Lapeer Community Schools

Flexible Benefits Plan

Restated Effective: October 1, 2008

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ARTICLE I - ESTABLISHMENT OF THE PLAN

The Lapeer Community Schools has established the Lapeer Community Schools Flexible Benefits Plan for the purpose of providing eligible Employees with a choice between cash and certain tax-free benefits. The Lapeer Community Schools Medical Insurance Waiver Plan was adopted effective July 1, 1995. The Lapeer Community Schools Flexible Benefits Plan was adopted effective as of January 1, 2001. This Restatement, which merges the Lapeer Community Schools Medical Insurance Waiver Plan with the Lapeer Community Schools Flexible Benefits Plan and amends certain features of the merged Plan, is effective October 1, 2008. 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 Lapeer Community Schools Flexible Benefits Plan only.

2.1 **"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.

2.2 **"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.

2.3 **"Agreement"** means the current Agreement between the Board of Education of Lapeer Community Schools and (1) the Lapeer Education Association; (2) Lapeer Community Schools Lapeer Educational Support Personnel (Lapeer E.S.P.); (3) Lapeer School District

Administrators' Association; (4) Lapeer Community Schools Custodial Employees Unit of Local 1421, Council 24 American Federation of State, county and Municipal Employees; (5) Lapeer Transportation Association; and (6) Service Employees International Union Local 517M (Food Service Personnel); or (7) Service Employees International Union Local 517M (Mechanics), as amended and restated from time to time. The term Agreement shall include any successor agreement. Agreement shall also mean an Administrator Contract or Individual Manager/Supervisor Contract executed on behalf of the Lapeer Community Schools.

2.4 "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. If the Participant elects qualified benefits, as required by the applicable Agreement, 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.

2.5 "Cafeteria Plan" means the Lapeer Community Schools Cafeteria Plan established in Article VII.

2.6 "Cafeteria Plan Account" means the Account established and maintained by the District under Article VI 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.

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

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

2.9 "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.

2.10 "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.

2.11 "Dependent Care Assistance Plan" means the Lapeer Community Schools Dependent Care Assistance Plan established under Article VI.

2.12 "District" means the Lapeer Community Schools located within the State of Michigan.

2.13 "Effective Date" means January 1, 1995 as to the Lapeer Community Schools Medical Waiver Plan and January 1, 2001 as to the Lapeer Community Schools Flexible Benefits Plan. The Effective Date of this restatement is October 1, 2008.

2.14 "Employee" means (1) any person employed by the District who is eligible to participate in this Plan pursuant to an Administrator Contract or Individual Manager/Supervisor Contract; and (2) any person employed by the District whose terms and conditions of employment are governed by the collective bargaining agreement between the Lapeer Community Schools and any of the following collective bargaining representatives: (a) the Lapeer Education Association (LEA); (b) the Lapeer Community Schools Educational Support Personnel (Lapeer E.S.P.); (c) Lapeer School District Administrators Association; (d) Lapeer Community Schools Custodial Employees Unit of Local 1421, Council 25 American Federation of State, County and Municipal Employees; (e) Lapeer Transportation Association; (f) Service Employees International Union Local 517M (Food Service Personnel); or (g) Service Employees International Union Local 517M (Mechanics).

2.15 "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.

2.16 "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.

2.17 "Medical Reimbursement Plan" means the Lapeer Community Schools Medical Reimbursement Plan established in Article V.

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

2.19 "Plan" means the Lapeer Community Schools Flexible Benefits Plan as set forth herein as amended from time to time.

2.20 "Plan Administrator" means the Lapeer Community Schools.

2.21 "Plan Year" means the twelve-month period commencing September 1st and ending August 31st. There shall be a short Plan Year commencing September 1, 2003 and ending on September 30, 2003. Effective October 1, 2003, Plan Year shall mean the twelve-month period commencing October 1 and ending September 30th.

2.22 "Short-Term Disability Coverage" means the group short-term disability coverage as amended from time to time offered pursuant to the collective bargaining agreement between the District and the Lapeer E.S.P..

ARTICLE III - PARTICIPATION

3.1 Participation. Every Employee (as defined in Section 2.14) of the District shall be entitled to participate in the Plan and the Cafeteria Plan on the date the Employee became eligible for Health Care Coverage pursuant to the Agreement or the Effective Date, if later. Any Employee (as defined in Section 2.14) who is regularly scheduled to work at least ten (10) hours per week shall be eligible to Participate in the Medical Reimbursement Plan and the Dependent Care Assistance Plan within 30 days after a person becomes an "Employee" as defined in Section 2.14 of the Plan who is regularly scheduled to work at least ten (10) hours per week. No Employee shall become a Participant unless the Employee complies with the provisions of the Plan and executes, completes and files forms required by the Administrator 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 2.14 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 2.14 (or, for purposes of the Medical Reimbursement Plan and Dependent Care Assistance Plan, ceases to be regularly scheduled to work at least ten (10) hours per week) shall cease to be a Participant hereunder as of the date of reclassification. Notwithstanding the foregoing, medical coverage shall be made available to the Employee and covered dependents on an employee-paid basis to the extent required by federal law.

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 Cafeteria Plan, the Medical Reimbursement Plan and the Dependent Care Assistance Plan by making

after-tax contributions in an amount equal to the amount which was credited to the individual's Cafeteria Plan Account, Medical Reimbursement Account and/or Dependent Care Assistance 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 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.

In the case of an individual's Dependent Care Assistance Account, this option of continuing to participate in the Dependent Care Assistance Plan is available for the remaining portion of the Plan Year during which the individual terminated employment.

If an individual does not elect to continue to participate in the Medical Reimbursement Plan or Dependent Care Assistance 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 or Dependent Care Assistance 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.

A former Participant will become a Participant again when he or she again becomes an Employee as defined in Section 2.14 of this Plan, complies with the provisions of this Plan and

executes, completes and files forms required by the Administrator with the Administrator. A former Participant shall re-enter the Medical Reimbursement Plan and/or Depending Care Assistance Plan within 30 days after becoming an Employee who is regularly scheduled to work at least ten (10) hours per week. A former Participant shall re-enter the Cafeteria Plan on the date he/she again becomes eligible for Health Care Coverage.

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 2.14 of this Plan, complies with the provisions of this Plan and executes, completes and files 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 and/or Short-Term Disability Coverage under the Cafeteria 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. 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. Cash Benefits elected in lieu of Health Care Coverage are paid as described in Section 7.6 below.

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 provide 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 eligible Participant or Employee shall specify on the Benefit Election/Compensation Reduction Agreement form either the Cash Benefit or Health Care Coverage. Employees or Participants who elect Health Care Coverage for which a premium copayment is required under an Agreement may also elect to make such premium copayment on a pre-tax basis under the Cafeteria Plan. Each Participant who is a member of the Lapeer E.S.P. may also elect to purchase Short-Term Disability Coverage 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.

An Employee who is expected to become a Participant and who does not deliver 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 his/her full compensation for the Plan Year through the District's regular payroll system and to have elected not to receive Health Care Coverage or Short-Term Disability Coverage under the Plan. All election forms must be returned 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 written election forms and beneficiary forms, if applicable, as soon as practicable after being employed. Such Employee must execute and return all such written election forms no later than thirty-one (31) calendar days after receipt of the written election form. The election shall be retroactive to the date of rehire or return from leave or layoff, if coverage was lost.

(b) Subsequent Election. Each Participant must complete a new Benefit Election/Compensation Reduction Agreement for each subsequent Plan Year and deliver it to the District during the annual enrollment period determined by the District. If a Participant does not deliver 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 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, 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-one (31) days of the qualifying event and is made as permitted under the applicable insurance policies. 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 medical care coverage 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 medical care 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 the medical care coverage to the extent that the Participant, Participant's spouse, or dependent becomes entitled to coverage under Medicare.

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 to the Administrator within five (5) calendar days after the pay day for the payroll period the amount necessary to maintain the qualified benefits under the Plan.

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 Lapeer Community 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. The amount 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 $3,000 per Plan Year.

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 45 days following the end of the grace period described in Section 5.8. All claims for reimbursement by terminated Participants must be filed no later than 90 days after the end of the grace period described in Section 5.8.

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.

5.6 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 Qualifying Medical Expense for which reimbursement is requested;

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

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

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

(e) 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.

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.

5.8 Annual Grace Period For Reimbursement

(a) Notwithstanding any other provision of this Plan, effective for Plan Years beginning on and after January 1, 2005, any amounts which remain in a Participant's Medical Reimbursement Account at the end of a Plan Year as they have not been used to reimburse Qualifying Medical Care Expenses may be used to reimburse Qualifying Medical Care Expenses which are incurred during the first two months and 15 days of the following Plan Year. Any amounts remaining in a Participant's Medical Reimbursement Account at the conclusion of the grace period which are attributable to the Plan Year immediately preceding that grace period shall be forfeited as provided in Sections 5.7 of the Plan.

(b) Effective for Plan Years beginning on and after January 1, 2005, all claims for reimbursement of Qualifying Medical Expenses must be filed no later than forty five (45) days following the conclusion of the grace period described in Section 5.8(a) above.

(c) This Section 5.8 is intended to comply with IRS Notice 2005-42 and subsequent guidance concerning the subjects addressed in that Notice. No Participant shall be permitted to use amounts in his/her Medical Reimbursement Account for any other taxable or non-taxable benefit or to convert such amounts to cash.

ARTICLE VI - DEPENDENT CARE ASSISTANCE PLAN

6.1 This Article Generally.

The District has established the Lapeer Community 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 45 days after the end of the Plan

Year. Claims for reimbursement by terminated Participants must be filed no later than 90 days after the end of the Plan Year. 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 or spouse 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 Lapeer Community Schools Cafeteria Plan for the purpose of providing eligible Employees with the opportunity to make premium co-payments on a

pre-tax basis 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 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. 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 Election Agreement.

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 and Short-Term Disability 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 either from the various Health Care Coverage plans described in the Agreements or the Short-Term Disability Coverage plans described in the Lapeer E.S.P. Agreement.

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 Short-Term Disability 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 with each payroll. For each Employee compensated on a twenty-one (21) payroll period basis, the total amount of the Cash Benefit shall be divided by twenty-one (21) and paid in equal installments with each payroll. Similarly, for each Employee compensated on a twenty-six (26) payroll period basis, the total amount of the Cash Benefit shall be divided by twenty-six (26) and paid in equal installments with each payroll. No Cash Benefit shall be paid to an Employee who is no longer a Participant as defined in Section 2.18.

7.7 Election Procedure.

During the open enrollment period prior to the commencement of each Plan Year, the Administrator shall provide 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 shall specify on the appropriate election form either the Cash Benefit or Health Care Coverage. All election forms must be returned 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 written election forms and beneficiary forms, if applicable, as soon as practicable after being employed. Such Employee must execute and return all such written election forms no later than thirty (30) calendar days after receipt of the written election form.

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 was covered by any qualified benefit plans prior to the Effective Date but who fails to return a completed election form by the Effective Date shall be deemed to have elected the benefit coverage in effect immediately preceding the Effective Date. Further, any Participant who subsequently fails to return a new election form by the specified due date set forth in the preceding section shall be deemed to have elected to continue any benefit coverage in effect for the preceding Plan Year.

Any Participant who had not previously elected to be covered by Health Care Coverage prior to becoming a Participant in this Plan and who fails to return an election form shall be deemed to have declined to elect Health Care Coverage and, if eligible, to have elected to receive only the Cash Benefit under the Plan. Any Participant who is a member of the Lapeer E.S.P. who had not previously elected to be covered by Short-Term Disability Coverage prior to becoming a Participant in this Plan and who fails to return an election form shall also be deemed to have declined to elect Short-Term Disability Coverage.

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. 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 plans 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 plans 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 District (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;

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

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(h) 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;

(I) 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;

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

(k) 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 September, 2008, by its officer thereunto duly authorized.

LAPEER COMMUNITY SCHOOLS

By:_____

Its:_____

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