, benefits, claims, appeals and inquiries, obtaining premium bids, evaluating plan design, placement, renewal or replacement of insurance contracts or health benefits. Authorized Employees, as set forth in Schedule B, may only use PHI for these Plan Administration purposes.

(iii) Payments. For payment operations which include the Plans': obtaining of premiums, determining eligibility and coverage, providing benefits to Participants, and enabling a health care provider or health plan to obtain or provide reimbursement for the provision of health care. Payment activities include coordination of benefits, determination of cost sharing, adjudication and subrogation of health benefit claims, risk adjustments of premiums or amounts due based on health status or demographic characteristics, billing, claims management, collection, obtaining reinsurance, stop loss or excess loss insurance, and reimbursements under those

insurance controls, reviewing health care services for medical necessity, appropriateness of care, or justification or accuracy of charge, utilization review including precertification, preauthorization, concurrent review and retrospective review of services, and disclosure to consumer reporting agencies of the following PHI that relates to collection of premiums or reimbursement: name, address, date of birth, social security number, payment history, account number and name and address of the health care plan or health care provider;

(iv) Treatment. To permit treatment activities by a health care provider which include: the provision, coordination or management of health care and related services by the health care provider or a third party, consultation between health care providers relating to a patient, or the referral of a patient for health care from one health care provider to another;

(v) Health Care Operations. For Health Care Operations which include:

(A) Quality Assessment/Improvement. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines (provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities), population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions;

(B) Provider Review. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(C) Premium/Underwriting. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop loss insurance and excess of loss insurance), provided that the requirements of the Privacy Rules (regarding uses and disclosures for underwriting purposes) are met;

(D) Review/Audit. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(E) Business Planning/Development. Business planning and development, such as conducting cost management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(F) General Administration/Business Management. Business management activities of the Plan, including, but not limited to:

(1) Management activities relating to implementation of and compliance with the Privacy Rules;

(2) Customer service, including the provision of data analyses for Participants or the Employer, provided that PHI is not disclosed to such policy holder, plan sponsor, or customer;

(3) Resolution of internal grievances;

(4) The transfer, merger, or consolidation of all or part of the Plan with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity;

(5) Consistent with the applicable requirements of the Privacy Rules, creating de-identified health information or a limited data set; and

(6) Obtaining funds for the benefit of the Plan, including making claims for health insurance or benefits, making claims under stop loss or excess loss coverage, together with any legal services and auditing functions (including detecting fraud and abuse).

(vii) Covered Entity. To a covered entity under HIPAA for the covered entity's payment activities, the covered entity's health care operations if the covered entity has or had a relationship with the individual whose PHI is being disclosed for quality assessment/improvement or provider review, detecting health care fraud and abuse or complying with those requirements, or in connection with the Plan's participation in an organized health care arrangement if the covered entity is also a participant in that arrangement.

(viii) Public Policy. For the following public policy purposes, provided the applicable requirements of Privacy Rule have been met: when required by law so long as the use or disclosure complies with and is limited to the relevant requirements of such law; for public health activities and purposes; to a government authority regarding an individual whom the Plan reasonably believes to be a victim of abuse, neglect, or domestic violence; to a health oversight agency for oversight activities authorized by law; for judicial and administrative proceedings in response to a court order, subpoena, or other lawful process; for law enforcement purposes to a law enforcement official; to

coroners, medical examiners and funeral directors; to organ procurement organizations regarding cadaveric organs, eyes, or tissue for donation and transplantation purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions, such as separation or discharge from the military, to determine eligibility for veterans' health benefits, or for national security purposes; or to the extent necessary to comply with workers' compensation law or similar law.

(c) Required Disclosure/Availability. The Plan Administrator shall disclose or make PHI available:

(i) Individual. To the individual when requested and as required by the Privacy Rules for amendment, inspection, copying, or to receive an accounting of disclosures.

(ii) HHS. When required by the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with HIPAA or the Privacy Rules.

(d) Limitations on Disclosure. The Plan Administrator:

(i) Minimum Necessary. Shall make reasonable efforts to limit the use or disclosure of PHI to the minimum amount necessary to accomplish the purpose of the use or disclosure. This standard does not apply to disclosures: to, or a request by, a health care provider for treatment; made to the individual; under a Valid Authorization; to HHS; or required by law;

(ii) Accounting Not Required. Shall not be required to account for disclosures: as permitted or required in this Section; before April 14, 2003; more than six years before request; for national security or intelligence purposes; to correctional institutions or law enforcement officials, or permitted under the Privacy Rules.

(iii) Disclosure Not Required. Shall not be required to disclose to the individual PHI compiled in preparation of a civil, criminal or administrative action or as otherwise limited by the Privacy Rules; or

(iv) Employment Functions/Other Plans. Shall not disclose PHI for employment related actions and decisions or in connection with any other benefit or benefit plan of the Plan Sponsor.

(e) HIPAA Duties. The Plan Administrator shall:

(i) Plan Sponsor. As to the Employer, disclose PHI only if the Plan has received certification by the plan sponsor that the Plan has been amended to comply with the Privacy Rules, and maintain adequate separation between the Plan and Plan Sponsor and employees other than Authorized Employees;

(ii) Security. Reasonably and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by the Plan (except for disclosures of summary health or enrollment/disenrollment information permitted by the Privacy rules or disclosure under a Valid Authorization), including implementing administrative, physical and technical safeguards that protect the confidentiality, integrity and availability of electronic PHI and ensure the separation required in (i) above.

(iii) Business Associates. Ensure that any agent or designee, including a subcontractor to whom it provides PHI in any form, observes HIPAA, the Privacy Rules and the Plan and implements reasonable and appropriate measures to protect the PHI.

(iv) Amend PHI. Amend PHI when required by the Privacy Rules.

(v) Accounting/Availability of Records. Account for disclosures and make its internal records, books and records available to HHS.

(vi) Destruction of PHI When No Longer Needed. If feasible, have the Employer return or destroy all PHI received from the Plan that the Employer still maintains in any form when no longer needed for the purpose for which disclosure was made; 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.

(f) HIPAA Definitions. If a term is not defined in this Article but is defined in the Privacy Rules, the definition in the Privacy Rules is incorporated by reference in this Article.

(i) Health Information. "Health Information" means any information, whether oral or recorded in any form or medium, that:

(A) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(B) Relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual.

(ii) Individually Identifiable Health Information. "Individually Identifiable Health Information" means Health Information, including demographic information collected from an Individual, that:

(A) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(B) Relates to the past, present, or future physical or mental health or condition of an Individual; the provision or health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual; and

(1) That identifies the Individual; or

(2) With respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

(iii) PHI (Protected Health Information). "PHI" means "Protected Health Information" which is Individually Identifiable Health Information that is transmitted by or maintained in electronic media or any other form or medium. PHI excludes employment records held by a Plan Sponsor in its role as employer.

(iv) Valid Authorization. "Valid Authorization" means a written document that contains the following elements:

(A) A specific and meaningful description of the PHI to be used or disclosed;

(B) The person(s) or category of persons authorized to make the requested use or disclosure;

(C) The person(s) or category of persons to whom the Plan Sponsor is authorized to make the requested use or disclosure;

(D) A description of each purpose of the requested use or disclosure (this description can merely say, "at the request of the individual" if the Individual initiates the authorization and does not provide a statement of the purpose);

(E) An expiration date or expiration event that relates to the Individual or the purpose of the use or disclosure (absent a specific instruction, the authorization shall continue until the earlier of its revocation or cessation of the person's participation under the Plan);

(F) The Individual's, or his or her personal representative's, signature and the date;

(G) Notification of the Individual's right to revoke the Valid Authorization in writing;

(H) Notification of the Plan's ability or inability to condition treatment, payment, enrollment or eligibility on the authorization;

(I) Notification of the potential for PHI disclosed pursuant to the Valid Authorization to be subject to re disclosure by the recipient and no longer protected by the Privacy Rules.

8.6 Duties, Powers, and Responsibilities of the Administrator.

Except to the extent properly delegated, the Administrator shall have the following duties, powers, and responsibilities and shall:

(a) Plan Interpretation. Interpret this instrument (including resolving an inconsistency or ambiguity or correcting an error or an omission);

(b) Participant Rights. Determine the rights of Participants and Dependents under the terms of this plan including eligibility and participation;

(c) Limits; Nondiscrimination Tests. Determine that this Plan complies with all limitations and nondiscrimination tests under the Code, maintain records necessary to demonstrate compliance, and if necessary modify Participant Elections to conform to those requirements;

(d) Accounts and Election. Provide Election Forms and maintain complete records of Participant accounts and Elections including crediting of contributions and earnings and debiting of forfeitures, benefits, and administrative expenses.

(e) Correct Errors. Correct (to the extent possible, by making adjustments to the accounts) an error in a Participant's account;

(f) Claims and Elections. Establish or approve the manner of making an Election, designation, application, claim for benefits, and review of claims;

(g) Benefit Payments. Determine and authorize the amount, time, and payment of uninsured benefits and expenses;

(h) Administrative Information. Obtain and transmit to the extent reasonably possible all information necessary for the proper administration of this Plan;

(i) Recordkeeping. Establish procedures for and supervise the establishment and maintenance of all records necessary and appropriate for the proper administration of this Plan;

(j) Reporting and Disclosure. Prepare and file annual and periodic reports if required under the Code;

(k) Penalties; Excise Tax. Report and pay any penalty tax or excise taxes incurred by this plan or the employer in connection with this plan on the proper tax form designated by the Internal Revenue Service and within the time limits specified for the tax form;

(l) Advisers. Employ attorneys, actuaries, accountants, clerical employees, agents, or other persons who are necessary for operation, administration, and management of this Plan;

(m) Expenses, Fees, and Charges. Present to the Employer for payment (if not paid by the Employer) or reimbursement (if advanced by the Employer) all reasonable and necessary expenses, fees and charges, including fees for attorneys, actuaries, accountants, and clerical employees, agents, or other persons, incurred in connection with the administration, management, or operation of this Plan;

(n) Nondiscriminatory Rules. Promulgate rules, policies, procedures, and perform other acts without discrimination among Participants; and

(o) Other Powers and Duties. Exercise all other powers and duties necessary or appropriate under this Plan.

8.7 Delegation of Administrative Duties.

The Administrator may delegate an administrative duty.

(a) In Writing. The written delegation shall specify (i) the date of the action and the effective date of the delegation; (ii) the responsibility delegated; (iii) the name, office or other reference of each agent to whom the responsibility is delegated; and (iv) if a responsibility is delegated to more than one agent, the allocation of the responsibility among the agents.

(b) Acceptance of Responsibility. The delegation shall be communicated to the agent to whom the responsibility is assigned, and written acceptance of the responsibility shall be made by the agent. An agent shall retain the responsibility until the agent resigns or rejects the responsibility in writing, or the Administrator takes a superseding action.

(c) Conflict. If an agent's powers or actions conflict with those of the Administrator, the powers of and actions of the Administrator will control.

8.8 Compensation; Indemnification.

An Employee who is compensated on a full-time basis by the Employer shall not receive compensation from this Plan, except for reimbursement of expenses. The Employer shall indemnify and hold harmless each of its Employees to whom responsibilities for the operation and administration of this plan have been delegated from any and all claims, loss, damages, expense, and liability arising from any action or failure to act. Indemnification shall not be required if an Employee's action or inaction is judicially determined to be due to gross negligence or willful misconduct of the Employee. The Employer may purchase and maintain liability insurance coverage itself or an Employee against part or all of any claim, loss, damage, expense, and liability.

8.9 Claims Administrator.

The Claims Administrator shall have the duties set forth in a written contract with the Employer (or the Administrator). These responsibilities shall include:

(a) Claims Processing. Processing claims in accordance with the Plan and under guidelines established by the Administrator, and

(b) Records. Providing the Employer and Administrator with all records, reports, documents, and information that are required in the discharge of their duties under the Plan.

8.10 Participant's Responsibilities.

All requests for action of any kind by a Participant or Beneficiary under this Plan shall be in writing, executed by the Participant or Beneficiary, and shall be subject to any other plan rules applicable to any specific type of request.

ARTICLE 9

FUNDING

9.1 General Assets.

The Plan shall be funded and benefits provided solely by the general assets of the Employer, insurance contracts or policies issued by an insurance company or similar organization qualified to do business in any state or through a qualified health maintenance organization as defined in the Federal Public Health Service Act.

9.2 Insurance.

Insurance Contracts shall be owned by the Employer. Dividends and other rights shall be considered as Plan Assets. A policy shall not: cause the Plan to violate any nondiscrimination requirement; cause the Employer or a Participant to lose favorable tax treatment; or conflict with any provision of the plan. If any conflict occurs, the Plan shall control.

ARTICLE 10

AMENDMENT, MERGERS, SUCCESSOR EMPLOYER

10.1 Amendment.

The Employer may amend this Plan. An amendment may be retroactive or prospective, in the sole discretion of the Employer, except where prohibited by the Code.

(a) Prohibition. An amendment may be made without the consent of any other person, except that an amendment shall not:

(i) Exclude Participant. Retroactively exclude an Employee who previously became a Participant;

(ii) Reduce Participant's Account or Benefit. Decrease the amount credited to a Participant's account or deprive a Participant of any benefit for a claim incurred (for which assets were available) prior to the amendment;

(b) Inactive, Former Participants. An amendment to this Plan shall apply to former Participants and to Participants not employed in Covered Employment on the effective date of the amendment only if it amends a provision of the plan that continues to apply to those Participants or only to the extent it expressly states that it is applicable. Except as specified in the preceding sentence, if a Participant is not employed in Covered Employment on the effective date of an amendment, the amendment shall not become applicable to the Participant unless the Participant performs service in Covered Employment after the effective date of the amendment.

10.2 Merger of Plans.

This Plan may be merged or consolidated, or its assets and liabilities may be transferred, in whole or in part, to another qualified cafeteria plan if:

(a) Preservation of Account Balance. Each Participant's benefit account balance would be equal to or greater than the benefit account balance the Participant would have been entitled to receive if this Plan had terminated immediately before the merger, consolidation, or transfer.

(b) Authorization. The Employer and any new or successor employer authorize the merger, consolidation, or transfer.

10.3 Successor Employer.

If an Employer is dissolved, merged, consolidated, restructured, or reorganized, or if the assets of the Employer are transferred, this Plan may be continued by the successor, and in that event, the successor will be substituted for the Employer.

ARTICLE 11

TERMINATION

11.1 Right to Terminate or Discontinue Contributions.

The Employer reserves the right to revoke this instrument and terminate this Plan or to cease or suspend further contributions.

11.2 Automatic Termination.

This plan shall automatically terminate, or partially terminate when applicable, and contributions to the Plan shall cease upon the Employer's legal dissolution, or upon its adjudication as a bankrupt or insolvent, or upon a general assignment by the Employer for the benefit of creditors, or upon the appointment of a receiver for its assets, or where required by the Code. Also, unless the Plan is continued, it shall terminate upon the merger or consolidation of the Employer into another entity which is the survivor, or the sale of substantially all of the Employer's assets.

11.3 Termination Distribution.

Upon termination of the Plan, remaining assets shall be applied or distributed under one of the following methods after a reasonable period of final claims administration and after all expenses of administration have been paid or accrued. Assets, upon termination, may:

(a) Transfer. Be transferred to another cafeteria plan or arrangement or be used to purchase, by insurance or other contract, benefits permitted under a cafeteria plan for Participants (and former Participants) at the date of termination.

(b) Benefits. Be utilized to pay benefits in the order submitted until all assets are exhausted.

(c) Forfeitures. Be distributed in the manner permitted for the allocation of forfeitures except for a per capita credit.

The application or distribution of assets shall not discriminate in favor of Highly Compensated or Key Employees.

11.4 No Reversion or Prohibited Inurement.

The Employer shall not receive an amount from the Plan upon termination and assets or earnings shall not inure to the benefit of any private shareholder or individual except to provide benefits and pay administrative expenses under the Plan.

ARTICLE 12

GENERAL PROVISIONS

12.1 Spendthrift Provision.

An interest in the Plan shall not be subject to assignment, conveyance, transfer, anticipation, pledge, alienation, sale, encumbrance, or charge, whether voluntary or involuntary, by Participant or Beneficiary except to provide Benefits under the Plan.

(a) Not Security. An interest shall not provide collateral or security for a debt of a Participant or be subject to garnishment, execution, assignment, levy, or to another form of judicial or administrative process or to the claim of a creditor of a Participant or Beneficiary, through legal process or otherwise, except for a claim by a provider for a Benefit provided by the Plan.

(b) Attempts Void. An attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of benefits payable, before actual receipt of the benefits, or a right to receive benefits, shall be void. The Plan shall not be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of a person entitled to benefits. The benefits and plan assets under this plan shall not be considered an asset of a Participant or Beneficiary in the event of insolvency or bankruptcy.

12.2 Effect Upon Other Plans.

Participation in this Plan is not intended to affect any other wage-related employee benefit plans that are maintained or sponsored by the Employer. Any contributions or benefits under such other plans with respect to a Participant shall, to the extent permitted by law and not otherwise provided for in such other plan, be based on the Participant's total compensation from the Employer, including any amounts by which the Participant's wages may be reduced pursuant to the provisions of this Plan.

12.3 Effect Upon Employment Relationship.

The adoption of this Plan shall not create a contract of employment between the Employer and an Employee, confer upon an Employee a legal right to continuation of employment, limit or qualify the right of the Employer to discharge or retire an Employee at will, or affect the right of the Employee to remain in service after the Normal Retirement Date.

12.4 No Interest in Employer Assets.

Nothing in this Plan shall be construed to give an Employee, Participant, or Beneficiary an interest in the assets or the business affairs of the Employer, or the right to examine the books and records of the Employer. A Participant's rights are solely those granted by this instrument.

12.5 Construction.

The singular includes the plural, and the plural includes the singular, unless the context clearly indicates the contrary. Similarly, gender terms shall include the masculine, feminine and neuter.

(a) Capitalized. Capitalized terms (except those at the beginning of a sentence or part of a heading) have the meaning specified in this Plan. If a capitalized term is not defined, the term shall have the general, accepted meaning of the term. If a term that is defined does not have the first letter capitalized, and the definition is applicable at that location in this Plan, the term shall have the stated definition.

(b) Consecutive. Any period of time described in this Plan shall consist of consecutive days, months, or years, as appropriate.

12.6 Severability.

If any provision of this Plan is invalid, unenforceable, or disqualified under Governing Law for any period of time, the affected provisions shall be ineffective but the remaining provisions shall be unaffected.

12.7 Governing Law.

This Plan shall be interpreted, administered, and managed in compliance with the Code and Regulations. To the extent not preempted by federal law, this Plan shall be interpreted, administered, and managed in compliance with the laws of the State of Michigan.

12.8 Entire Agreement.

The Plan constitute the entire agreement. All previous negotiations, representatives, or agreements are merged and void unless expressly incorporated into these documents (or documents expressly incorporated by reference).

12.9 Counterparts.

This plan may be executed in any number of counterparts each of which shall be considered an original.

The Employer has executed this instrument this ____ day of _____, 2009.

BALDWIN COMMUNITY SCHOOLS

_____

SCHEDULE A

A.1	Original Effective Date.	Effective April 1, 1997
A.2	Amendment and Restatement.	Effective July 1, 2008
A.3	First Amendment.	Effective April 1, 2009

SCHEDULE B

AUTHORIZED EMPLOYEES WITH ACCESS TO PROTECTED HEALTH INFORMATION

Employees in the following positions may access Protected Health Information for those purposes set forth in Section 8.5(b)(2):

- human resources personnel
- accounting, finance and payroll personnel
- information systems/information technology personnel
- superintendent