Gresham-Barlow School District

BOARD OF EDUCATION

Regular Board Meeting / Business

AGENDA

October 6, 2016

GRESHAM-BARLOW SCHOOL DISTRICT NO. 10 JT. **AGENDA**

BOARD OF EDUCATION
October 6, 2016

Regular Board Work Session – 6 p.m.
Subjects: Physical Restraint and Seclusion Review
Election, Budget and District Goals

Regular Board Meeting / Business – 7 p.m.

Public Safety and Schools Building
1331 NW Eastman Parkway, Gresham, OR

I. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

II. ROLL CALL

_____	Carla Piluso, Chair	_____	Kathy Ruthruff, Director
_____	Kris Howatt, Vice-Chair	_____	Kent Zook, Director
_____	Sharon Garner, Director		
_____	John Hartsock, Director	_____	Jim Schlachter, Superintendent
_____	Matt O'Connell, Director	_____	Mike Schofield, Chief Financial Officer

III. COMMUNICATION FROM THE AUDIENCE

Time has been set aside later on the agenda for Citizens' Requests of the Board. If anyone in the audience wishes to address the board this evening, there are yellow "Citizens' Requests of the Board" forms on the table in the back of the room; please complete a form and give it to our board secretary, Ms. Cook.

IV. APPROVE MEETING AGENDA

V. CONSENT AGENDA

All items listed below are matters considered by the board to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a member of the board or persons in the audience requests specific items be removed from the consent agenda and placed on the regular agenda.

1. Minutes from Board Planning Session ..... August 19, 2016
   Minutes from Special Work Session ..... September 1, 2016
   Minutes from Regular Business Meeting ..... September 1, 2016
   Minutes from Regular Work Session ..... September 8, 2016
2. Financial Report
3. Personnel Changes
4. Out-of-State Travel
5. Policy Updates
6. Section 125 Plan Update

VI. RECOGNITIONS

7. Community Care Day ..... Hiu, Huston

VII. GRESHAM-BARLOW EDUCATION FOUNDATION REPORT

8. Gresham-Barlow Education Foundation (GBEF) Report ..... Vadnais

VIII. SUPERINTENDENT'S REPORT

IX. PRESENTATIONS

9. Nutrition Services Annual Report ..... Schofield

X. RECESS/RECONVENE (5 Minutes)

XI. COMMITTEE MEETING MINUTES AND/OR REPORTS

This portion of the board meeting agenda has been provided for the presentation of advisory committee minutes. No action or discussion is required by the board; however, there may be occasional reports or discussion regarding work being completed by the committee(s).

10. District Advisory Council (DAC) ..... Vadnais

XII. BOARD REPORTS

XIII. CABINET REPORTS

XIV. ASSOCIATIONS REPORTS

- Gresham-Barlow Education Association (GBEA) (2 Minutes)
- Oregon School Employees Association (OSEA) (2 Minutes)

XV. CITIZENS' REQUESTS OF BOARD (3 Minutes per Guest / 15 Minutes Total)

XVI. RECESS/RECONVENE (5 Minutes)

XVII. ACTION ITEMS

First Reading

11. Bond Oversight Committee ..... Schofield

Second Reading

None

XVIII. INFORMATION ITEMS

12. Enrollment and Class Size Report ..... Hiu, Evans
13. Bond Information Update ..... Schlachter

XIX. ANNOUNCEMENTS

Oct. 20, 2016: Board Work Session - 6 p.m.
Partnership Room
Center for Advanced Learning

Oct. 27, 2016: DAC Meeting - 7 p.m.
Gresham High School
Board Representatives: John Hartsock and Sharon Garner

Nov. 3, 2016: Board Work Session - 6 p.m.
Council Chambers Conference Room
Public Safety and Schools Building

Nov. 3, 2016: Board Business Meeting - 7 p.m.
Council Chambers
Public Safety and Schools Building

XX. ADJOURNMENT (Estimated time for adjournment: No later than 9 p.m.)

Note: The board may, by majority vote, take action on items listed under first reading or information.

JS:lc:9/30/16:12:58 PM

GRESHAM-BARLOW SCHOOL DISTRICT NO. 10 JT.
Minutes of Regular Board Meeting / Work Session

August 19, 2016

The Gresham-Barlow School District Board of Education held a work session on Friday, August 19, 2016, in the Partnership Room at the Center for Advanced Learning, 1484 NW Civic Drive, Gresham, Oregon.

The meeting was called to order at 8:05 a.m. by the chair, Carla Piluso. Other board members in attendance were Kris Howatt, Kathy Ruthruff, Sharon Garner, Carla Piluso, Kent Zook, and John Hartsock.

The following members of the superintendent's cabinet were present:

Jim Schlachter	Superintendent
James Hiu	Deputy Superintendent of Secondary Education and Operations
Teresa Ketelsen	Deputy Superintendent of Teaching and Learning
Mike Schofield	Chief Financial Officer
Randy Bryant	Executive Director of Human Resources
Julie Evans	Executive Director of Elementary Education
Sara Huston	Executive Director of School Performance
John Koch	Executive Director of Student Support Services
Athena Vadnais	Director of Communications and Community Engagement

The following guest presenters were present (at the times noted in various sections below):

Jeremy Wright	Wright Public Affairs
Karen Montovino	DLR Artchitects
Kerry Scott	DLR Artchitects

WELCOME, ICEBREAKER, AND AGENDA REVIEW (8:05 a.m.)

Following welcoming comments from Superintendent Schlachter, Chair Piluso facilitated a warm-up activity involving the characteristics of various totem pole symbols described in a handout.

MOTION 12 INTERDISTRICT TRANSFERS FOR 2016-2017 (8:30 a.m.)

James Hiu explained that the board approved 84 slots for students to transfer into the Gresham-Barlow School District, and 40 slots for students wishing to transfer to another district. Requests to transfer out of the district have exceeded the 40 approved slots; therefore, there are 20 students on a wait list.

Kris Howatt moved to approve the addition of 20 slots for resident district releases for the 2016-17 school year. Kent Zook seconded the motion.

Following discussion, the motion carried unanimously.

COMMUNICATING DISTRICT VISION (8:36 a.m.)

Superintendent Schlachter presented a new flyer, updated posters, and a brochure designed to communicate the district's vision and strategic themes. He also provided an overview of steps to advance the district's 2020 Vision, the development of district goals, and quarterly updates that will be provided throughout the school year. (A copy of Mr. Schlachter's slide presentation has been filed with these minutes.)

Teresa Ketelsen presented information about the teaching and learning framework. Discussion included instruction curriculum assessment, learning environments, the district's work related to equity, and steps to address the disproportionality in student suspensions and expulsions.

RECESS / RECONVENE (9:37 a.m.)

The meeting was recessed at 9:37 a.m. and reconvened at 9:46 a.m.

DEVELOPMENT OF DISTRICT GOALS (9:46 a.m.)

Board and cabinet members divided into individual work groups to discuss district goals and targets. Topics included Equitable Outcomes, College and Career Readiness, Early Learning, Class Size and Learning Environments, Community Partnerships, and Community Investment.

Following the breakout sessions, one person from each group summarized their group's discussion.

EXECUTIVE PROJECTS (10:55 a.m.)

Superintendent Schlachter reminded the board that the cabinet identifies executive projects each year, and reviews them every two weeks throughout the year.

Written briefings regarding three of the executive projects were included in the agenda materials for board information, and summarized by cabinet members as follows:

- Teresa Ketelsen reviewed the *School District Collaborative Grant*, and *K-3 Technology Integration;*

- James Hiu and Sara Huston reported on *Equitable Outcomes*.

2016 BOND (11:15 a.m.)

Jeremy Wright and Athena Vadnais provided a brief overview of previous bond measures, what the proposed 2016 bond will accomplish, and reasons for presenting the bond measure on the November ballot. They also summarized efforts underway to inform stakeholders about the district's bond measure. A handout titled "2016 Gresham-Barlow Bond, What to Expect and When" was provided to supplement their presentation. (A copy of the handout has been filed with these minutes.)

Karen Montovino introduced "charrettes," and demonstrated how this envisioning process engages stakeholders in brainstorming activities regarding facility designs. She then led a mock charrette exercise so that board members could experience the process firsthand. Handouts included an example of a charrette product, and a schedule of pre-bond design charrettes. Similar charrettees will held at each school over the next week. (Copies of the handouts and a slide presentation have been filed with these minutes.)

Mike Schofield provided an update regarding the bond communications budget, including expenditures to date (approximately $193,000) and projections (an estimated $194,000). The bond communications budget is funded by construction excise tax dollars, not the general fund operating budget. It was noted that the expenditures are used for information/education purposes only, not for endorsement. (For more information, refer to the handout titled, Pre-Bond Planning/Information Services, Costs and Estimates, 08/18/2016. A copy has been filed with these minutes.)

John Hartsock reported about a political action committee [Vote YES for Student Success] that has formed to support the bond measure. Stefanie Craft, a Damascus-area, parent has been retained to serve as the campaign manager.

RECESS/RECONVENE (12:05 p.m.)

The board recessed for lunch at 12:05 p.m. The meeting was reconvened at 1:00 p.m.

BOARD PLANNING TOPICS (1:00 p.m.)

Board Meeting Procedures: The following suggestions were discussed, and the conclusions are summarized below:

- Add more student, staff, and school recognitions at board meetings -

  James Hiu and John Koch will seek input from principals about increasing the number of recognitions at board meetings. The results will be reported at a future work session.

- Include student representation at board meetings -

  James Hiu and John Koch will seek input from principals about including student representatives to sit with the board. The results will be reported at a future work session.

- Expand the use of the consent agenda to include more routine items -

  As future board meeting agendas are developed, Superintendent Schlachter and Mike Schofield will work with board leadership to identify topics for inclusion on the consent agenda, as suggested.

- Add a work session to precede every board business meeting throughout the year –

  At a future business meeting, the board will be asked to consider a revised board meeting schedule to include a work session before every business meeting.

- Subscribe to BoardBook for board agenda packets -

  The use of BoardBook will be revisited at the mid-year planning session.

- Continue the fall School Improvement Plan (SIP) fair -

  Continuation of the annual SIP fair was supported by the board and cabinet.

Community Relations: Board members talked about the purpose of and value in continuing DAC (District Advisory Committee) meetings. This topic will be revisited at a future work session. For the balance of the 2016-17 school year, the adopted DAC meeting schedule will remain enforce.

Curriculum: Information provided at a National School Boards Associations (NSBA) conference about Next Generation Science Standards, etc., was discussed.

District Communications: A suggestion was made that a review of the district's communications plan be considered as a future work session topic. Included in the discussion could be the district's web site, newsletters, newspaper articles, budget allocations for staffing the communications department, an updated district logo, etc.

Policy and Practices: Policies related to gifts and donations, equity, and field trips were identified for review at a future work session.

Other: Miscellaneous topics included educational partnerships (e.g., ACE Academy and Mt. Hood Community College), homeless youth, funding for the district's technology plan, the addition of a budget committee meeting on May 22, 2017, etc.

RECESS/RECONVENE (2:15 p.m.)

The board recessed at 2:15 p.m., and cabinet members were excused.

The meeting was reconvened at 2:23 p.m.

BOARD RESPONSIBILITIES (2:23 p.m.)

Board / Superintendent Working Agreements: Board members reviewed the working agreements, and advanced them without changes for re-adoption at the next business meeting.

Board Self-Evaluation: Board members reviewed background information regarding prior board self-evaluations, and a list of questions identified at a recent work session for inclusion in the next evaluation process. Board members then asked the board secretary to send the questions to each board member via Survey Monkey on Monday, August 22, 2016, with a two-week deadline for responses. When all of the responses have been received and compiled in Survey Monkey, the board will review the results in a future work session. (Note: During the discussion of board committee assignments below, Director Howatt volunteered to serve on the board self-evaluation committee.)

Superintendent Evaluation Process: Board members discussed last year's 360° evaluation process. There was consensus that the results were beneficial and the process should be repeated, but not every year. It was acknowledged that State statutes and board policy require the completion of an evaluation every year. It was agreed that a committee of three board members should meet to develop a new evaluation process for this year, possibly using some of the questions from last year's 360° evaluation. There was also consensus that this year's evaluation should be completed by March 15, 2017, in order to comply with State statutes. (Note: Three board members volunteered to be on the evaluation committee during the discussion of board committee assignments. See below.)

BOARD PLANNING (3:16 p.m.)

Board Committee Assignments: Board members reviewed a list of board committee assignments. Existing assignments were reaffirmed, and new opportunities were filled for 2016-17 as follows:

Committee	Number	Carla Piluso	Sharon Garner	John Hartsock	Kathy Ruthruff	Kent Zook	Kris Howatt	Matt O'Connell	Other / Appointed	Advisory to Superintendent	Advisory to Board
Audit Involvement Team	2	●					●		Budget Committee Member		
Board Evaluation Committee	1						●				
Board Leadership	2	●					●				
Bond	1			●							
Communications Project	2			●			●				
Counselor Advisory Committee	2	●			●				John Koch?		
DAC	All	●	●	●	●	●	●	●			
District Data Team *(On Hold)*	1	------	------	-----	-----	------	------	-----	------		
District Equity Focus Team	2	●	●								
Federal Relations Network (FRN) *(AKA Advocacy Institute)*	1						●				
Gresham-Barlow Education Foundation *(On Hold)*	1	------	------	-----	-----	------	------	-----	------		
MESD Budget Committee *(A 3-year commitment)*	1			●							
Metro Policy Advisory Committee (MPAC)	1					●					
OSBA Board of Directors	1						●				
OSBA Legislative Policy Committee (LPC)	1					●					
OSEA/GBSD Contract Review Team	1						●				
Policy Review Committee	2			●			●				
Superintendent's Evaluation	3		●	●			●				

There was also discussion about the differences between advisory committees to the superintendent, advisory committees to the board, standing committees, and ex-officio representation.

It was noted that the Federal Relations Network (FRN) is now referred to as the Advocacy Network, and attendance is limited to OSBA board and/or legislative policy committee members. It is included in the list of Board Committee Assignments primarily because the board's budget funds a portion of the related expenses. (OSBA funds the other portion.) It also provides an opportunity for another board member to express an interest in participation, if they qualify. In addition, the chart helps to illustrate the volume/balance of commitments board members assume in addition to regular school board meetings.

2016-17 Calendar Highlights: Board members discussed upcoming events, such as the August 31, 2016, all-district convocation to be held at Gresham High School, and a Gresham-Barlow Education Foundation social. The board also discussed a suggestion to cancel a fall board work session (e.g., September 22 or October 20) in consideration of other obligations related to the bond. It was decided to revisit the suggestion at the September 1, 2016, board meeting, along with other meeting schedule changes previously discussed.

Board Development Opportunities: Board members were given information regarding 2016-17 board development opportunities, such as the annual Oregon School Boards Association (OSBA) convention, the National School Boards Association (NSBA) convention, and an OSBA fall regional dinner meeting. It was agreed that the full board and the superintendent should attend the NSBA convention, if possible, March 25-27, 2017, in Denver, Colorado. (Sign-up sheets were passed around for the events described above.)

Other: The superintendent presented a list of proposed work session topics for 2016-17. He explained that the list was developed as part of the district's on-going process for planning future agendas, and to ensure that subjects being considered are timely and meet expectations of the board. It is also a tool to help manage the length of work sessions. The list is updated frequently as the need to add, delete, or move items is identified. Regular updates will be presented at future work sessions, and board members are invited to provide input throughout the year.

ADJOURNMENT (3:44 p.m.)

The meeting was adjourned at 3:44 p.m.

Submitted by: _____

Linda J. Cook
Administrative Assistant to the Superintendent and
Board of Directors

GRESHAM-BARLOW SCHOOL DISTRICT NO. 10 JT.
Minutes of Special Board Meeting / Work Session

September 1, 2016

The Gresham-Barlow School District Board of Education held a special work session on Thursday, September 1, 2016, in the council chambers conference room of the Public Safety and Schools building, 1331 NW Eastman Parkway, Gresham, Oregon.

The meeting was called to order at 6:10 p.m. by the chair, Carla Piluso. Other board members in attendance were Sharon Garner, Kris Howatt, Kent Zook, Matt O'Connell, and John Hartsock. Kathy Ruthruff was absent.

The following members of the superintendent's cabinet were present:

Jim Schlachter ..... Superintendent
James Hiu ..... Deputy Superintendent of Secondary Education and Operations
Teresa Ketelsen ..... Deputy Superintendent of Teaching and Learning
Mike Schofield ..... Chief Financial Officer
Randy Bryant ..... Executive Director of Human Resources
Julie Evans ..... Executive Director of Elementary Education
Sara Huston ..... Executive Director of School Performance
John Koch ..... Executive Director of Student Support Services
Athena Vadnais ..... Director of Communications and Community Engagement

FUTURE WORK SESSION TOPICS (6:10 p.m.)

Board members discussed a recommendation to add [9] work sessions to the 2016-17 board meeting schedule; one to precede each regularly-scheduled business meeting. The proposal was to begin each of the new work sessions at 6 p.m., and adjourn at approximately 6:45 p.m. to allow transition time before convening the 7 p.m. business meetings.

Handouts included a draft of the 2016-17 board meeting schedule showing the additional work sessions, and a list of suggested protocols to help guide the process and maximize the benefits of the additional meetings. (Copies of the handouts have been filed with these minutes and are available upon request.)

Board members were supportive of the recommendation, and requested that a revised meeting schedule be included on the September 8, 2016, board meeting agenda for approval. It was noted that a list of topics for all work sessions is being developed, and a first-draft will be presented at the business meeting later this evening.

ADJOURNMENT (6:25 p.m.)

The work session was adjourned at 6:25 p.m. The board's business meeting followed at 7 p.m. in the council chambers.

Submitted by: _____
Linda J. Cook
Administrative Assistant to the Superintendent and
Board of Directors

GRESHAM-BARLOW SCHOOL DISTRICT NO. 10 JT.
Minutes of Regular Board Meeting / Business

September 1, 2016

The Gresham-Barlow School District Board of Education met in regular session on Thursday, September 1, 2016, in the council chambers of the Public Safety and Schools building, 1331 NW Eastman Parkway, Gresham, Oregon.

The meeting was called to order at 7:02 p.m. by the chair, Carla Piluso. Other board members in attendance were Sharon Garner, Kris Howatt, Kent Zook, Matt O'Connell, and John Hartsock. Kathy Ruthruff was absent.

The following members of the superintendent's cabinet were present:

Jim Schlachter ..... Superintendent
James Hiu ..... Deputy Superintendent of Secondary Education and Operations
Teresa Ketelsen ..... Deputy Superintendent of Teaching and Learning
Mike Schofield ..... Chief Financial Officer
Randy Bryant ..... Executive Director of Human Resources
Julie Evans ..... Executive Director of Elementary Education
Sara Huston ..... Executive Director of School Performance
John Koch ..... Executive Director of Student Support Services
Athena Vadnais ..... Director of Communications and Community Engagement

The chair led board members, administrators and all those present in the Pledge of Allegiance.

MOTION 13 **MEETING AGENDA** (7:03 p.m.)

It was moved by Matt O'Connell, seconded by Kris Howatt, and carried 6 to 0 to approve the meeting agenda as presented.

MOTION 14 **CONSENT AGENDA** (7:04 p.m.)

The following items were included on the consent agenda:

1. Minutes from Regular Business Meeting ..... July 7, 2016
   Minutes from Special Work Session ..... July 19, 2016
   Minutes from Special Business Meeting ..... August 4, 2016
2. Financial Report
3. ~~Personnel Changes~~ *(Removed from Consent Agenda; see Motion 14 below)*
4. ~~Physical Restraint and Seclusion Review~~ *(Removed from Consent Agenda; see Motion 15 below)*
5. Board and Superintendent Working Agreements
6. Board Meeting Schedule Amendment

Director Hartsock asked to remove Personnel Changes, and Director Howatt asked to remove Physical Restraint and Seclusion Review from the consent agenda for discussion. (See notes below.)

It was moved by Kris Howatt, seconded by John Hartsock, and carried 6 to 0 to approve the remaining items on the consent agenda as presented.

MOTION 15 **PERSONNEL CHANGES** (7:05 p.m.)

A concern was expressed regarding the rationale behind the board's practice of approving individual personnel changes, noting that the board provides for the employment of district staff when it approves collective bargaining agreements and the budget. The policy [GB] regarding the board's role in approving the "employment of candidates to fill positions" was referenced, with a recommendation that it be reviewed at a future date. In the interim, research will be continued to determine if the current practice is required, or if the approval of individual staff hires should be finalized by the superintendent without board action.

Kris Howatt moved to, in compliance with ORS 332.075(2)(3), approve the licensed employment contracts as presented to the board by the superintendent. Matt O'Connell seconded the motion.

In the discussion that followed, Mrs. Howatt declared a potential conflict of interest because her daughter's name was included in the list of recommended new hires. She explained that she was not involved with any part of the interview or placement process.

There being no further discussion, the chair called for the vote. The motion carried 5 to 0. John Hartsock abstained.

Chair Piluso acknowledged that a review of the policy pertaining to the board's role in hiring staff will be advanced to a future work session [as requested during the discussion above].

MOTION 16 **PHYSICAL RESTRAINT AND SECLUSION REVIEW** (7:09 p.m.)

It was moved by Kris Howatt and seconded by Matt O'Connell to accept the physical restraint and seclusion report as presented.

In the discussion that followed, it was noted that the report provides a "snapshot" without historical data, or information about trends, etc. It was requested that a more comprehensive report be considered for a future work session.

The motion carried 6 to 0.

RECOGNITIONS (7:11 p.m.)

Sam Barlow High School Theater Department Champions: The board recognized members of Sam Barlow High School's theatre department for winning first place in the Chapter Select One-Act Competition at the State Thespian Festival for their performance of "Bang, Bang You're Dead." In addition, 16 students from Sam Barlow won first Place in the nation for their performance at the NEIS Individual Events Competition with their group musical, "Stronger," from the Broadway musical, "Finding Neverland."

National School Public Relations Association Award: The board recognized Athena Vadnais for her work that resulted in the district's "Award of Merit" received from the National School Public Relations Association (NSPRA). The award was given for the district's Spring/Summer 2015 edition of its newsletter, "Gresham-Barlow Schools Today," during NSPRA's 2016 Publications and Electronic Media Contest.

GRESHAM-BARLOW EDUCATION FOUNDATION REPORT (7:24 p.m.)

Vicki Moen, manager of the Gresham-Barlow Education Foundation, reported on foundation activities which included a successful school supply drive, and upcoming events such as the annual "Scramble for Students" golf tournament, and "Authors for Education."

SUPERINTENDENT'S REPORT (7:27 p.m.)

Superintendent Schlachter reported that several events took place over the past month as the district prepared for the opening of school; for example, the new teacher academy was held in August, and the district's All-Staff Convocation took place on August 31. Also during August, Superintendent Schlachter met with Gresham's mayor, Shane Bemis, and each of the city councilors to review partnerships the district has with the city in variety of areas. They also discussed possibilities for future partnerships.

K-3 TECHNOLOGY INTEGRATION PROJECT (7:31 p.m.)

Angie Kautz, director of teaching and learning, and Elizabeth Rossmiller, instructional technology coach, provided an update regarding the four-year, $1.37 million grant the district received from the Mt. Hood Cable Regulatory Commission (MHCRC) in April. Their report included information regarding the purchase and installation of technology bundles for the two elementary schools participating in the grant: Kelly Creek and North Gresham.

SCHOOL DISTRICT COLLABORATION GRANT (7:37 p.m.)

Grant managers, Mark Kim and Regina Norris, summarized the focus of their work as they begin leading the school district collaboration grant project. In July, the school district was awarded a $1,025,000 collaboration grant from the Oregon Department of Education for the 2016-17 school year.

COMMITTEE MEETING MINUTES AND/OR REPORTS (7:41 p.m.)

District Advisory Council (DAC): Athena Vadnais referenced the 2016-17 DAC meeting schedule that was provided in the board's agenda packet, and reminded board members that the first meeting of the new school year will be held on September 15 at North Gresham Elementary School. She also announced that she will soon be meeting with the DAC chair to identify a list of topics for 2016-17 meetings.

BOARD REPORTS (7:42 p.m.)

Board members summarized various meetings and other activities they participated in during the month.

CABINET REPORTS (7:59 p.m.)

James Hiu provided a brief overview of the 2016 Community Care Day, which was held on August 27, 2016. A full report and recognition of the participants has been scheduled for the October 6, 2016, board meeting.

ASSOCIATIONS REPORTS (8:04 p.m.)

Rhett Hyman, a teacher at East Orient Elementary School, reported on behalf of the Gresham-Barlow Education Association (GBEA).

Erika Fuller, a secretary at West Gresham Elementary School, reported on behalf of Oregon School Education Association (OSEA) Chapter 8 employees.

CITIZENS' REQUESTS OF THE BOARD (8:07 p.m.)

There were no citizens' requests of the board.

MOTION 17 ACCEPTANCE OF A DONATION: GRAY FAMILY FOUNDATION (8:07 p.m.)

It was moved by Matt O'Connell and seconded by Kent Zook to accept the $19,500 donation from the Gray Family Foundation to support costs associated with Outdoor School.

Following discussion, the motion carried 6 to 0.

BOND PROPOSAL RECOMMENDATION, RESOLUTION, NOTICE OF BOND ELECTION, AND EXPLANATORY STATEMENT (8:12 p.m.)

Mike Schofield reviewed minor edits that were made to the Notice of Bond Election after it was approved by the board on August 4, 2016. The district's bond counsel has advised that no board action is required because the edits are not substantial; therefore, this update was provided as information only.

FUTURE AGENDA TOPICS (8:14 p.m.)

A preliminary list of topics for 2016-17 board work sessions was introduced. The board will discuss the inclusion of additional topics at its next work session on September 8, 2016. There will be periodic updates to the list as the school year progresses.

ANNOUNCEMENTS (8:16 p.m.)

Sept. 8, 2016: Board Work Session - 6 p.m.
Partnership Room
Center for Advanced Learning

Sept. 12, 2016: Gresham-Barlow Education Foundation
"Scramble for Students" Golf Tournament – 10 a.m.
Persimmon Country Club, Gresham, OR

Sept. 15, 2016: DAC Meeting - 7 p.m.
North Gresham Elementary School
Board Representatives: All

Sept. 22, 2016: Board Work Session - 6 p.m.
Partnership Room
Center for Advanced Learning

Oct. 3, 2016: OSBA Fall Regional Dinner Meeting – 5:30 p.m.
Embassy Suites Portland Airport
7900 NE 82nd Avenue, Portland, OR

Oct. 6, 2016: Regular Board Meeting - 7 p.m.
Council Chambers
Public Safety and Schools Building

Kris Howatt announced that a "Yes for Student Success" kick-off event has been scheduled for September 13, 2016, at 7 p.m. It will be held at 238 NE Roberts in Gresham.

MOTION 15 **ADJOURNMENT** (8:17 p.m.)

Kris Howatt moved to adjourn the meeting. Kent Zook seconded the motion, and it carried 6 to 0.

Chair Piluso adjourned the meeting at 8:17 p.m.

Submitted by: _____
Linda J. Cook
Administrative Assistant to the Superintendent and
Board of Directors

GRESHAM-BARLOW SCHOOL DISTRICT NO. 10 JT.
Minutes of Regular Board Meeting / Work Session

September 8, 2016

The Gresham-Barlow School District Board of Education held a work session on Thursday, September 8, 2016, in the Partnership Room at the Center for Advanced Learning, 1484 NW Civic Drive, Gresham, Oregon.

The meeting was called to order at 6:04 p.m. by the vice-chair, Kris Howatt. Other board members in attendance were Matt O'Connell, Sharon Garner, Kathy Ruthruff, Kent Zook, and John Hartsock. Chair Carla Piluso arrived at approximately 6:08 p.m., and presided for the balance of the meeting.

The following members of the superintendent's cabinet were present:

Jim Schlachter	Superintendent
James Hiu	Deputy Superintendent of Secondary Education and Operations
Teresa Ketelsen	Deputy Superintendent of Teaching and Learning
Mike Schofield	Chief Financial Officer
Randy Bryant	Executive Director of Human Resources
Julie Evans	Executive Director of Elementary Education
Sara Huston	Executive Director of School Performance
John Koch	Executive Director of Student Support Services
Athena Vadnais	Director of Communications and Community Engagement

Guests included:

Ben Patinkin	Patinkin Research Strategies, LLC
Jeremy Wright	Wright Public Affairs
Karina Bruzzese	Gresham-Barlow School District ELL Director
Terry Taylor	Gresham-Barlow School District Director of Facilities

AGENDA REVIEW (6:05 p.m.)

Director Howatt announced that the order of agenda topics would be renumbered to accommodate guest presenters.

SCHOOL BOND COMMUNICATIONS UPDATE (6:06 p.m.)

Ben Patinkin summarized findings of a recent telephone poll of 400 registered voters in the Gresham-Barlow School District regarding the district's November 2016 bond measure. (A copy of his slide presentation has been filed with these minutes.)

Following Mr. Patinkn's presentation, Jeremy Wright provided an overview of communications work being conducted to share factual information with staff, parents, and the community regarding the November 2016 school district facilities bond measure.

HOUSE BILL 3499: ENGLISH LANGUAGE LEARNER STRATEGIC PLAN UPDATE (6:37 p.m.)

Karina Bruzzese provided an overview of House Bill 3499, the statewide education plan, and the implications for ELL (English Language Learner) students who are being served in the Gresham-Barlow School District. (A copy of her handouts have been included in the agenda packet.)

HEALTHY AND SAFE SCHOOLS PLAN (7:49 p.m.)

Mike Schofield reported on recently-adopted Oregon administrative rules that require school districts, education service districts, and charter schools to develop a "Healthy and Safe Schools Plan." Included in the requirements is a report to the school board, on or before October 1, 2016, regarding mandatory elements of the plan. Formal board action is not required, however.

Mr. Schofield handed out a draft document titled, "Gresham-Barlow School District Healthy and Safe Schools Plan, September 8, 2016" for board review. In addition, the following documents were presented: 1) Radon Testing and Reporting Plan, September 1, 2016; 2) Draft GBSD Drinking Water Testing Plan updated 9/8/2016; 3) Draft GBSD Lead Paint Testing Plan updated 9/9/2016; and, 4) Gresham-Barlow School District Integrated Pest Management Plan 3/3/2014.

RECESS / RECONVENE (7:05 p.m.)

The meeting was recessed at 7:05 p.m. and reconvened at 7:15 p.m.

2016-17 BOARD MEETING SCHEDULE AMENDMENT (7:15 p.m.)

It was moved by Carla Piluso to approve the 2016-17 Board Meeting Schedule as amended to add 6 p.m. work sessions that will precede the board's regular business meetings throughout the school year, and cancel the September 22, 2016, work session. Matt O'Connell seconded the motion.

Following discussion, the motion carried 5 to 2. John Hartsock and Kathy Ruthruff cast the dissenting votes.

POLICY REVIEW (7:23 p.m.)

Board members reviewed proposed updates to the following policies for first reading:

Policy Code	Title
BBAA	Individual Board Member's Authority and Responsibility
BBC	Board Member Resignation
BD/BDA	Board Meetings
BDC	Executive Sessions
BFC	Adoption and Revision of Policies
ECACB	Unmanned Aircraft System (UAS) a.k.a. Drone
GBM	Staff Complaints
GBMA	Whistleblower
GCBDD/GDBDD	Sick Time

IGAI	Human Sexuality, AIDS/HIV, Sexually Transmitted Diseases, Health Education
IGBBA	Identification – Talented and Gifted Students
IGBBB	Identification – Talented and Gifted Students Among Nontypical Populations
JED	Student Absences and Excuses
JFC	Student Conduct
JHCA/JHCB	Immunization, Physical Examination, Vision Screening/Eye Examination and Dental Screening
KGB	Public Conduct on District Property

The policy updates will be presented for second reading and adoption at a subsequent meeting.

AUDIT REVIEW COMMITTEE REPORT (7:41 p.m.)

The board heard an audit review committee report from Carla Piluso and Kris Howatt. It was noted that final 2016 Fiscal Year Comprehensive Annual Financial Report will be presented to the board at the November 3, 2016, regular board meeting.

MISCELLANEOUS (7:48 p.m.)

Miscellaneous items included Measure 97, a recent newspaper article regarding graduation rates, and city and school district partnerships.

ANNOUNCEMENTS (7:55 p.m.)

Sept. 12, 2016: Gresham-Barlow Education Foundation
"Scramble for Students" Golf Tournament – 10 a.m.
Persimmon Country Club, Gresham, OR

Sept. 15, 2016: DAC Meeting - 7 p.m.
North Gresham Elementary School
Board Representatives: All

Sept. 22, 2016: ~~Regular Board Work Session - 6 p.m~~. *Canceled*
Partnership Room
Center for Advanced Learning

Oct. 3, 2016: OSBA Fall Regional Dinner Meeting – 5:30 p.m.
Embassy Suites Portland Airport
7900 NE 82nd Avenue, Portland, OR

Oct. 6, 2016: Regular Board Work Session - 6 p.m.
Council Chambers Conference Room
Public Safety and Schools Building

Oct. 6, 2016: Regular Board Business Meeting - 7 p.m.
Council Chambers
Public Safety and Schools Building

ADJOURNMENT (8:00 p.m.)

There being no other business, the meeting was adjourned at 8:00 p.m.

Submitted by: _____

Linda J. Cook
Administrative Assistant to the Superintendent and
Board of Directors

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
Mike Schofield

DATE: October 6, 2016

RE: No. 2 – Financial Report

EXPLANATION: Open Enrollment: The district's benefits team has had a busy month with open enrollment for medical, dental and vision insurance. The financial audit fieldwork is complete and on track to be presented to the board in November.

The attached financial report reflects some, but not all, staffing additions made for enrollment at the start of the school year.

PRESENTER: Mike Schofield

SUPPLEMENTARY MATERIALS: Financial Report, as of August 31, 2016

RECOMMENDATION: None

REQUESTED ACTION: Consent agenda approval

MS:mkh

GRESHAM-BARLOW SCHOOL DISTRICT

As of August 31, 2016 — **Financial Report** — 2016-2017

GENERAL FUND

	Actual Aug	Projected QTR 1	Projected QTR 2	Projected QTR 3	Projected QTR 4	Projected Annual	Actual YTD	**Adopted Budget**	Variance To Budget	
Revenue										
Current Taxes	-	-	24,000,000	1,200,000	1,000,000	26,200,000	-	26,204,668	-4,668	
Prior Year Taxes	77,241	152,241	197,500	87,500	132,500	569,741	77,241	570,000	-259	
Other Taxes / Interest	135	5,285	200	2,950	550	8,985	135	15,000	-6,015	
Total Taxes	77,376	157,526	24,197,700	1,290,450	1,133,050	26,778,726	77,376	26,789,668	-10,942	
Common School Fund	-	-	-	580,000	580,000	1,160,000	-	1,170,000	-10,000	
County School Fund	-	-	-	-	2,000	2,000	-	2,000	0	
Federal Forest Fees	-	-	-	-	12,000	12,000	-	12,000	0	
State School Fund (SSF)	6,697,288	26,797,192	20,091,864	20,091,864	13,394,576	80,375,496	20,099,904	80,420,000	-44,504	
Other SSF Revenue	6,697,288	26,797,192	20,091,864	20,671,864	13,988,576	81,549,496	20,099,904	81,604,000	-54,504	
Total Formula Revenue	6,774,664	26,954,718	44,289,564	21,962,314	15,121,626	108,328,222	20,177,280	108,393,668	-65,446	
High Cost Disability	-	-	-	-	550,000	550,000	-	550,000	0	
Prior Year SSF	-	-	-	-	-	-	-	-	0	
State Restricted	-	-	-	-	-	-	-	-	0	
Other State Revenue	-	-	-	-	550,000	550,000	-	550,000	0	
Tuition / Transportation	120	620	7,500	15,500	70,000	93,620	120	115,000	-21,380	
Earning on Investment	17,734	44,959	40,000	45,000	35,000	164,959	29,959	160,000	4,959	
Student Fees / Admissions	2,088	25,582	76,500	88,000	172,000	362,082	9,582	360,000	2,082	
Rentals	15,136	47,925	62,000	80,000	45,000	234,925	42,925	225,000	9,925	
Donations	1,500	16,500	85,000	50,000	125,000	276,500	1,500	275,000	1,500	
Services to other Funds	-	10,000	15,000	-	405,000	430,000	-	390,000	40,000	
Misc.	(2,906)	47,728	130,000	55,000	160,000	392,728	17,728	400,000	-7,272	
MESD Transfer	-	-	2,050,000	-	-	2,050,000	-	2,050,000	0	
Other County Funds	-	-	-	-	-	-	-	-	0	
Drivers' Education	-	-	-	-	-	-	-	-	0	
Other Federal Revenue	-	-	-	-	-	-	-	-	0	
Child Care Development	-	-	10,000	15,000	10,000	35,000	-	30,000	5,000	
Sale of Fixed Assets	379	10,729	-	-	-	10,729	10,729	5,000	5,729	
Bond Proceeds	-	-	-	-	-	-	-	-	0	
TRANFERS	-	-	-	-	-	-	-	-	0	
Total Other Revenue	34,051	204,043	2,476,000	348,500	1,022,000	4,050,543	112,543	4,010,000	40,543	
TOTAL REVENUE	$6,808,715	$27,158,761	$46,765,564	$22,310,814	$16,693,626	$112,928,765	$20,289,823	$112,953,668	-24,903	18.0%
								9,103,818	BFB Budget	
Expenditures										
Licensed Salaries	25,519	3,149,042	9,300,000	9,300,000	15,500,000	37,249,042	49,042	37,123,010	-126,032	
Support Staff Salaries	317,382	1,536,952	2,700,000	2,700,000	4,500,000	11,436,952	636,952	11,581,529	144,577	
Admin Salaries	461,158	1,392,157	1,407,750	1,407,750	1,407,750	5,615,407	922,907	5,484,637	-130,770	
Confidential Salaries	34,985	115,600	120,000	120,000	120,000	475,600	75,600	556,088	80,488	
Subs' / Temp Salaries	94,891	356,114	1,025,000	900,000	1,425,000	3,706,114	131,114	3,742,812	36,698	
Total Salaries	933,935	6,549,865	14,552,750	14,427,750	22,952,750	58,483,115	1,815,615	**58,488,076**	4,961	
PERS	159,798	1,284,232	2,925,000	2,925,000	4,450,000	11,584,232	309,232	11,685,827	101,595	
FICA	70,304	486,768	1,050,000	1,050,000	1,700,000	4,286,768	136,768	4,463,814	177,046	
Insurance	162,556	1,502,810	3,525,000	3,525,000	5,250,000	13,802,810	327,810	13,680,969	-121,841	
Other Benefits	128,510	272,901	300,000	475,000	425,000	1,472,901	172,901	1,423,231	-49,670	
Total Benefits	521,168	3,546,711	7,800,000	7,975,000	11,825,000	31,146,711	946,711	**31,253,841**	107,130	
Purchased Services	721,627	2,115,865	3,300,000	3,300,000	4,700,000	13,415,865	1,015,865	13,933,070	517,205	
Charter School Payments	520,094	2,146,691	1,725,000	1,725,000	1,150,000	6,746,691	1,571,691	6,741,087	-5,604	
Supplies & Materials	294,283	624,071	440,000	375,000	1,295,000	2,734,071	374,071	2,739,936	5,865	
Capital Outlay	170,583	180,583	35,000	35,000	55,000	305,583	170,583	308,000	2,417	
Other Objects	21,875	601,008	21,000	20,000	145,000	787,008	576,008	790,308	3,300	
Transfers	-	840,000	-	-	-	840,000	840,000	840,000	0	
TOTAL EXPENDITURES	$3,183,565	$16,604,794	$27,873,750	$27,857,750	$42,122,750	$114,459,044	$7,310,544	**$115,094,318**	$635,274	6.4%
Reserves - Contingency/Unappropriated Ending Balance								6,963,168		
Beginning Cash Balance							**$10,278,093**	$0		
							($1,530,279)	$122,057,486	**Budget**	
							$8,747,814			
							7.6%	(Percentage of Projected Expenditures)		

Expenditure Summary

Salaries	1,815,615	24.8%
Benefits	946,711	12.9%
Purchased Serv	2,587,556	35.4%
Supplies	374,071	5.1%
Capital Outlay	170,583	2.3%
Other Objects	576,008	7.9%
Transfers	840,000	11.5%
$	**7,310,544**	100.0%

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
Randy Bryant

DATE: October 6, 2016

RE: No. 3 - Personnel Changes: Resignations/Terminations and New Hires

EXPLANATION:

ORS 332.075(2)-(3), states that, "All contracts of the school district must be approved by the district school board before an order can be drawn for payment." As stated, this statute is applicable to all contracts, which includes employment contracts entered into between the district and licensed employees. (Note: Classified employees are not hired by contract.)

In addition, Board Policy GB, General Personnel Policies, provides that, "The employment of candidates to fill positions will be approved by the Board upon the superintendent's recommendation."

In compliance with both the State statute and the school board policy listed above, this executive summary provides a list of all new hires recommended for employment, and board approval is requested.

Also provided in this executive summary are lists of employment resignations and/or terminations. Historically, the board has requested the inclusion of this information to explain where and why vacancies have been created, and to serve as supplemental information for the recommendation of new hires.

Administrative New Hires

Donna Ravenberg, Program Director, Student Support Services. Probationary Contract. Replacing Terry Cosentino, resigned.

Peter Kane, Substitute Assistant Principal, Gresham High School. Temporary replacement for Assistant Principal.

Licensed New Hires

Elizabeth Brown, ELL Teacher, Hall Elementary School. Temporary Contract. Replacing Sean Wilcox, resigned.

Mistie Burrows, Math Teacher, Gordon Russell Middle School. Temporary Contract. Replacing Angela Williams, resigned.

William Cassidy, Special Education Teacher, East Gresham Elementary School. Temporary Contract. Replacing Tara Nelson, resigned.

Patty Chesla, Art Teacher, West Orient Middle School. Temporary Contract. Replacing River Wylde, reassigned.

Connie Dilts, School Psychologist, Student Support Services. Temporary Contract. Replacing Connie Dilts, non-renewed.

Samantha Gale, Grade 2 Teacher, Hogan Cedars Elementary School. Temporary Contract. New FTE.

Keith Hamilton, Grade 2 Teacher, East Gresham Elementary School. Probationary Contract. Replacing Karla Daman, resigned

Tiffany Pate, Kindergarten Teacher, DCD K-8 School. Temporary Contract. New FTE.

Maria Plesa, Kindergarten Teacher, Highland Elementary School. Probationary Contract. Heidi Miller-Craddock, reassigned.

Kelly Potter-Kemper, Licensed Substitute/Elementary and Middle School Level. District Wide. Replacing Jeffrey Latter, temporary non-renewed.

Shelley Robertson, Special Education Teacher, East Orient Elementary School. Probationary Contract. Replacing Karla Daman, resigned.

Joseph Rosas, Special Education Teacher, Gresham High School. Probationary Contract. Replacing Stacy Perez, resigned.

Michal Rubin, Speech Language Pathologist, Hall Elementary School. Probationary Contract. Replacing Annelise Bliss, resigned.

Anthony Sinclair, Special Education RMT Teacher, Clear Creek Middle School. Probationary Contract. Replacing Linda Lanning, reassigned.

Jason Tuckness, Science Teacher, Gordon Russell Middle School. Temporary Contract. Replacing Jennifer Sorcinelli, resigned.

Classified New Hires

Melina Bacon, Educational Assistant – Supervision / Instruction, North Gresham Elementary School. New temporary position for 2016-17 (Title funding).

Maricela Diaz, Educational Assistant – Instruction (Title I), Highland Elementary School. New temporary position for 2016-17 (Title funding).

Kyrsten Hansen, Educational Assistant – Special Ed, Hall Elementary School. Replacing Robert Payne who resigned.

Ashley Harper, Educational Assistant – Special Ed, Sam Barlow High School / Center for Advanced Learning. Replacing Jamie Alwine who resigned.

Sarah Jette, Educational Assistant – Special Ed, Highland Elementary School. Continuing in same position held as temporary in 2015-16.

Marian Mikhael, Educational Assistant – Supervision, East Gresham Elementary School. Replacing Cazoshay Ward who has been reassigned.

Kelsey Miller, Educational Assistant / Health Assistant, Powell Valley Elementary School. Replacing Amoreana Collins who has been reassigned.

Tia Molony, Educational Assistant, Sam Barlow High School. Replacing Amy Swank who resigned.

Geraldine Ponce-Rickards, Educational Assistant – Instruction, North Gresham Elementary School. New temporary position for 2016-17 (Title funding).

Rebecca Robinson, Educational Assistant – Instruction, Highland Elementary School. Replacing Cathi Mercer who retired.

Danielle Robison, Educational Assistant – Childcare, Gresham High School. New position.

Rosa Sanchez Marquez, ELL Liaison, Dexter McCarty Middle School. Replacing Perla Taylor who retired.

Laura Schneider, Educational Assistant – Supervision / Special Education, Powell Valley Elementary School. Replacing Megan Cochran Palau who has been reassigned.

Cassandra Snow, Educational Assistant – Supervision, East Gresham Elementary School. Replacing Margaret Collins who has been reassigned.

Brenda Stubblefield, Attendance Case Manager – East Gresham, Hall and Highland elementary schools. Replacing Reyna Martinez-Martinez who resigned.

Safiyah Thorne, Educational Assistant – In School Suspension, Gresham High School. Replacing John Wilson who has been reassigned.

Classified Resignations/Terminations

Reyna Martinez-Martinez, School and Community Liaison, East Gresham Elementary School. Notice of resignation received June 16, 2016, effective June 15, 2016.

PRESENTER: Randy Bryant

SUPPLEMENTARY MATERIALS: None

RECOMMENDATION:

1. In compliance with ORS 332.075(2)(3), the administration recommends board approval of the licensed employment contracts described above.

2. As required by Policy GB, the administration recommends the employment of candidates to fill positions as listed above.

REQUESTED ACTION: Consent agenda approval

RHB:mc:lc

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
James Hiu

DATE: October 6, 2016

RE: No. 4 - Out-of-State Travel

EXPLANATION: The administration seeks approval for the following out-of-state travel plans:

School	Destination	Date(s)	Group	Funds
Gresham HS	Spring Break Tournament Orlando, FL	March 26-31, 2017	Varsity and JV Baseball	No District Funds Required
Purpose: Team building and experience playing in an elite tournament.				
Gresham HS	Anaheim, CA	June 18-22, 2017	Wind Symphony & Band	No District Funds Required
Purpose: Students will have a quasi-professional soundtrack recording session; and will perform on a professional stage.				
Sam Barlow HS	Spring Baseball Tournament Palm Desert, CA	March 25-April 1, 2017	Varsity Baseball	No District Funds Required
Purpose: Varsity baseball players "encouraging" post secondary options in college				
Sam Barlow HS	Spudder Speech & Debate Tournament Ridgefield, WA	Dec 9-10, 2016	Barlow Speech & Debate	No District Funds Required
Purpose: Academic debate and discourse.				
Sam Barlow HS	Cal Berkeley Invitational, Berkeley, CA	Feb. 16-20, 2017	Barlow Speech & Debate	No District Funds Required
Purpose: Academic debate and discourse				
Sam Barlow HS	National Speech & Debate Tournament Birmingham, AL	June 18-25, 2017	Barlow Speech & Debate	No District Funds Required
Purpose: Academic debate and discourse				

PRESENTER: James Hiu

SUPPLEMENTARY MATERIALS: None

RECOMMENDATION: The administration recommends approval of the out-of-state travel requests listed above.

REQUESTED ACTION: Consent agenda approval

JH:pkh:lc

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
Teresa Ketelsen

DATE: October 6, 2016

RE: No. 5 – Policy Updates

EXPLANATION: Policy updates recommended by Oregon School Boards Association and district staff were presented for first reading at the September 8, 2016, board work session.

The board reviewed and provided input regarding the policy updates. These policies are now being submitted for approval through the consent agenda.

Policy Code	Policy Title
BBAA	Individual Board Member's Authority and Responsibility
BBC	Board Member Resignation
BD/BDA	Board Meetings
BDC	Executive Sessions
BFC	Adoption and Revision of Policies
ECACB	Unmanned Aircraft System (UAS) a.k.a. Drone
GBM	Staff Complaints
GBMA	Whistleblower
GCBDD/GDBDD	Sick Time
IGAI	Human Sexuality, AIDS/HIV, Sexually Transmitted Diseases, Health Education
IGBBA	Identification – Talented and Gifted Students
IGBBB	Identification – Talented and Gifted Students Among Nontypical Populations
JED	Student Absences and Excuses
JFC	Student Conduct
JHCA/JHCB	Immunization, Physical Examination, Vision Screening/Eye Examination and Dental Screening
KGB	Public Conduct on District Property

PRESENTER:	Teresa Ketelsen
SUPPLEMENTARY MATERIALS:	Revised policies (16) with recommended changes
RECOMMENDATION:	The administration recommends board approval of the policies changes as presented.
REQUESTED ACTION:	Consent agenda approval

TK:lc

Gresham-Barlow School District

Board Policies

Second Reading

October 6, 2016

Policy	Title
BBAA	Individual Board Member's Authority and Responsibility
BBC	Board Member Resignation
BD/BDA	Board Meetings
BDC	Executive Sessions
BFC	Adoption and Revision of Policies
ECACB	Unmanned Aircraft System (UAS) a.k.a. Drone
GBM	Staff Complaints
GBMA	Whistleblower
GCBDD/GDBDD	Sick Time
IGAI	Human Sexuality, AIDS/HIV, Sexually Transmitted Diseases, Health Education
IGBBA	Identification – Talented and Gifted Students
IGBBB	Identification – Talented and Gifted Students Among Nontypical Populations
JED	Student Absences and Excuses
JFC	Student Conduct
JHCA/JHCB	Immunization, Physical Examination, Vision Screening/Eye Examination and Dental Screening
KGB	Public Conduct on District Property

Gresham-Barlow SD 10

Code: **BBAA**
Adopted: 5/01/97
Readopted: 2/04/99; 5/02/02; 11/01/12
Orig. Code(s): BBAA

Individual Board Member's Authority and Responsibilities

An individual Board member exercises the authority and responsibility of his or her position when the Board is in legal session only.

A Board member has the authority to act in the name of the Board when authorized by a specific Board motion. The affirmative vote of the majority of members of the Board is required to transact any business. When authorized to act as the district's designated representative in collective bargaining, a Board member may make and accept proposals in bargaining subject to subsequent approval by the Board.

A Board member has the right to express personal opinions. When expressing such opinions in public, the Board member must clearly identify the opinions as his or her own.

Board members will be knowledgeable of information requested through Board action, supplied by the superintendent, gained through attendance at district activities and professional Board activities.

Members of the Board will adhere to the following ~~procedures~~ in carrying out the responsibilities of membership:

1. Request for Information

   Any individual Board member who desires a copy of an existing written report or survey prepared by the administrative staff will make such a request to the superintendent. A copy of the material may be made available to each member of the Board. Requests for the generation of reports or information, which require additional expense to the district, must be submitted to the Board for consideration.

2. Requests for Legal Opinions

   ~~Any Board member may request a legal opinion. Such request, however, shall be made through the Board chair to the superintendent.~~ A request for a legal opinion by a Board member, must be approved by a majority vote of the Board before the request is made to legal counsel. If the legal opinion sought involves the superintendent's employment or performance, the request shall be submitted to the Board chair for approval. Legal counsel is responsible to the Board.

3. Action on Complaints or Requests Made to Board Members

   When Board members receive complaints or requests for action from staff, students or members of the public, the Board members will direct the staff, students, or members of the public to the appropriate complaint policy (Board policy KL - Public Complaints, Board Policy GBM -Staff Complaints). Such information is to be conveyed to the superintendent.

4. Board Member's Relationship to Administration

Individual Board members will be informed about the district's educational program, may visit schools or other facilities to gain information and may request information from the superintendent. Individual Board members will not intervene in the administration of the district or its schools.

5. Contracts ~~Made by Individual Board Members~~ or Agreements

~~Contracts or agreements made by individual Board members without the Board's authority are invalid.~~ All contracts of the district must be approved by the Board, unless otherwise delegated by the Board to the superintendent or designee for approval, before an order can be drawn for payment. If a contract is made without authority of the Board, the individual making such contract shall be personally liable.

END OF POLICY

Legal Reference(s):

ORS 332.045
ORS 332.055
ORS 332.057
ORS 332.075

38 OR. ATTY. GEN. OP. 1995 (1978)
S. Benton Educ. Ass'n v. Monroe Union High Sch. Dist., 83 Or. App. 425 (1987).

Cross Reference(s):

BHD - Board Member Compensation and Expense Reimbursement

Gresham-Barlow SD 10

Code: **BBC**
Adopted: 5/02/94
Readopted: 2/04/99; 5/02/02; 3/07/13
Orig. Code(s): BBC

Board Member Resignation

The Board believes that any citizen who files and seeks election or appointment to the Board should do so with full knowledge of and appreciation for the investment in time, effort and dedication expected of all Board members, and that the citizen's intent is to ~~serve reflects intention to~~ serve a full term of office.

~~The Board requests earliest possible notification of intent to resign so that the Board may plan for the continuity of Board business. Board members resigning their positions should present such resignation in writing to the Board chair no later than 30 days before the effective resignation date so the Board may appoint and orient the replacement in a timely manner.~~ When a member decides to terminate service, the Board requests earliest possible notification of intent to resign so the Board may plan for the continuity of Board business. Resignations must be made in writing. Board members can resign the office effective at a future date. If the resignation is effective at a future date, the resignation is binding unless withdrawn in writing by the end of the third business day after the resignation is made.

The Board will announce the resignation and declare the vacancy at ~~its next regular~~ a Board meeting.

The Board will determine the procedures to be used in filling the vacancy. The Board may begin a replacement process and select a successor prior to the effective date of resignation; however, the actual appointment shall not be made before the resignation date.

END OF POLICY

Legal Reference(s):

ORS 236.320
ORS 236.325
ORS 332.030

Gresham-Barlow SD 10

Code: **BD/BDA**
Adopted: 5/01/97
Revised/Readopted: 2/04/99; 5/02/02; 3/07/13
Orig. Code(s): BD/BDA

Board Meetings/~~Regular Board Meetings~~

~~"Meeting" means the convening of the Board as the district's governing body to make a decision or to deliberate toward a decision on any matter.~~ The Board has the authority to act only when a quorum is present at a duly called regular, ~~or~~ special or emergency meeting. ~~Communications between and among a quorum of members convening on electronically linked personal computers or by telephone conference call are subject to the Public Meetings Law.~~ "Meeting" means the convening of a quorum of the Board as the district's governing body to make a decision or to deliberate toward a decision on any matter. This includes meeting for the purpose of gathering information to serve as the basis for a subsequent decision or recommendation by the governing body, i.e., a work session. The affirmative vote of the majority of members of the Board is required to transact any business.

~~1. Regular Meetings~~

All regular, ~~and~~ special and emergency meetings of the Board will be open to the public except as provided by law. All meetings will be conducted in compliance with state and federal statutes. All Board meetings, including Board retreats and work sessions, will be held within the district boundaries. The Board may attend training sessions outside the district boundaries but cannot deliberate or discuss district business.[1] No meeting will be held at any place where discrimination on the basis of disability, race, creed, color, sex, sexual orientation[2], age or national origin is practiced.

The Board will give public notice reasonably calculated to give actual notice to interested persons, including those with disabilities, of the time and place for all Board meetings and of the principal subjects to be considered. The Board may consider additional subjects at a meeting, even if they were not included in the notice.

If requested to do so at least 48 hours before a meeting held in public, the Board shall provide an interpreter for hearing impaired persons. Such other appropriate auxiliary aids and services will be provided upon request and appropriate advance notice. Communications with all qualified individuals with disabilities shall be as effective as communications with others.

All meetings held in public shall comply with the Oregon Indoor Clean Air Act and the smoking provisions contained in the Public Meetings Law.

[1]ORS 192.630(4). Meetings of the governing body of a public body shall be held within the geographic boundaries over which the public body has jurisdiction, or at the administrative headquarters of the public body or at the other nearest practical location. Training sessions may be held outside the jurisdiction as long as no deliberations toward a decision are involved.
[2]As defined in ORS 174.100.

1. Regular, Special and Emergency Meetings

~~The first~~ No later than the next regular meeting ~~after~~ following July 1, ~~of each year will be~~ the Board will hold an organizational meeting to elect Board officers for the coming year and to establish the year's schedule of Board meetings~~.~~ (~~I~~in Board election years, the first meeting will be held no later than July 31).

~~One~~ Generally, a regular ~~or special~~ Board meeting will be held each month. The regular meeting schedule ~~will be established at the organizational meeting in July but~~ may be changed by the Board with proper notice. The purpose of each regular monthly meeting will be to conduct the regular Board business. ~~The Board chair will conduct the meeting, or in his/her absence, the vice chair will conduct the meeting. If both are absent, the person with the longest period of service on the Board will conduct the meeting.~~

Special meetings can be convened by the Board chair upon request of three Board members, or by common consent of the Board at any time to discuss any topic. A special meeting may also be scheduled if less than a quorum is present at a meeting or additional business still needs to be conducted at the ending time of a meeting. At least 24 hours' notice must be provided to all Board members, the news media, which have requested notice, and the general public for any special meeting.

Emergency meetings can be called by the Board in the case of an actual emergency upon appropriate notice under the circumstances. The minutes of the emergency meeting must describe the emergency. Only topics necessitated by the emergency may be discussed or acted upon at the emergency meeting.

2. Electronic Communication

~~E-mail~~ Communications to, by~~,~~ and among a quorum of Board members outside of a legally called Board meeting, in their capacity as Board members, shall not be used for the purpose of discussing district business. This includes electronic communication. ~~E-mail~~ Electronic communications among Board members shall be limited to~~: (1) disseminating information, and (2)~~ messages not involving deliberation, debate, ~~or~~ decision-making, or gathering of information on which to deliberate. ~~E-mail~~ Electronic communications may contain:

a. Agenda item suggestions;
b. Reminders regarding meeting times, dates and places;
c. Board meeting agendas or information concerning agenda items;
d. One-way information from Board members or the superintendent to each Board member (e.g., an article on student achievement or to share a report on district progress on goals) so long as that information is also being made available to the public;
e. Individual responses to questions posed by community members, subject to other limitations in Board policy.

E-mails sent to other Board members will have the following notice:

> *Important: Please do not reply or forward this ~~e-mail~~ communication if this communication constitutes a decision or deliberation toward a decision between and among a quorum of a governing body which could be considered a public meeting. ~~E-mails~~ Electronic communications on district business are governed by ~~p~~Public ~~r~~Records and Meetings ~~l~~Law.*

3. Private or Social Meetings

Private or social meetings of a quorum of the Board for the purpose of making a decision or to deliberate toward a decision on any matter are prohibited by the Public Meetings Law.

4. Work Sessions

The Board may use regular or special meetings for the purpose of conducting work sessions to provide its members with opportunities for planning and thoughtful discussion. Work sessions will be conducted in accordance with the state law on public meetings, including notice and minutes. The Board may make official decisions during a work session.

5. Executive Sessions

Executive sessions may be held as an agenda item during regular, special or emergency meetings for a reason permitted by law.

~~6. Special Meetings~~

~~a. A Board meeting may be adjourned to another time if a quorum is not present or if additional business needs to be conducted at the regular time of adjournment. The time, date and place of the special meeting will be specified and appropriate notice given.~~

~~All meetings held in public shall comply with the Oregon Indoor Clean Air Act and the smoking provisions contained in the Public Meetings Law.~~

~~The possession of dangerous or deadly weapons and firearms, as defined in law and Board policy, is prohibited on district property.~~

END OF POLICY

Legal Reference(s):

ORS 174.104
ORS Chapter 192
ORS Chapter 193
ORS 332.045 - 332.111
ORS 433.835 - 433.875

38 OR. ATTY. GEN. OP. 1995 (1978)
41 OR. ATTY. GEN. OP. 28 (1980)
Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213; 29 C.F.R. Part 1630 (2006); 28 C.F.R. Part 35 (2006).
Americans with Disabilities Act Amendments Act of 2008.

Cross Reference(s):
ACA - Americans with Disabilities Act
BDB - Special and Emergency Board Meetings
BDC - Executive Sessions

Gresham-Barlow SD 10

Code: **BDC**
Adopted: 2/04/99
Readopted: 5/02/02; 6/06/13

Executive Sessions

The Board may meet in executive session to discuss subjects allowed by statute but may not take final action except for the expulsion of students and matters pertaining to or examination of the confidential medical records of a student, including that student's educational program.

~~Executive sessions may be held during regular, special or emergency meetings for any reason permitted by law.~~An executive session may be convened by the Board chair upon request of three Board members or by common consent of the Board for a purpose authorized under Oregon Revised Statute (ORS) 192.660, during a regular, special or emergency meeting. The presiding officer will announce the executive session by identifying the authorization under ORS 192.660 for holding such session and by noting the subject of the executive session.

The Board may hold an executive session:

1. To consider the employment of a public officer, employee, staff member or individual agent. (ORS 192.660(2)(a))

2. To consider the dismissal or disciplining of, or to hear complaints or charges brought against, a public officer, employee, staff member or individual agent who does not request an open hearing. (ORS 192.660(2)(b))

3. To conduct deliberations with persons designated by the governing body to carry on labor negotiations. (ORS 192.660(2)(d))

4. To conduct deliberations with persons designated by the governing body to negotiate real property transactions. (ORS 192.660(2)(e))

5. To consider information or records that are exempt by law from public inspection. (ORS 192.660(2)(f))

6. To consult with counsel concerning the legal rights and duties of a public body with regard to current litigation or litigation likely to be filed. (ORS 192.660(2)(h))

7. To review and evaluate the employment-related performance of the chief executive officer of any public body, a public officer, employee or staff member who does not request an open hearing. (ORS 192.660(2)(i))

8. To consider matters relating to school safety or a plan that responds to safety threats made toward a school. (ORS 192.660(k))

9. To review the expulsion of a minor student from a public elementary or secondary school. (ORS 332.061(1)(a))

10. To discuss matters pertaining to or examination of the confidential medical records of a student, including that student's educational program. (ORS 332.061(1)(b))

~~The presiding officer will announce the executive session by identifying the authorization under ORS 192.660 for holding such session and by noting the subject of the executive session.~~ Members of the press may attend executive sessions except those matters pertaining to:

1. ~~d~~Deliberations with persons designated by the Board to carry on labor negotiations;

2. ~~h~~Hearings on the expulsion of minor students~~; matters pertaining to~~ or examination of the confidential medical records of a student including that student's educational program; and

3. ~~c~~Current litigation or litigation likely to be filed if the member of the news media is a party to the litigation or is an employee, agent or contractor of a news media organization that is a party to the litigation.

~~An executive session may be convened upon request of three Board members or by common consent of the Board for a purpose authorized under ORS 192.660.~~

If an executive session is held pursuant to ORS 332.061, ~~in accordance with laws pertaining to student confidentiality~~ the following shall not be made public: the name of the minor student; the issue, including the student's confidential medical records and educational program; the discussion; and each Board member's vote on the issue.

~~All executive session m~~Minutes shall be kept ~~in written or audio or video form~~ for all executive sessions.

Content discussed in executive sessions is confidential~~ and must not be made public~~.

END OF POLICY

Legal Reference(s):

ORS 192.610 to -192.710
ORS 332.045
ORS 332.061

Cross Reference(s):

BD/BDA - Board Meetings/Regular Board Meetings
CBG - Evaluation of the Superintendent

Gresham-Barlow SD 10

Code: **BFC**
Adopted: 6/06/13

Adoption and Revision of Policies

Board policies will be subject to alteration, addition or deletion ~~only~~ upon majority vote of the Board at any regular or special meeting in which all members have been notified in writing of the proposed alteration, addition or deletion at least 24 hours in advance. In most cases, a first reading of the policy will be scheduled on a regular meeting agenda prior to its adoption at a subsequent regular or special meeting. A first reading does not require Board action, and can be included in the board packet as an information item.

A proposed change in policy will not be made at the meeting in which the change is proposed unless by majority vote of the Board. The Board may vote a single reading adoption upon the request of the superintendent.

The formal adoption of policies will be recorded in the Board minutes. Only those written statements so adopted and so recorded will be regarded as official Board policy.

Board policy documents will be made available on the districts web site. ~~A hard copy of official policies will be kept at the district office.~~ When additions, deletions or amendments are made to Board policy, the addition, deletion or amendment will carry the adoption date and the corrected copy will be published ~~and inserted in the district Board policy manual and posted on the district's web site~~ at the earliest opportunity.

The operation of any individual policy, section or sections of policies not established by law or specifically listed in the current collective bargaining agreement may be temporarily suspended by a majority vote of the Board at a regular or special meeting.

The policy manual will be reviewed periodically to keep it current.

END OF POLICY

Legal Reference(s):

ORS 332.107
ORS 332.505
OAR 581-022-1610
OAR 581-022-1720

Cross Reference(s):

BCE - Board Committees
KC - Community Involvement in Decision Making

Gresham – Barlow SD 10

Code: **ECACB**
Adopted:

Unmanned Aircraft System (UAS) a.k.a. Drone

Any employee or representative of the district operating a district unmanned aircraft system shall do so in accordance with this policy and all applicable Federal Aviation Administration (FAA) regulations.

An "unmanned aircraft system" (UAS) means an unmanned flying machine, commonly known as a drone, and its associated elements, including communication links and the components that control the machine.

The district recognizes the academic value of student operation of a UAS as one component of curricula pertaining to principles of flight, aerodynamics and airplane design and construction, which can also serve as an academic tool in other areas such as television, film production or the arts in general. Therefore, in compliance with the Federal Aviation Administration Modernization and Reform Act of 2012, Section 336, students may operate a UAS as part of a course requirement, as long as that student does not receive compensation directly or incidentally from such operation. District staff teaching a class that allows use of a UAS may assist a student in their operation of the UAS, provided the assistance is needed as part of the curriculum and assistance is to a student enrolled in the course. The staff member's participation must be limited to the student's operation of the UAS.

District employees shall work with administrators to ensure that proper insurance, registration and authorization are in place prior to adoption of curriculum that allows operation of a UAS as part of the curriculum.

A UAS shall be operated in accordance with the policies of the Oregon School Activities Association (OSAA)[1] at OSAA sanctioned events. Use of a UAS at other district-sponsored athletics or activities is prohibited.

A student in violation of this policy may be subject to disciplinary action, up to and including suspension and/or expulsion.

A staff member in violation of this policy may be subject to disciplinary action, up to and including dismissal.

All data gathered by the district as part of a UAS operation will belong to the district. The data gathering by the district will follow appropriate state and federal laws. Retention of such data will follow state and federal laws.

The superintendent shall develop procedures for the implementation of this policy.

The district shall post a copy of this policy, associated procedures and a copy of Oregon Revised Statute (ORS) 192.501 on the district's website.

[1] http://www.osaa.org/governance/handbooks/osaa #85

Third Party Use

Third party use of a UAS on district property or at district-sponsored events for any purpose is prohibited, unless granted permission from the superintendent or designee.

If permission is granted by the superintendent or designee, the third party operating a UAS will comply with all FAA regulations and shall provide the following to the district:

1. Proof of insurance that meets the liability limits established by the district;

2. Appropriate registration and authorization issued by the FAA when required; and

3. A signed agreement holding the district harmless from any claims of harm to individuals or damage to property.

END OF POLICY

Legal Reference(s):

ORS 164.885
ORS 174.109
ORS 192.501
ORS 837.300 to -837.390
ORS 837.995

Federal Aviation Administration Modernization and Reform Act of 2012, P.L. 112-95,§ 336 (2012).
Federal Aviation Administration, Educational Use of Unmanned Aircraft Systems (UAS) Memorandum, May 4, 2016.
Family Educational Rights Privacy Act
OREGON SCHOOL ACTIVITIES ASSOCIATION HANDBOOK #85 (2015-2016).

CR6/30/16 | PH

Gresham-Barlow SD 10

Code: **GBM**
Adopted: 7/11/94
Revised/Readopted: 1/11/01; 5/02/02; 10/02/14; 10/01/15
Orig. Code(s): GBM

Staff Complaints

~~It is an unlawful employment practice for an employer to discharge, demote, suspend or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith reported information in a manner as to disclose employer violations of any federal or state law, rule or regulation, mismanagement, gross waste of funds, abuse of authority, or substantial and specific danger to public health and safety.~~

The superintendent or designee will develop and maintain a complaint procedure which will be available for all employees who ~~contend they have been subject to~~ believe there is evidence of, and wishes to report a violation, misinterpretation or inappropriate application of district personnel policies and/or administrative regulations; a mismanagement, gross waste of funds or abuse of authority; or believe there is evidence that the district created a substantial and specific danger to public health and safety by its actions. The complaint procedure will provide an orderly process for the consideration and resolution of problems in the application or interpretation of district personnel policies.

The complaint procedure will not be used to resolve disputes and disagreements related to the provisions of any collective bargaining agreement, nor will it be used in any instance where a collective bargaining agreement provides a dispute resolution procedure. Disputes concerning an employee's dismissal or contract nonrenewal or contract nonextension will not be pursued under this procedure.

All reasonable efforts will be made to resolve complaints informally.

The district will use the complaint process in ~~Policy~~ administrative regulation KL-AR Public Complaints ~~shall be used as the procedural timelines and steps under~~ to address any alleged violations of this policy.

END OF POLICY

Legal Reference(s):

ORS 332.107
ORS 659A.199 to -659A.224

OAR 581-022-1720

Anderson v. Central Point Sch. Dist., 746 F.2d 505 (9th Cir. 1984).
Connick v. Myers, 461 U.S. 138 (1983).

Gresham-Barlow SD 10

Code: **GBMA**
Adopted:

Whistleblower *

When an employee has good faith and reasonable belief the employer has violated any federal, state or local, law, rule or regulation; has engaged in mismanagement, gross waste of funds or abuse of authority; or created a substantial and specific danger to public health and safety by its actions, and an employee then discloses or plans to disclose such information, it is an unlawful employment practice for an employer to:

1. Discharge, demote, transfer, reassign or take disciplinary action against an employee or threaten any of the previous actions.

2. Withhold work or suspend an employee.

3. Discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment.

4. Direct an employee or to discourage an employee to not disclose or to give notice to the employer prior to making any disclosure.

5. Prohibit an employee from discussing, either specifically or generally, the activities of the state or any agency of or political subdivision in the state, or any person authorized to act on behalf of the state or any agency of or political subdivision in the state, with:

    a. Any member of the Legislative assembly;
    b. Any Legislative committee staff acting under the direction of any member of the Legislative assembly; or
    c. Any member of the elected governing body of a political subdivision in the state or any elected auditor of a city, county or metropolitan service district.

The district will use the complaint process in administrative regulation KL-AR - Public Complaints Procedure to address any alleged violations of this policy.

The district shall deliver a written or electronic copy of this policy to each staff member.

END OF POLICY

Legal Reference(s):

ORS 192.501 to -192.505
ORS 659A.199 to -659A.224 OAR 581-022-1720

Anderson v. Central Point Sch. Dist., 746 F.2d 505 (9th Cir. 1984).
Connick v. Myers, 461 U.S. 138 (1983).

Gresham-Barlow SD 10

Code: GCBDD/GDBDD
Adopted:

Sick Time*

This policy shall only apply to employees not otherwise eligible for Gresham-Barlow School District's substantially equivalent Sick Leave benefits enumerated in the collective bargaining agreements with our bargaining groups (Oregon School Employees Association and the Gresham-Barlow Education Association), as defined in 839-007-0055.

"Employee" means an individual who is employed by the district and who is paid on an hourly, stipend or salary basis, and for whom withholding is required under Oregon Revised Statute (ORS) 316.162-316.221. The definition does not include volunteers or independent contractors.

Employees qualify to begin earning and accruing sick time on the first day of employment with the district.

The district shall allow an eligible employee to access up to 40 hours of paid sick time each fiscal year. Paid sick time shall accrue at the rate of at least one hour of paid sick time for every 30 hours or 1-1/3 hours for every 40 hours the employee works for all part time employees, including licensed and classified substitutes. Paid sick time of 40 hours shall be front-loaded for coaches, not currently covered in a collectively bargained position, at the beginning of the first sport season that the employee coaches each fiscal year.

The employee may carry up to 40 hours of unused sick time from one year to the subsequent year. An employee is limited to using no more than 40 hours of sick time in a fiscal year.

Sick time shall be taken in hourly increments except for licensed and classified substitutes which must take sick time in 4 hour increments, and may be used for the employee's or a family member's mental or physical illness, injury or health condition, need for medical diagnosis, care or treatment of a mental or physical illness, injury or health condition or need for preventive care, or for reasons consistent with the Family Medical Leave Act (FMLA) or OFLA. Sick time may also be used in the event of a public health emergency.

The use of sick time may not lead to, or result in, an adverse employment action against the employee.

The district reserves the right after three consecutive days of absence, to require proof of personal illness or injury from an employee, including a medical examination by a physician chosen and paid for by the district. An employee refusing to submit to such an examination or to provide other evidence as required by the district, shall be subject to appropriate disciplinary action, up to and including dismissal.

When the reason for sick time is consistent with FMLA/OFLA leave, the sick time and the FMLA/OFLA leave will run concurrently.

When the reason for sick time is consistent with ORS 332.507, the sick time and leave pursuant to ORS 332.507 will run concurrently.

If the reason for sick time is a foreseeable absence, the district may require the employee to provide advance notice of their intention to use sick time as soon as practicable. When the employee uses sick time for a foreseeable absence, the employee shall take reasonable effort to schedule the sick time in a manner that does not unduly disrupt the operations of the district (e.g., grading deadlines, inservice training, and mandatory meetings).

If the reason for sick time is unforeseeable, such as an emergency, accident or sudden illness, the employee shall notify the district at least 24 hours in advance or as soon as practicable.

The district shall establish a standard process to track the eligibility for sick time of a substitute.

Nothing in this policy impacts the districts sick leave obligation under Oregon Revised Statue (ORS) 332.507.

END OF POLICY

Legal Reference(s):

ORS 332.507
ORS 342.545
ORS 342.610
ORS 659A.150 to -659A.186
SB 454 (2015)

Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213; 29 C.F.R. Part 1630 (2006); 28 C.F.R. Part 35 (2006).
Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601-2654 (2006); Family and Medical Leave Act of 1993, 29 C.F.R. Part 825 (2006).
Americans with Disabilities Act Amendments Act of 2008.

R1/14/16 | PH

Gresham-Barlow SD 10

Code: **IGAI**
Adopted: 7/11/94
Revised/Readopted: 4/12/01; 5/02/02; 5/01/08; 5/01/08; 3/04/10; 11/06/14
Orig. Code(s): IGAI

Human Sexuality, AIDS/HIV, Sexually Transmitted Diseases, Health Education**

The district shall provide an age appropriate, comprehensive plan of instruction focusing on human sexuality, HIV/AIDS and sexually transmitted infections and disease prevention in elementary and secondary schools as an integral part of health education and other subjects.

Course material and instruction for all human sexuality education courses that discuss human sexuality shall enhance student's understanding of sexuality as a normal and healthy aspect of human development. A part of the comprehensive plan of instruction shall provide age-appropriate child sexual abuse prevention instruction for students in kindergarten through grade 12. The district must provide a minimum of four instructional sessions annually; one instructional session is equal to one standard class period. In addition, the HIV/AIDS and sexually transmitted infections and disease prevention education and the human sexuality education comprehensive plan shall provide adequate instruction at least annually, for all students in grades 6- through 8 and at least twice during grades 9- through 12.

Parents, teachers, school administrators, local health departments staff, other community representatives and persons from the medical community who are knowledgeable of the latest scientific information and effective education strategies shall develop the plan of instruction and align it with the Oregon Health Education Standards and Benchmarks.

The Board shall approve the plan of instruction and require that it be reviewed and updated biennially in accordance with new scientific information and effective educational strategies.

Parents of minor students shall be notified in advance of any human sexuality or AIDS/HIV instruction. Any parent may request that his/her child be excused from that portion of the instructional program under the procedures set forth in Oregon Revised Statute (ORS) 336.035 (2).

The comprehensive plan of instruction shall include the following information that:

1. Promotes abstinence for school age youth and mutually monogamous relationships with an uninfected partner for adults;

2. Allays those fears concerning HIV that are scientifically groundless;

3. Is balanced and medically accurate;

4. Provides balanced, accurate information and skills-based instruction on risks and benefits of contraceptives, condoms and other disease reduction measures;

5. Discusses responsible sexual behaviors and hygienic practices which may reduce or eliminate unintended pregnancy, exposure to HIV, hepatitis B/C and other sexually transmitted infections and diseases;

6. Stresses the risks of behaviors such as the sharing of needles or syringes for injecting and controlled substances;

7. Discusses the characteristics of emotional, physical and psychological aspects of a healthy relationship;

8. Discusses the benefits of delaying pregnancy beyond the adolescent years as a means to better ensure a healthy future for parents and their children. The student shall be provided with statistics based on the latest medical information regarding both the health benefits and the possible side effects of all forms of contraceptives including the success and failure rates for prevention of pregnancy, sexually transmitted infections and diseases;

9. Stresses that HIV/STDs and ~~H~~hepatitis B/C can be hazards of sexual contact;

10. Provides students with information about Oregon laws that address young people's rights and responsibilities related to childbearing and parenting;

11. Advises students of consequences of having sexual relations with persons younger than 18 years of age to whom they are not married;

12. Encourages family communication and involvement and helps students learn to make responsible, respectful and health decisions;

13. Teaches that no form of sexual expression or behavior is acceptable when it physically or emotionally harms oneself or others and that it is wrong to take advantage of or exploit another person;

14. Teaches that consent is an essential component of healthy sexual behavior. Course material shall promote positive attitudes and behaviors related to healthy relationships and sexuality, and encourage active student bystander behavior;

15. Teaches students how to identify and respond to attitudes and behaviors which contribute to sexual violence;

16. Validates the importance of one's honesty, respect for each person's dignity and well-being, and responsibility for one's actions;

17. Uses inclusive materials and strategies that recognizes different sexual orientations, gender identities and gender expression.

The comprehensive plan of instruction shall emphasize skill-based instruction that:

1. Assists students to develop and practice effective communication skills, development of self esteem and ability to resist peer pressure;

2. Provides students with the opportunity to learn about and personalize peer, media, technology and community influences that both positively and negatively impact their attitudes and decisions related to healthy sexuality, relationships and sexual behaviors, including decisions to abstain from sexual intercourse;

3. Enhances students' ability to access valid health information and resources related to their sexual health;

4. Teaches how develop and communicate sexual and reproductive boundaries;

5. Is research based, evidence based or best practice; and

6. Aligns with the Oregon Health Education Content Standards and Benchmarks.

All sexuality education programs emphasize that abstinence from sexual intercourse, when practiced consistently and correctly, is the only 100 percent effective method against unintended pregnancy, sexually transmitted HIV and hepatitis B/C infection and other sexually transmitted infections and diseases.

Abstinence is to be stressed, but not to the exclusion of contraceptives and condoms for preventing unintended pregnancy, HIV infection, hepatitis B/C infection and other sexually transmitted infections and diseases ~~and hepatitis B/C~~. Such courses are to acknowledge the value of abstinence while not devaluing or ignoring those students who have had or are having sexual relationships. Further, sexuality education materials, including instructional strategies and activities, must not in any way use shame or fear-based tactics.

Materials and information shall be presented in a manner sensitive to the fact that there are students who have experienced, perpetrated or witnessed sexual abuse and relationship violence.

END OF POLICY

Legal Reference(s):

ORS 336.035
ORS 336.107
ORS 336.455 to -336.475

ORS 339.370 to -339.400

OAR 581-022-0705

OAR 581-022-1440
OAR 581-022-1910

Cross Reference(s):

IGBHD - Program Exemptions

Gresham-Barlow SD 10

Code: **IGBBA**
Adopted: 7/11/94
Revised/Readopted: 4/12/01; 5/02/02; 11/06/14
Orig. Code(s): IGBB/IGBBA

Identification - Talented and Gifted Students**

In order to serve academically talented and intellectually gifted students in grades K-12, the district directs the superintendent to establish a written identification process. This process or identification shall include as a minimum:

1. Use of research based best practices to identify talented and gifted students from under-represented populations such as ethnic minorities, students with disabilities, students who are culturally and/or linguistically diverse or economically disadvantaged.

2. Behavioral, learning and/or performance information~~;~~.

3. A nationally standardized mental ability test for assistance in ~~identifying~~ the identification of intellectually gifted students~~;~~.

4. A nationally standardized academic achievement test of reading or mathematics such as the Smarter Balanced Assessment for assistance in identifying academically talented students ~~or Smarter Balanced Assessment~~.

Identified students shall score at or above the 97th percentile on these tests. Other students who demonstrate the potential to perform at the eligibility criteria, as well as additional students who are talented and gifted may be identified. A team shall make the final decisions on the identification of students. No single test, measure or score shall be the sole criterion. A record of the team's decision and the data used by the team to make the decision shall become part of the education record.

~~The Board will provide an appeals process for parents to utilize if they are dissatisfied with the identification process of their student for the district program for talented and gifted students and wish to request reconsideration.~~ If a parent is dissatisfied with the identification process or placement of their student, they may appeal the decision through the accompanying administrative regulation, IGBBA-AR. After exhausting the district's appeal procedure and receiving a final decision, a parent may appeal the decision to the State Superintendent of Public Instruction.

END OF POLICY

Legal Reference(s):

ORS 343.395
ORS 343.407
ORS 343.411
OAR 581-021-0030
OAR 581-022-1310 to -1330
OAR 581-022-1940
OAR 581-022-1941

Cross Reference(s):

IGBBB - Identification - Talented and Gifted Students Among Nontypical Populations
IGBBC - Programs and Services - Talented and Gifted

Gresham-Barlow SD 10

Code: **IGBBB**
Adopted: 7/11/94
Readopted: 4/12/01; 5/02/02; 11/06/14
Orig. Code(s): IGBB/IGBBA

Identification - Talented and Gifted Students Among Nontypical Populations**

The district will make an effort to identify talented and gifted students from populations such as:

1. Ethnic minorities;

2. Economically disadvantaged;

3. Culturally different;

4. Underachieving gifted;

5. Students with disabilities.

Careful selection of appropriate measures and a collection of behavioral or learning characteristics shall be used.

The Board will provide an appeals process for parents to utilize if they are dissatisfied with the identification process of their child for the district program for talented and gifted students and wish to request reconsideration.

END OF POLICY

Legal Reference(s):

ORS 343.395
ORS 343.407
ORS 343.411
OAR 581-022-1310 to -1330
OAR 581-022-1940

Cross Reference(s):

IGBBA - Identification - Talented and Gifted
IGBBC - Programs and Services - Talented and Gifted

Gresham-Barlow SD 10

Code: **JED**
Adopted: 7/11/94
Readopted: 5/02/02; 9/01/11; 12/04/14
Orig. Code(s): JED

Student Absences and Excuses**

It is the student's responsibility to maintain regular attendance in all assigned classes. Absence from school or class will be excused under the following circumstances:

1. Illness of the student;

2. Illness of an immediate family member when the student's presence at home is necessary;

3. Emergency situations that require the student's absence;

4. Field trips and school-approved activities;

5. Religious instruction;

6. Medical (dental) appointments. Confirmation of appointments may be required;

7. Other reasons deemed appropriate by the school administrator when satisfactory arrangements have been made in advance of the absence.

A student who is excused must still fulfill the school's requirements.

~~With these beliefs in mind, the district will develop procedures that foster a partnership with parents in the early detection of truancy, related counseling and appropriate consequences.~~

A ~~P~~parent~~s~~/ or guardian~~s~~ of an elementary and middle school student~~s~~ will be notified early in the school day if their child had an unplanned absences. A ~~P~~parent~~s~~/ or guardian~~s~~ of a high school student~~s~~ will be notified by the end of the school day if their child had an unplanned absence. The notification will be either in person, by telephone or another method identified in writing by the parent~~/~~ or guardian. If the parent~~/~~ or guardian cannot be notified by the above methods, a message shall be left, if possible.

Additionally, the superintendent will develop procedures that foster a partnership with parents in the early detection of truancy, related counseling and appropriate consequence.

END OF POLICY

Legal Reference(s):

ORS 109.056
ORS 332.107
ORS 339.030
ORS 339.055
ORS 339.065
ORS 339.071
ORS 339.420
OAR 581-021-0046
OAR 581-021-0050
OAR 581-023-0006(11)

Cross Reference(s):

IGBHD - Program Exemptions

Gresham-Barlow SD 10

Code: **JFC**
Adopted: 7/11/94
Readopted: 5/02/02; 8/15/14
Orig. Code(s): JFC

Student Conduct**

The Board expects student conduct to contribute to a productive learning climate. Students shall comply with the district's written rules, pursue the prescribed course of study, submit to the lawful authority of district staff and conduct themselves in an orderly manner at school during the school day or during district-sponsored activities.

Careful attention shall be given to procedures and methods whereby fairness and consistency without bias in discipline shall be assured each student. The objectives of disciplining any student must be to help the student develop a positive attitude toward self-discipline, realize the responsibility of one's actions and maintain a productive learning environment. All staff members have responsibility for consistency in establishing and maintaining an appropriate behavioral atmosphere.

A student handbook, code of conduct, or other document shall be developed by district administration and will be made available on the district's website and distributed to parents, students and employees outlining student conduct expectations and possible disciplinary actions, including consequences for disorderly conduct, as required by the No Child Left Behind Act of 2001 (NCLBA). In addition, each school in the district shall publish a student/parent handbook detailing additional rules specific to that school.

Students in violation of Board policy, administrative regulation and/or code of conduct provisions will be subject to discipline up to and including expulsion. Students are subject to discipline for conduct while traveling to and from school, at the bus stop, at school-sponsored events, while at other schools in the district and while off campus, whenever such conduct causes a substantial and material disruption of the educational environment or the invasion of rights of others. Students may be denied participation in extracurricular activities. Titles and/or privileges available to or granted to students may also be denied and/or revoked (e.g., valedictorian, salutatorian, student body, class or club office positions, senior trip, prom, etc.). A referral to law enforcement may also be made.

The district will annually record and report expulsion data for conduct violations as required by the Oregon Department of Education.

END OF POLICY

Legal Reference(s):

ORS 339.240 ORS 659.850 OAR 581-021-0050 to -0075
ORS 339.250

Tinker v. Des Moines Sch. Dist., 393 U.S. 503 (1969).
Hazelwood Sch. District v. Kuhlmeier, 484 U.S. 260 (1988).
Bethel Sch. Dist. v. Fraser, 478 U.S. 675 (1986).
Shorb v. Grotting and Powers Sch. Dist., Case No. 00CV-0255 (Coos County Circuit Ct.) (2000).
Ferguson v. Phoenix Talent Sch. Dist. #4, 172 Or. App. 389 (2001).
No Child Left Behind Act of 2001, 20 U.S.C. § 7912 (2006).

Cross Reference(s):

ECAB - Vandalism/Malicious Mischief/Theft
IGAEC - Anabolic Steroids and Performance-Enhancing Substances
JF/JFA - Student Rights and Responsibilities
JG - Student Discipline

Gresham-Barlow SD 10

Code: **JHCA/JHCB**
Adopted: 12/04/14

Immunization, Physical Examination, ~~and~~ Vision Screening/Eye Examination and Dental Screening**

Immunization

Proof of immunization must be presented prior to the time of initial enrollment in school or within 30 days of transfer to the district. Proof consists of a signed Certificate of Immunization Status form documenting either evidence of immunization or a religious, philosophical beliefs and/or medical exemption.[1]

Physical Examination

The Board recommends that all students initially enrolling in school have a physical examination. Parents will be asked to complete a district Health History form when initially enrolling their student~~s~~ in the district and when registering them for seventh grade.

All students participating in athletic programs are required to submit to the district a School Sports Pre-participation Examination[2] form prior to their initial participation in a district athletic program. The form is to be completed and signed by a parent or guardian and physician giving permission for the student to participate.

A student who is subsequently diagnosed with a significant illness or has had a major surgery is required to have a physical examination prior to further participation in extracurricular sports.

A ~~S~~student~~s~~ who continues to participate in extracurricular sports in grades 7 through 12 shall be required to complete a physical examination once every two years, thereafter.

Vision Screening or Eye Examination

The parent~~s~~ or guardian of a student who is 7 years of age or younger and is beginning an education program with the district for the first time shall, within 120 days of beginning the education program, submit a certification that the student has received:

1. ~~The student has received a~~ A vision screening or eye examination; and

2. Any further examination, treatments or assistance necessary.

[1]Documentation requirements for exemptions are outlined in ORS 433.267.
[2]Form available at *www.osaa.org*.

The certification is not required if the parent or guardian provides a statement to the district that:

1. The student submitted a certification to a prior education provider; or

2. The vision screening or eye examination is contrary to the religious beliefs of the student or the parent~~s~~ or guardian of the student.

Dental Screening

The district shall file in the student's dental health record any dental screening certifications and any results of a dental screening known by the district. The district will provide to the parent or guardian of each student, standardized information developed by the Oregon Health Authority's dental director regarding dental screenings, further examinations or necessary treatments and preventative care including fluoride varnish, sealants and daily brushing and flossing.

The parent or guardian of a student who is 7 years of age or younger and is beginning an education program with the district for the first time, shall submit a certification within 120 days of beginning the education program, that the student has received a dental screening within the previous 12 months.

The certification is not required if the parent or guardian provides a statement to the district that:

1. The student submitted a certification to a prior education provider;

2. The dental screening is contrary to the religious beliefs of the student or the parent or guardian of the student; or

3. The dental screening is a burden for the student or the parent or guardian of the student in the following ways:

    a. The cost of obtaining the dental screening is too high;
    b. The student does not have access to an approved screener;
    c. The student was unable to obtain an appointment with an approved screener.

The certification may be provided by a licensed dentist, a dental hygienist or a health care practitioner as defined by state law. The certification must include the:

1. Student's name;

2. Date of screening; and

3. Name of entity conducting the dental screening.

The district shall submit to the Oregon Department of Education a report that identifies the percentage of students who failed to submit the certification for the previous year, no later than October 1 of each year.

END OF POLICY

Legal Reference(s):

ORS 326.580
ORS 336.479
ORS 433.235 to -433.280

OAR 333-019-0010
OAR 333-050-0010 to -0120
OAR 581-021-0031

OAR 581-021-0041
OAR 581-022-0705

OREGON SCHOOL ACTIVITIES ASSOCIATION, OSAA HANDBOOK.

Gresham-Barlow SD 10

Code: **KGB**
Adopted: 12/04/14
Readopted: 10/01/15

Public Conduct on District Property

No person on district property or grounds, including parking lots, shall:

1. Haze, harass, intimidate, bully or menace another, or engage in behavior deemed by the district to endanger the safety of students, employees, self or others;

2. Use or engage in abusive verbal expression or physical conduct that interferes with the performance of students, event officials or sponsors of approved activities;

3. Damage the property of another or of the district;

4. Initiate or circulate a report, one knows to be false, concerning an alleged hazardous substance, impending fire, explosion, catastrophe or other emergency that will take place in or upon a school;

5. Construct or transport to district property for temporary or permanent purposes any structure not approved for construction on, or transportation to, district property;

6. Uproot, pick, cut, mutilate or remove plant life or other natural resources of any kind; roots, tubers, flowers and stems may not be collected; soil or rock may not be dug up or removed; unless employed or directed by the district to do so;

7. Dump or spill any sewage, waste water or other fluids from any vehicle;

8. Use district waste containers or other district property for the deposit of waste or refuse generated from household, commercial, industrial, construction or other uses not related to approved use on district property;

9. Block, obstruct or interfere with vehicular or pedestrian traffic on any district road, parking area, walkway, pathway or common area. Occupying or impeding access to any district facility in a manner that interferes with the approved use of such facility by district employees, students or other authorized users is prohibited;

10. Fly, launch or otherwise operate motorized model airplanes/helicopters/rockets or other similar propulsion devices unless approved in advance by the district;

11. Operate an unmanned aircraft system (UAS) or drone unless granted permission from the superintendent or designee, as prohibited by Board policy ECACB - Unmanned Aircraft System (UAS) a.k.a. Drone;

12. Distribute or post circulars, notices, leaflets, pamphlets or other written or printed material in violation of Board policy KJA - Materials Distribution;

13. Operate a concession, solicit, sell or offer for sale any goods, wares, merchandise, food, beverages or services without prior district approval. Public sales and solicitation on district property will be governed by Board policies KGA - Public Sales on District Property, KI - Public Solicitation in District Facilities and KJ - Advertising in District Facilities;

14. Operate a motor vehicle in an area other than on roads and in parking areas constructed or designated for motor vehicle use. Vehicles shall be driven in a safe manner, at posted speeds ~~only~~ and will only be appropriately parked in areas designated by the district. Motorized vehicles such as minibikes, scooters, go-carts, all-terrain-vehicles, snowmobiles and other similar devices are prohibited on district grounds. Bicyclists must comply with motor vehicle and bike regulatory signs;

15. Use a skateboard, rollerblades, scooter or similar device other than in designated areas during nonschool hours at the user's risk;

16. Bring an animal into a district building without prior administrator approval and, where appropriate, only when proof of current rabies vaccination has been provided. Dogs are permitted on district grounds only when confined to a vehicle or on a leash and when kept under the physical control of the individual at all times. The owner is responsible for the animal's behavior and containment and for the removal of the animal's wastes while on district property. All other animals on district property are permitted with prior district approval only. Animals serving the disabled are permitted as provided by law;

17. Camp overnight, loiter or otherwise be present on district property after the conclusion of approved activities or as otherwise posted or authorized by the district. Individuals are prohibited from entering any portion of district premises at any other time for purposes other than those which are lawful and authorized by district officials;

18. Use or operate any noise-producing machine, vehicle, device or instrument in a manner that, in the judgment of district officials, is disturbing to, or interferes with, the orderly conduct of district programs or approved activities;

19. Impede, delay or otherwise interfere with the orderly conduct of the district's educational program or any other activity taking place on district property which has been authorized by the district;

20. Bring, possess or use a weapon as prohibited by Board policy JFCJ - Weapons in the Schools and state and federal law;

21. Possess, consume, sell, give or deliver unlawful drugs and/or alcoholic beverages. Possess, sell, give or deliver drug paraphernalia;

22. Use, distribute or sell tobacco products or inhalant delivery systems, in any form. In accordance with the Pro-Children Act of 1994, ORS 433.835 - 433.990 and OAR 581-021-0110;

23. Wear, possess, use, distribute, display or sell any clothing, jewelry, emblem, badge, symbol, sign or other item~~s which are~~ that is evidence of membership or affiliation ~~in~~ with any gang. Use speech or commit any act or omission in furtherance of the interests of any gang or gang activity. A "gang" is defined as a group that identifies itself through the use of a name, unique appearance or language including hand signs, claiming of geographical territory or the espousing of a distinctive belief system that frequently results in criminal activity;

24. Violate posted regulatory signs;

25. Willfully violate other district policies, administrative regulations or school rules designed to maintain public order on school property.

Persons having no legitimate purpose or business on district property, or those violating or threatening to violate the above rules, may be ejected from the premises, excluded from district-approved activities temporarily or permanently and/or referred to law enforcement officials.

The superintendent will ensure that appropriate notice of these rules is provided.

END OF POLICY

Legal Reference(s):

ORS 161.015
ORS 164.245
ORS 164.255
ORS 166.025
ORS 166.155 to -166.165
ORS 166.210 to -166.370
ORS 336.109
ORS 339.883
ORS 431.840
ORS 433.835 to -433.990
ORS 806.060 to -806.080

OAR 333-015-0025 to -0090
OAR 581-021-0110
OAR 584-020-0040(4)(e),(g)

Gun-Free Schools Act, 20 U.S.C. 7151 (2006).
Pro-Children Act of 1994, 20 U.S.C. §§ 6081-6084 (2006).
Gun-Free School Zones Act of 1990, 18 U.S.C. §§ 921(a)(25)-(26), 922(q) (2006).

Cross Reference(s):

ECAB - Vandalism/Malicious Mischief/Theft
KGC/GBK/JFCG - Tobacco-Free Environment

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
Mike Schofield

DATE: October 6, 2016

RE: No. 6 – Section 125 Plan Update

EXPLANATION: As the board is aware, the district offers a Section 125 Flexible Benefit Plan to eligible employees. This plan was originally adopted in 1992 and last amended in 2014.

Attached are revised plans for licensed, administration and confidential, classified, and a voluntary plan that have been recently updated. The updates are based on changes in law.

PRESENTER: Mike Schofield

SUPPLEMENTARY MATERIALS: Section 125 Flexible Benefit Plan Documents 501, 502, 503 and 504

RECOMMENDATION: The administration recommends board approval of the revised Section 125 Flexible Benefit Plans, as presented.

REQUESTED ACTION: Consent agenda approval

MS:mkh:lc

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Section 125 Flexible Benefit Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	Gresham Barlow School District
Address:	1331 NW Eastman Pky Gresham, OR 97030
Employer Identification Number:	93-6000831
Nature of Business:	Public School
Name of Plan:	Gresham Barlow School District Flexible Benefit Plan Administration and Confidential Premium Only Plan
Plan Number:	501

B. EFFECTIVE DATE

Original effective date of the Plan:	February 1, 1992
If Amendment to existing plan, effective date of amendment:	October 1, 2016

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item F.

Length of Service:	First of the following month
Retiree Wording:	N/A
Minimum Hours:	All employees with 15 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 19 years.

D. PLAN YEAR

The current plan year will begin on October 1, 2016 and end on September 30, 2017. Each subsequent plan year will begin on October 1 and end on September 30.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

The maximum amount available to each Participant for the purchase of elected benefits with non-elective contributions will be:

Insurance cap is $1,110.00 for full time and prorated for less than full time.

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will not be paid to the Participant as taxable cash.

Elective Contributions (Salary Reduction):

The maximum amount available to each Participant for the purchase of elected benefits through salary reduction will be:

$13000.00 per plan year.
Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

F. **AVAILABLE BENEFITS:** Each of the following components should be considered a plan that comprises this Plan.

1. **Group Medical Insurance** -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

Kaiser Permanente

Moda Health

Eligibility Requirements for Participation, if different than Item C.

Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.

Moda Health:Employees must work 15 hours per week to be eligible for this benefit.

2. **Disability Income Insurance** -- The terms, conditions, and limitations for the Disability Income Insurance will be as set forth in the insurance policy or policies described below: (See Section VI of the Plan Document)

The Standard

Eligibility Requirements for Participation, if different than Item C.

The Standard:Employees must work 20 hours per week to be eligible for this benefit.

3. **Cancer Coverage** -- The terms, conditions, and limitations for the Cancer Coverage will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

N/A

Eligibility Requirements for Participation, if different than Item C.

4. **Dental/Vision Insurance** -- The terms, conditions, and limitations for the Dental/Vision Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

Kaiser Permanente
Dental

Moda Health
Dental

Kaiser Permanente
Vision

Moda Health
Vision

Eligibility Requirements for Participation, if different than Item C.

Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.

Moda Health:Employees must work 15 hours per week to be eligible for this benefit.

Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.

Moda Health:Employees must work 15 hours per week to be eligible for this benefit.

5. **Group Life Insurance** which will be comprised of Group term life insurance and Individual term life insurance under Section 79 of the Code.

The terms, conditions, and limitations for the Group Life Insurance will be as set forth in the insurance policy or policies described below: (See Section VII of the Plan Document)

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, may not exceed $50,000.

Standard Life

Eligibility Requirements for Participation, if different than Item C.

Standard Life:Employees must work 20 hours per week to be eligible for this benefit.

6. **Dependent Care Assistance Plan** -- The terms, conditions, and limitations for the Dependent Care Assistance Plan will be as set forth in Section IX of the Plan Document and described below:

Minimum Contribution - **$0.00** per Plan Year

Maximum Contribution - **$0.00** per Plan Year

Recordkeeper: N/A

Eligibility Requirements for Participation, if different than Item C.

N/A

7. **Medical Expense Reimbursement Plan** -- The terms, conditions, and limitations for the Medical Expense Reimbursement Plan will be as set forth in Section VIII of the Plan Document and described below:

Minimum Coverage - **$0.00** per Plan Year or a Prorated Amount for a Short Plan Year.

Maximum Coverage - **$0.00** per Plan Year or a Prorated Amount for a Short Plan Year. In no event can the maximum exceed $2,550 as adjusted for inflation in accordance with the law.

Recordkeeper:

Restrictions:

Grace Period: The Provisions in Section 8.06 of the Plan to permit a Grace Period with respect to the Medical Expense Reimbursement Plan are not elected.

Carryover: The Provisions in Section 8.07 of the Plan to permit a Carryover with respect to the Medical Expense Reimbursement Plan N/A elected.

Eligibility Requirements for Participation, if different than Item C.

8. **Health Savings Accounts** – The Plan permits contributions to be made to a Health Savings Account on a pretax basis in accordance with Section X of the Plan and the following provisions:

HSA Trustee – **As designated by the employee and mutually agreed upon by the employer.**

Maximum Contribution – **indexed annually by the IRS.**

Limitation on Eligible Medical Expenses – For purposes of the Medical Reimbursement Plan, Eligible Medical Expenses of a Participant that is eligible for and elects to participate in a Health Savings Account shall be limited to expenses for:

Dental and Vision

Eligibility Requirements for Participation, if different than Item C.

a. An Employee must complete a Certification of Health Savings Account Eligibility which confirms that the Participant is an eligible individual who is entitled to establish a Health Savings Account in accordance with Code Section 223(c)(1).
b. Eligibility for the Health Savings Account shall begin on the later of (i) first day of the month coinciding with or next following the Employee's commencement of coverage under the High Deductible Health Plan, or (ii) the first day following the end of a Grace Period available to the Employee with respect to the Medical Reimbursement Accounts that are not limited to vision and dental expenses (unless the participant has a $0.00 balance on the last day of the plan year).
c. An Employee's eligibility for the Health Savings Account shall be determined monthly.

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of Oregon. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted this _____ day of _____, 20_____.

Gresham Barlow School District - 501
(Name of Employer)

Witness:_____ **By:_____**

Title:_____ **Title:_____**

APPENDIX A

Related Employers that have adopted this Plan

Name(s):

SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

The Employer is establishing this Flexible Benefit Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01 **Administrator** — The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).

2.02 **Beneficiary** — Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.02a **Carryover** — The amount equal to the lesser of (a) any unused amounts from the immediately preceding Plan Year or (b) five hundred dollars ($500), except that in no event may the Carryover be less than five dollars ($5).

2.03 **Code** — Internal Revenue Code of 1986, as amended.

2.04 **Dependent** Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom

Code Section 152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Student on a Medically Necessary Leave of Absence: With respect to any plan that is considered a group health plan under Michelle's Law (and not a HIPAA excepted benefit under Code Sections 9831(b), (c) and 9832(c)) and to the extent the Employer is required by Michelle's Law to provide continuation coverage, a Dependent includes a child who qualifies as a Tax Dependent (defined in Section 2.04(a)) because of his or her full-time student status, is enrolled in a group health plan, and is on a medically necessary leave of absence from school. The child will continue to be a Dependent if the medically necessary leave of absence commences while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the group health plan's benefits coverage. Written physician certification that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary is required at the Administrator's request. The child will no longer be considered a Dependent as of the earliest date that the child is no longer on a medically necessary leave of absence, the date that is one year after the first day of the medically necessary leave of absence, or the date benefits would otherwise terminate under either the group health plan or this Plan. Terms related to Michelle's Law, and not otherwise defined, will have the meaning provided under the Michelle's Law provisions of Code Section 9813.

(c) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30, 2010 (subject to any other limitations of the Plan).

Dependent for purposes of the Dependent Care Reimbursement Plan is defined in Section 9.04(a).

2.05 **Effective Date**

The effective date of this Plan as shown in Item B of the Adoption Agreement.

2.06 **Elective Contribution**

The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.

2.07	**Eligible Employee**	Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.
2.08	**Employee**	Any person employed by the Employer on or after the Effective Date.
2.09	**Employer**	The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 11.01 and 11.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
2.10	**Employer Contributions**	Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
2.11	**Entry Date**	The date that an Employee is eligible to participate in the Plan.
2.12	**ERISA**	The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
2.13	**Fiduciary**	The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
2.14	**Health Savings Account**	A "health savings account" as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
2.15	**HSA Trustee**	The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
2.16	**Highly Compensated**	Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
2.17	**High Deductible Health Plan**	A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).
2.18	**HIPAA**	The Health Insurance Portability and Accountability Act of 1996, as amended.
2.19	**Insurer**	Any insurance company that has issued a policy pursuant to the terms of this Plan.
2.20	**Key Employee**	Any Participant who is a "key employee" as defined in Section 416(i) of the Code.

2.21	**Non-Elective Contribution**	A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.
2.22	**Participant**	An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.
2.23	**Plan**	The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.
2.24	**Plan Year**	The Plan Year as specified in Item D of the Adoption Agreement.
2.25	**Policy**	An insurance policy issued as a part of this Plan.
2.26	**Preventative Care**	Medical expenses which meet the safe harbor definition of "preventative care" set forth in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.
2.27	**Recordkeeper**	The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.
2.28	**Related Employer**	Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent. Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and

shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder.

3.03 TERMINATION OF PARTICIPATION: A Participant shall continue to participate in the Plan until the earlier of the following dates:

a. The date the Participant terminates employment by death, disability, retirement or other separation from service; or
b. The date the Participant ceases to work for the Employer as an eligible Employee; or
c. The date of termination of the Plan; or
d. The first date a Participant fails to pay required contributions while on a leave of absence.

3.04 SEPARATION FROM SERVICE: The existing elections of an Employee who separates from the employment service of the Employer shall be deemed to be automatically terminated and the Employee will not receive benefits for the remaining portion of the Plan Year.

3.05 QUALIFYING LEAVE UNDER FAMILY LEAVE ACT: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's existing coverage under the Plan with respect to benefits under Section V and Section VIII of the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer

Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a

children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

(g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

(h) Cancellation due to reduction in hours of service. A Participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to

average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the cancellation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is cancelled.

(i) Cancellation due to enrollment in a Qualified Health Plan. A participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant is eligible for a Special Enrollment Period (as as defined in Code Section 9801(f)) to enroll in a Qualified Health Plan(as described in section 1311 of the Patient Protection and Affordable Care Act (PPACA)) through a competitive marketplace established under section 1311(c) of PPACA (Marketplace), pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is cancelled.

Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Plan, or may not be modified with respect to the Medical Expense Reimbursement Plan if the Plan is being administered by a Recordkeeper other than the Employer, unless the Employer and the Recordkeeper otherwise agree in writing.

4.03 OTHER EXCEPTIONS TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes and apply to all qualified benefits except for Medical Expense Reimbursement Plans, as follows:

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

5.08 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.

6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement. Any individual policies purchased by the Employer for the Participant will be owned by the Participant.

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

c. Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

e. Forfeiture. Subject to Section 8.06 and 8.07, any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

f. COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of

desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

g. Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

h. Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan (increased by any Carryover to the Plan Year), shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

i. Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

j. Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

k. Continuation Coverage for Certain Dependent Children. In the event that benefits under the Medical Expense Reimbursement Plan does not qualify for the exception from the portability rules of HIPAA, then, effective for Plan Years beginning on or after October 9, 2009, notwithstanding the foregoing provisions, coverage for a Dependent child who is enrolled in the Medical Expense Reimbursement Plan as a student at a post-secondary educational institution will not terminate due to a medically necessary leave of absence before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the Plan.

For purposes of this paragraph, "medically necessary leave of absence" means a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that: (i) commences while the child is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) causes the child to lose student status for purposes of coverage under the terms of the Plan. A written certification must be provided by a treating physician of the dependent child to the Plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

8.04 ELIGIBLE MEDICAL EXPENSES:

(a) Eligible Medical Expense in General. The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his Dependents (subject to the restrictions in Sections 8.04(b) and (c)) during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, or from any other source. Notwithstanding the above, capital expenditures are not Eligible Medical Expenses under this Plan. Further, notwithstanding the above, effective January 1, 2011, only the following drugs or medicines will constitute Eligible Medical Expenses:

(i.) Drugs or medicines that require a prescription;
(ii.) Drugs or medicines that are available without a prescription ("over-the-counter drugs or medicines") and the Participant or Dependent obtains a prescription; and
(iii.) Insulin.

(b) Expenses Incurred After Commencement of Participation. Only medical care expenses incurred by a Participant or the Participant's Dependent(s) on or after the date such Participant commenced participation in the Medical Expense Reimbursement Plan shall constitute an Eligible Medical Expense.

(c) Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and (b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 8.04(b)).

(d) Health Savings Accounts. If the Employer has elected in Item F.8 of the Adoption Agreement to allow Eligible Employees to contribute to Health Savings Accounts under the Plan, then for a Participant who is eligible for and elects to contribute to a Health Savings Accounts, Eligible Medical Expenses shall be limited as set forth in Item F.8 of the Adoption Agreement.

8.05 USE OF DEBIT CARD: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses (other than over-the-counter drugs or medicines) under the Medical Expense Reimbursement Plan, the provisions described in this Section shall apply. However, beginning January 1, 2011, a Debit Card may not be used to purchase drugs or medicines over-the-counter.

a. Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.

(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

b. Status of Charges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

c. Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

(i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

d. Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of

such cards set forth in Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

8.06 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

8.07 CARRYOVER: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Carryover with respect to the Medical Reimbursement Plan, the provisions of this Section 8.07 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2013-71, the Carryover for a Participant who has an amount remaining unused as of the end of the run-off period for the Plan Year, may be used to pay or reimburse Eligible Medical Expenses during the following entire Plan Year. The Carryover does not count against or otherwise affect the Maximum benefit set forth in Section 8.03 (b). Eligible Medical Expenses incurred during a Plan Year shall be reimbursed first from unused contributions for the current Plan Year, and then from any Carryover carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run-off period, (b) must be counted against any Carryover amount from the prior Plan Year, and (c) cannot exceed the maximum Carryover from the prior Plan Year. If the Employer elects to apply Section 8.06 in Section F.7 of the Adoption Agreement, this Section 8.07 shall not apply.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.

For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

c. Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

e. Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.

f. Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

a. "Dependent" (for purposes of this Section IX) means any individual who is:

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

b. "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:

(i) provides care for more than six individuals (other than individuals who reside at the facility);
(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and
(iii) satisfies all applicable laws and regulations of a state or unit of local government.

c. "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;
(ii) paid or payable to a Dependent Care Service Provider; and
(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

d. "Dependent Care Service Provider" (for purposes of this Section IX) means:

(i) a Dependent Care Center, or
(ii) a person who provides care or other services described in Section 9.04(b) and who is not a related individual described in Section 129(c) of the Code.

SECTION X

HEALTH SAVINGS ACCOUNTS

10.01 PURPOSE: If elected by the Employer in Section F.8 of the Adoption Agreement, the Plan will permit pre-tax contributions to the Health Savings Account, and the provisions of this Article X shall apply.

10.02 BENEFITS: A Participant can elect benefits under the Health Savings Accounts portion of this Plan by electing to pay his or her Health Savings Account contributions on a pre-tax salary reduction basis. In addition, the Employer may make contributions to the Health Savings Account for the benefit of the Participant.

10.03 TERMS, CONDITIONS AND LIMITATION:

a. Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.

b. Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

10.04 RESTRICTIONS ON MEDICAL REIMBURSEMENT PLAN: If the Employer has elected in Section F.8 of the Adoption Agreement both Health Savings Accounts under this Plan and the Medical Expense Reimbursement Plan, then the Eligible Medical Expenses that may be reimbursed under the Medical Reimbursement Plan for Participants who are eligible for and elect to participate in Health Savings Accounts shall be limited as set forth in Section F.8 of the Adoption Agreement.

10.05 NO ESTABLISHMENT OF ERISA PLAN: It is the intent of the Employer that the establishment of Health Savings Accounts are completely voluntary on the part of Participants, and that, in accordance with Department of Labor Field Assistance Bulletin 2004-1, the Health Savings Accounts are not "employee welfare benefit plans" for purposes of Title I of ERISA.

SECTION XI

AMENDMENT AND TERMINATION

11.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

a. General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

b. Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

c. Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate.

The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

a. Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

b. Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and

shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

c. Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

12.10 SPECIAL CLAIMS REVIEW PROCEDURE: The provisions of this Section 12.10 shall be applicable to claims under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan, effective on the first day of the first Plan Year beginning on or after July 1, 2002, but in no event later than January 1, 2003, provided such plans are subject to ERISA.

a. Benefit Denials: The Administrator is responsible for evaluating all claims for reimbursement under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan.

The Administrator will decide a Participant's claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Participant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The Participant will be given 45 days in which to complete an incomplete claim. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Administrator denies the claim, in whole or in part, the Participant will be furnished with a written notice of adverse benefit determination setting forth:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

b. Appealing Denied Claims: If the Participant's claim is denied in whole or in part, he may appeal to the Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Administrator's initial notice of adverse benefit determination, or else the participant will lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Participant's written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant may also ask additional questions and make written comments, and may review (on request and at no charge) documents and other information relevant to his appeal. The Administrator will review all written comment the Participant submits with his appeal.

c. Review of Appeal: The Administrator will review and decide the Participant's appeal within a reasonable time not longer than 60 days after it is submitted and will notify the Participant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with the Participant's appeal will be provided.) If the decision on appeal affirms the initial denial of the Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

5. A statement of the Participant's right to bring suit under ERISA § 502(a).

12.11 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

12.12 PROTECTED HEALTH INFORMATION. The provisions of this Section will apply only to those portions of the Plan that are considered a group health plan for purposes of 45 CFR Parts 160 and 164. The Plan may disclose PHI to employees of the Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164. The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and use of, electronic PHI, in accordance with Subpart C of 45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Employer will:

- not use or disclose PHI other than as permitted or required by the plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the it on behalf of the Plan, in accordance with Subpart C of 45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents including a subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available PHI in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or his designee upon request for purposes of determining compliance with 45 CFR Section 164.504(f);
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and,
- ensure that the adequate separation required in paragraph (f)(2)(iii) of 45 CFR Section 164.504 is established.

For purposes of this Section, "PHI" is "Protected Health Information" as defined in 45 CFR Section 160.103, which means individually identifiable health information, except as provided in paragraph (2) of the definition of "Protected Health Information" in 45 CFR Section 160.103, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XIII

MISCELLANEOUS PROVISIONS

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

13.02 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent'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 or Dependent.

13.04 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

13.05 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.06 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

13.07 CONSTRUCTION:

a. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

b. Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

13.08 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.09 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Section 125 Flexible Benefit Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	Gresham Barlow School District
Address:	1331 NW Eastman Pky Gresham, OR 97030
Employer Identification Number:	93-6000831
Nature of Business:	Public School
Name of Plan:	Gresham Barlow School District Flexible Benefit Plan Licensed Premium Only Plan
Plan Number:	502

B. EFFECTIVE DATE

Original effective date of the Plan:	February 1, 1992
If Amendment to existing plan, effective date of amendment:	October 1, 2016

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item F.

Length of Service:	First of the following month
Retiree Wording:	N/A
Minimum Hours:	All employees with 15 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 19 years.

D. PLAN YEAR

The current plan year will begin on October 1, 2016 and end on September 30, 2017. Each subsequent plan year will begin on October 1 and end on September 30.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

The maximum amount available to each Participant for the purchase of elected benefits with non-elective contributions will be:

Insurance cap is $1,200.00 for full time and prorated for less than full time.

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will not be paid to the Participant as taxable cash.

Elective Contributions (Salary Reduction):

The maximum amount available to each Participant for the purchase of elected benefits through salary reduction will be:

$13000.00 per plan year.
Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

F. **AVAILABLE BENEFITS:** Each of the following components should be considered a plan that comprises this Plan.

1. **Group Medical Insurance** -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

Kaiser Permanente

Moda Health

Eligibility Requirements for Participation, if different than Item C.

Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.

Moda Health:Employees must work 15 hours per week to be eligible for this benefit.

2. **Disability Income Insurance** -- The terms, conditions, and limitations for the Disability Income Insurance will be as set forth in the insurance policy or policies described below: (See Section VI of the Plan Document)

The Standard

Eligibility Requirements for Participation, if different than Item C.

The Standard:Employees must work 20 hours per week to be eligible for this benefit.

3. **Cancer Coverage** -- The terms, conditions, and limitations for the Cancer Coverage will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

N/A

Eligibility Requirements for Participation, if different than Item C.

4. **Dental/Vision Insurance** -- The terms, conditions, and limitations for the Dental/Vision Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

Kaiser Permanente
Dental

Moda Health
Dental

Willamette Dental

Kaiser Permanente

Vision

Moda Health
Vision

Eligibility Requirements for Participation, if different than Item C.

Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.
Moda Health:Employees must work 15 hours per week to be eligible for this benefit.
Willamette Dental:Employees must work 15 hours per week to be eligible for this benefit.
Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.
Moda Health:Employees must work 15 hours per week to be eligible for this benefit.

5. **Group Life Insurance** which will be comprised of Group term life insurance and Individual term life insurance under Section 79 of the Code.

The terms, conditions, and limitations for the Group Life Insurance will be as set forth in the insurance policy or policies described below: (See Section VII of the Plan Document)

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, may not exceed $50,000.

Standard Life

Eligibility Requirements for Participation, if different than Item C.

Standard Life:Employees must work 20 hours per week to be eligible for this benefit.

6. **Dependent Care Assistance Plan** -- The terms, conditions, and limitations for the Dependent Care Assistance Plan will be as set forth in Section IX of the Plan Document and described below:

Minimum Contribution - **$0.00** per Plan Year

Maximum Contribution - **$0.00** per Plan Year

Recordkeeper: N/A

Eligibility Requirements for Participation, if different than Item C.

N/A

7. **Medical Expense Reimbursement Plan** -- The terms, conditions, and limitations for the Medical Expense Reimbursement Plan will be as set

forth in Section VIII of the Plan Document and described below:

Minimum Coverage - **$0.00** per Plan Year or a Prorated Amount for a Short Plan Year.

Maximum Coverage - **$0.00** per Plan Year or a Prorated Amount for a Short Plan Year. In no event can the maximum exceed $2,550 as adjusted for inflation in accordance with the law.

Recordkeeper:

Restrictions:

Grace Period: The Provisions in Section 8.06 of the Plan to permit a Grace Period with respect to the Medical Expense Reimbursement Plan are not elected.

Carryover: The Provisions in Section 8.07 of the Plan to permit a Carryover with respect to the Medical Expense Reimbursement Plan N/A elected.

Eligibility Requirements for Participation, if different than Item C.

8. **Health Savings Accounts** – The Plan permits contributions to be made to a Health Savings Account on a pretax basis in accordance with Section X of the Plan and the following provisions:

HSA Trustee – **As designated by the employee and mutually agreed upon by the employer.**

Maximum Contribution – **indexed annually by the IRS.**

Limitation on Eligible Medical Expenses – For purposes of the Medical Reimbursement Plan, Eligible Medical Expenses of a Participant that is eligible for and elects to participate in a Health Savings Account shall be limited to expenses for:

Dental and Vision

Eligibility Requirements for Participation, if different than Item C.

a. An Employee must complete a Certification of Health Savings Account Eligibility which confirms that the Participant is an eligible individual who is entitled to establish a Health Savings Account in accordance with Code Section 223(c)(1).

b. Eligibility for the Health Savings Account shall begin on the later of (i) first day of the month coinciding with or next following the Employee's commencement of coverage under the High Deductible Health Plan, or (ii) the first day following the end of a Grace Period available to the Employee with respect to the Medical Reimbursement Accounts that are not limited to vision and dental expenses (unless the participant has a $0.00 balance

on the last day of the plan year).

c. An Employee's eligibility for the Health Savings Account shall be determined monthly.

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of Oregon. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted this _____ day of _____, 20_____.

Gresham Barlow School District - 502
(Name of Employer)

Witness:_____ **By:_____**

Title:_____ **Title:_____**

APPENDIX A

Related Employers that have adopted this Plan

Name(s):

SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

The Employer is establishing this Flexible Benefit Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01 **Administrator** The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).

2.02 **Beneficiary** Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.02a **Carryover** The amount equal to the lesser of (a) any unused amounts from the immediately preceding Plan Year or (b) five hundred dollars ($500), except that in no event may the Carryover be less than five dollars ($5).

2.03 **Code** Internal Revenue Code of 1986, as amended.

2.04 **Dependent** Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom

Code Section 152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Student on a Medically Necessary Leave of Absence: With respect to any plan that is considered a group health plan under Michelle's Law (and not a HIPAA excepted benefit under Code Sections 9831(b), (c) and 9832(c)) and to the extent the Employer is required by Michelle's Law to provide continuation coverage, a Dependent includes a child who qualifies as a Tax Dependent (defined in Section 2.04(a)) because of his or her full-time student status, is enrolled in a group health plan, and is on a medically necessary leave of absence from school. The child will continue to be a Dependent if the medically necessary leave of absence commences while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the group health plan's benefits coverage. Written physician certification that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary is required at the Administrator's request. The child will no longer be considered a Dependent as of the earliest date that the child is no longer on a medically necessary leave of absence, the date that is one year after the first day of the medically necessary leave of absence, or the date benefits would otherwise terminate under either the group health plan or this Plan. Terms related to Michelle's Law, and not otherwise defined, will have the meaning provided under the Michelle's Law provisions of Code Section 9813.

(c) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30, 2010 (subject to any other limitations of the Plan).

Dependent for purposes of the Dependent Care Reimbursement Plan is defined in Section 9.04(a).

2.05 **Effective Date**

The effective date of this Plan as shown in Item B of the Adoption Agreement.

2.06 **Elective Contribution**

The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.

2.07	**Eligible Employee**	Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.
2.08	**Employee**	Any person employed by the Employer on or after the Effective Date.
2.09	**Employer**	The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 11.01 and 11.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
2.10	**Employer Contributions**	Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
2.11	**Entry Date**	The date that an Employee is eligible to participate in the Plan.
2.12	**ERISA**	The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
2.13	**Fiduciary**	The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
2.14	**Health Savings Account**	A "health savings account" as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
2.15	**HSA Trustee**	The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
2.16	**Highly Compensated**	Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
2.17	**High Deductible Health Plan**	A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).
2.18	**HIPAA**	The Health Insurance Portability and Accountability Act of 1996, as amended.
2.19	**Insurer**	Any insurance company that has issued a policy pursuant to the terms of this Plan.
2.20	**Key Employee**	Any Participant who is a "key employee" as defined in Section 416(i) of the Code.

2.21 **Non-Elective Contribution** — A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.

2.22 **Participant** — An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.

2.23 **Plan** — The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.

2.24 **Plan Year** — The Plan Year as specified in Item D of the Adoption Agreement.

2.25 **Policy** — An insurance policy issued as a part of this Plan.

2.26 **Preventative Care** — Medical expenses which meet the safe harbor definition of "preventative care" set forth in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.

2.27 **Recordkeeper** — The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.

2.28 **Related Employer** — Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent. Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and

shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder.

3.03 TERMINATION OF PARTICIPATION: A Participant shall continue to participate in the Plan until the earlier of the following dates:

a. The date the Participant terminates employment by death, disability, retirement or other separation from service; or
b. The date the Participant ceases to work for the Employer as an eligible Employee; or
c. The date of termination of the Plan; or
d. The first date a Participant fails to pay required contributions while on a leave of absence.

3.04 SEPARATION FROM SERVICE: The existing elections of an Employee who separates from the employment service of the Employer shall be deemed to be automatically terminated and the Employee will not receive benefits for the remaining portion of the Plan Year.

3.05 QUALIFYING LEAVE UNDER FAMILY LEAVE ACT: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's existing coverage under the Plan with respect to benefits under Section V and Section VIII of the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer

Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a

children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

(g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

(h) Cancellation due to reduction in hours of service. A Participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to

average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the cancellation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is cancelled.

(i) Cancellation due to enrollment in a Qualified Health Plan. A participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant is eligible for a Special Enrollment Period (as as defined in Code Section 9801(f)) to enroll in a Qualified Health Plan(as described in section 1311 of the Patient Protection and Affordable Care Act (PPACA)) through a competitive marketplace established under section 1311(c) of PPACA (Marketplace), pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is cancelled.

Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Plan, or may not be modified with respect to the Medical Expense Reimbursement Plan if the Plan is being administered by a Recordkeeper other than the Employer, unless the Employer and the Recordkeeper otherwise agree in writing.

4.03 OTHER EXCEPTIONS TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes and apply to all qualified benefits except for Medical Expense Reimbursement Plans, as follows:

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

5.08 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.

6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement. Any individual policies purchased by the Employer for the Participant will be owned by the Participant.

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

c. Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

e. Forfeiture. Subject to Section 8.06 and 8.07, any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

f. COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of

desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

g. Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

h. Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan (increased by any Carryover to the Plan Year), shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

i. Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

j. Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

k. Continuation Coverage for Certain Dependent Children. In the event that benefits under the Medical Expense Reimbursement Plan does not qualify for the exception from the portability rules of HIPAA, then, effective for Plan Years beginning on or after October 9, 2009, notwithstanding the foregoing provisions, coverage for a Dependent child who is enrolled in the Medical Expense Reimbursement Plan as a student at a post-secondary educational institution will not terminate due to a medically necessary leave of absence before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the Plan.

For purposes of this paragraph, "medically necessary leave of absence" means a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that: (i) commences while the child is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) causes the child to lose student status for purposes of coverage under the terms of the Plan. A written certification must be provided by a treating physician of the dependent child to the Plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

8.04 ELIGIBLE MEDICAL EXPENSES:

(a) Eligible Medical Expense in General. The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his Dependents (subject to the restrictions in Sections 8.04(b) and (c)) during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, or from any other source. Notwithstanding the above, capital expenditures are not Eligible Medical Expenses under this Plan. Further, notwithstanding the above, effective January 1, 2011, only the following drugs or medicines will constitute Eligible Medical Expenses:

(i.) Drugs or medicines that require a prescription;
(ii.) Drugs or medicines that are available without a prescription ("over-the-counter drugs or medicines") and the Participant or Dependent obtains a prescription; and
(iii.) Insulin.

(b) Expenses Incurred After Commencement of Participation. Only medical care expenses incurred by a Participant or the Participant's Dependent(s) on or after the date such Participant commenced participation in the Medical Expense Reimbursement Plan shall constitute an Eligible Medical Expense.

(c) Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and (b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 8.04(b)).

(d) Health Savings Accounts. If the Employer has elected in Item F.8 of the Adoption Agreement to allow Eligible Employees to contribute to Health Savings Accounts under the Plan, then for a Participant who is eligible for and elects to contribute to a Health Savings Accounts, Eligible Medical Expenses shall be limited as set forth in Item F.8 of the Adoption Agreement.

8.05 USE OF DEBIT CARD: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses (other than over-the-counter drugs or medicines) under the Medical Expense Reimbursement Plan, the provisions described in this Section shall apply. However, beginning January 1, 2011, a Debit Card may not be used to purchase drugs or medicines over-the-counter.

a. Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.

(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

b. Status of Charges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

c. Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

(i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

d. Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of

such cards set forth in Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

8.06 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

8.07 CARRYOVER: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Carryover with respect to the Medical Reimbursement Plan, the provisions of this Section 8.07 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2013-71, the Carryover for a Participant who has an amount remaining unused as of the end of the run-off period for the Plan Year, may be used to pay or reimburse Eligible Medical Expenses during the following entire Plan Year. The Carryover does not count against or otherwise affect the Maximum benefit set forth in Section 8.03 (b). Eligible Medical Expenses incurred during a Plan Year shall be reimbursed first from unused contributions for the current Plan Year, and then from any Carryover carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run-off period, (b) must be counted against any Carryover amount from the prior Plan Year, and (c) cannot exceed the maximum Carryover from the prior Plan Year. If the Employer elects to apply Section 8.06 in Section F.7 of the Adoption Agreement, this Section 8.07 shall not apply.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.

For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

c. Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

e. Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.

f. Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

a. "Dependent" (for purposes of this Section IX) means any individual who is:

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

b. "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:

(i) provides care for more than six individuals (other than individuals who reside at the facility);
(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and
(iii) satisfies all applicable laws and regulations of a state or unit of local government.

c. "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;
(ii) paid or payable to a Dependent Care Service Provider; and
(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

d. "Dependent Care Service Provider" (for purposes of this Section IX) means:

(i) a Dependent Care Center, or
(ii) a person who provides care or other services described in Section 9.04(b) and who is not a related individual described in Section 129(c) of the Code.

SECTION X

HEALTH SAVINGS ACCOUNTS

10.01 PURPOSE: If elected by the Employer in Section F.8 of the Adoption Agreement, the Plan will permit pre-tax contributions to the Health Savings Account, and the provisions of this Article X shall apply.

10.02 BENEFITS: A Participant can elect benefits under the Health Savings Accounts portion of this Plan by electing to pay his or her Health Savings Account contributions on a pre-tax salary reduction basis. In addition, the Employer may make contributions to the Health Savings Account for the benefit of the Participant.

10.03 TERMS, CONDITIONS AND LIMITATION:

a. Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.

b. Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

10.04 RESTRICTIONS ON MEDICAL REIMBURSEMENT PLAN: If the Employer has elected in Section F.8 of the Adoption Agreement both Health Savings Accounts under this Plan and the Medical Expense Reimbursement Plan, then the Eligible Medical Expenses that may be reimbursed under the Medical Reimbursement Plan for Participants who are eligible for and elect to participate in Health Savings Accounts shall be limited as set forth in Section F.8 of the Adoption Agreement.

10.05 NO ESTABLISHMENT OF ERISA PLAN: It is the intent of the Employer that the establishment of Health Savings Accounts are completely voluntary on the part of Participants, and that, in accordance with Department of Labor Field Assistance Bulletin 2004-1, the Health Savings Accounts are not "employee welfare benefit plans" for purposes of Title I of ERISA.

SECTION XI

AMENDMENT AND TERMINATION

11.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

a. General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

b. Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

c. Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate.

The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

a. Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

b. Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and

shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

c. Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

12.10 SPECIAL CLAIMS REVIEW PROCEDURE: The provisions of this Section 12.10 shall be applicable to claims under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan, effective on the first day of the first Plan Year beginning on or after July 1, 2002, but in no event later than January 1, 2003, provided such plans are subject to ERISA.

a. Benefit Denials: The Administrator is responsible for evaluating all claims for reimbursement under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan.

The Administrator will decide a Participant's claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Participant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The Participant will be given 45 days in which to complete an incomplete claim. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Administrator denies the claim, in whole or in part, the Participant will be furnished with a written notice of adverse benefit determination setting forth:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

b. Appealing Denied Claims: If the Participant's claim is denied in whole or in part, he may appeal to the Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Administrator's initial notice of adverse benefit determination, or else the participant will lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Participant's written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant may also ask additional questions and make written comments, and may review (on request and at no charge) documents and other information relevant to his appeal. The Administrator will review all written comment the Participant submits with his appeal.

c. Review of Appeal: The Administrator will review and decide the Participant's appeal within a reasonable time not longer than 60 days after it is submitted and will notify the Participant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with the Participant's appeal will be provided.) If the decision on appeal affirms the initial denial of the Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

5. A statement of the Participant's right to bring suit under ERISA § 502(a).

12.11 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

12.12 PROTECTED HEALTH INFORMATION. The provisions of this Section will apply only to those portions of the Plan that are considered a group health plan for purposes of 45 CFR Parts 160 and 164. The Plan may disclose PHI to employees of the Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164. The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and use of, electronic PHI, in accordance with Subpart C of 45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Employer will:

- not use or disclose PHI other than as permitted or required by the plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the it on behalf of the Plan, in accordance with Subpart C of 45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents including a subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available PHI in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or his designee upon request for purposes of determining compliance with 45 CFR Section 164.504(f);
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and,
- ensure that the adequate separation required in paragraph (f)(2)(iii) of 45 CFR Section 164.504 is established.

For purposes of this Section, "PHI" is "Protected Health Information" as defined in 45 CFR Section 160.103, which means individually identifiable health information, except as provided in paragraph (2) of the definition of "Protected Health Information" in 45 CFR Section 160.103, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XIII

MISCELLANEOUS PROVISIONS

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

13.02 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent'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 or Dependent.

13.04 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

13.05 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.06 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

13.07 CONSTRUCTION:

a. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

b. Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

13.08 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.09 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Section 125 Flexible Benefit Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	Gresham Barlow School District
Address:	1331 NW Eastman Pky Gresham, OR 97030
Employer Identification Number:	93-6000831
Nature of Business:	Public School
Name of Plan:	Gresham Barlow School District Flexible Benefit Plan Classified Premium Only Plan
Plan Number:	503

B. EFFECTIVE DATE

Original effective date of the Plan:	September 1, 1992
If Amendment to existing plan, effective date of amendment:	October 1, 2016

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item F.

Length of Service:	First of the following month
Retiree Wording:	N/A
Minimum Hours:	All employees with 19 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 15 years.

D. PLAN YEAR

The current plan year will begin on October 1, 2016 and end on September 30, 2017. Each subsequent plan year will begin on October 1 and end on September 30.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

The maximum amount available to each Participant for the purchase of elected benefits with non-elective contributions will be:

Insurance cap is $1,200.00 for full time employees and $600.00 for part time employees.

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will not be paid to the Participant as taxable cash.

Elective Contributions (Salary Reduction):

The maximum amount available to each Participant for the purchase of elected benefits through salary reduction will be:

$13000.00 per plan year.
Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

F. **AVAILABLE BENEFITS:** Each of the following components should be considered a plan that comprises this Plan.

1. **Group Medical Insurance** -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

Kaiser Permanente

Moda Health

Eligibility Requirements for Participation, if different than Item C.

Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.

Moda Health:Employees must work 15 hours per week to be eligible for this benefit.

2. **Disability Income Insurance** -- The terms, conditions, and limitations for the Disability Income Insurance will be as set forth in the insurance policy or policies described below: (See Section VI of the Plan Document)

The Standard

Eligibility Requirements for Participation, if different than Item C.

The Standard:Employees must work 20 hours per week to be eligible for this benefit.

3. **Cancer Coverage** -- The terms, conditions, and limitations for the Cancer Coverage will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

N/A

Eligibility Requirements for Participation, if different than Item C.

4. **Dental/Vision Insurance** -- The terms, conditions, and limitations for the Dental/Vision Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

Kaiser Permanente
Dental

Willamette Dental

Moda Health
Dental

Moda Health

Vision

Kaiser Permanente
Vision

Eligibility Requirements for Participation, if different than Item C.
Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.
Willamette Dental:Employees must work 15 hours per week to be eligible for this benefit.
Moda Health:Employees must work 15 hours per week to be eligible for this benefit.
Moda Health:Employees must work 15 hours per week to be eligible for this benefit.
Kaiser Permanente:Employees must work 15 hours per week to be eligible for this benefit.

5. **Group Life Insurance** which will be comprised of Group term life insurance and Individual term life insurance under Section 79 of the Code.

The terms, conditions, and limitations for the Group Life Insurance will be as set forth in the insurance policy or policies described below: (See Section VII of the Plan Document)

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, may not exceed $50,000.

Standard Life

Eligibility Requirements for Participation, if different than Item C.
Standard Life:Employees must work 20 hours per week to be eligible for this benefit.

6. **Dependent Care Assistance Plan** -- The terms, conditions, and limitations for the Dependent Care Assistance Plan will be as set forth in Section IX of the Plan Document and described below:

Minimum Contribution - **$0.00** per Plan Year

Maximum Contribution - **$0.00** per Plan Year

Recordkeeper: N/A

Eligibility Requirements for Participation, if different than Item C.
N/A

7. **Medical Expense Reimbursement Plan** -- The terms, conditions, and limitations for the Medical Expense Reimbursement Plan will be as set

forth in Section VIII of the Plan Document and described below:

Minimum Coverage - **$0.00** per Plan Year or a Prorated Amount for a Short Plan Year.

Maximum Coverage - **$0.00** per Plan Year or a Prorated Amount for a Short Plan Year. In no event can the maximum exceed $2,550 as adjusted for inflation in accordance with the law.

Recordkeeper:

Restrictions:

Grace Period: The Provisions in Section 8.06 of the Plan to permit a Grace Period with respect to the Medical Expense Reimbursement Plan are not elected.

Carryover: The Provisions in Section 8.07 of the Plan to permit a Carryover with respect to the Medical Expense Reimbursement Plan N/A elected.

Eligibility Requirements for Participation, if different than Item C.

8. **Health Savings Accounts** – The Plan permits contributions to be made to a Health Savings Account on a pretax basis in accordance with Section X of the Plan and the following provisions:

HSA Trustee – **As designated by the employee and mutually agreed upon by the employer.**

Maximum Contribution – **indexed annually by the IRS.**

Limitation on Eligible Medical Expenses – For purposes of the Medical Reimbursement Plan, Eligible Medical Expenses of a Participant that is eligible for and elects to participate in a Health Savings Account shall be limited to expenses for:

Dental and Vision

Eligibility Requirements for Participation, if different than Item C.

a. An Employee must complete a Certification of Health Savings Account Eligibility which confirms that the Participant is an eligible individual who is entitled to establish a Health Savings Account in accordance with Code Section 223(c)(1).

b. Eligibility for the Health Savings Account shall begin on the later of (i) first day of the month coinciding with or next following the Employee's commencement of coverage under the High Deductible Health Plan, or (ii) the first day following the end of a Grace Period available to the Employee with respect to the Medical Reimbursement Accounts that are not limited to vision and dental expenses (unless the participant has a $0.00 balance

on the last day of the plan year).

c. An Employee's eligibility for the Health Savings Account shall be determined monthly.

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of Oregon. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted this _____ day of _____, 20_____.

Gresham Barlow School District - 503
(Name of Employer)

Witness:_____ **By:_____**

Title:_____ **Title:_____**

APPENDIX A

Related Employers that have adopted this Plan

Name(s):

SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

The Employer is establishing this Flexible Benefit Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01 **Administrator** — The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).

2.02 **Beneficiary** — Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.02a **Carryover** — The amount equal to the lesser of (a) any unused amounts from the immediately preceding Plan Year or (b) five hundred dollars ($500), except that in no event may the Carryover be less than five dollars ($5).

2.03 **Code** — Internal Revenue Code of 1986, as amended.

2.04 **Dependent** Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom

Code Section 152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Student on a Medically Necessary Leave of Absence: With respect to any plan that is considered a group health plan under Michelle's Law (and not a HIPAA excepted benefit under Code Sections 9831(b), (c) and 9832(c)) and to the extent the Employer is required by Michelle's Law to provide continuation coverage, a Dependent includes a child who qualifies as a Tax Dependent (defined in Section 2.04(a)) because of his or her full-time student status, is enrolled in a group health plan, and is on a medically necessary leave of absence from school. The child will continue to be a Dependent if the medically necessary leave of absence commences while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the group health plan's benefits coverage. Written physician certification that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary is required at the Administrator's request. The child will no longer be considered a Dependent as of the earliest date that the child is no longer on a medically necessary leave of absence, the date that is one year after the first day of the medically necessary leave of absence, or the date benefits would otherwise terminate under either the group health plan or this Plan. Terms related to Michelle's Law, and not otherwise defined, will have the meaning provided under the Michelle's Law provisions of Code Section 9813.

(c) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30, 2010 (subject to any other limitations of the Plan).

Dependent for purposes of the Dependent Care Reimbursement Plan is defined in Section 9.04(a).

2.05 **Effective Date**

The effective date of this Plan as shown in Item B of the Adoption Agreement.

2.06 **Elective Contribution**

The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.

2.07	**Eligible Employee**	Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.
2.08	**Employee**	Any person employed by the Employer on or after the Effective Date.
2.09	**Employer**	The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 11.01 and 11.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
2.10	**Employer Contributions**	Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
2.11	**Entry Date**	The date that an Employee is eligible to participate in the Plan.
2.12	**ERISA**	The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
2.13	**Fiduciary**	The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
2.14	**Health Savings Account**	A "health savings account" as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
2.15	**HSA Trustee**	The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
2.16	**Highly Compensated**	Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
2.17	**High Deductible Health Plan**	A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).
2.18	**HIPAA**	The Health Insurance Portability and Accountability Act of 1996, as amended.
2.19	**Insurer**	Any insurance company that has issued a policy pursuant to the terms of this Plan.
2.20	**Key Employee**	Any Participant who is a "key employee" as defined in Section 416(i) of the Code.

2.21	**Non-Elective Contribution**	A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.
2.22	**Participant**	An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.
2.23	**Plan**	The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.
2.24	**Plan Year**	The Plan Year as specified in Item D of the Adoption Agreement.
2.25	**Policy**	An insurance policy issued as a part of this Plan.
2.26	**Preventative Care**	Medical expenses which meet the safe harbor definition of "preventative care" set forth in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.
2.27	**Recordkeeper**	The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.
2.28	**Related Employer**	Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent. Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and

shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder.

3.03 TERMINATION OF PARTICIPATION: A Participant shall continue to participate in the Plan until the earlier of the following dates:

a. The date the Participant terminates employment by death, disability, retirement or other separation from service; or
b. The date the Participant ceases to work for the Employer as an eligible Employee; or
c. The date of termination of the Plan; or
d. The first date a Participant fails to pay required contributions while on a leave of absence.

3.04 SEPARATION FROM SERVICE: The existing elections of an Employee who separates from the employment service of the Employer shall be deemed to be automatically terminated and the Employee will not receive benefits for the remaining portion of the Plan Year.

3.05 QUALIFYING LEAVE UNDER FAMILY LEAVE ACT: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's existing coverage under the Plan with respect to benefits under Section V and Section VIII of the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer

Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a

children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

(g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

(h) Cancellation due to reduction in hours of service. A Participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to

average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the cancellation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is cancelled.

(i) Cancellation due to enrollment in a Qualified Health Plan. A participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant is eligible for a Special Enrollment Period (as as defined in Code Section 9801(f)) to enroll in a Qualified Health Plan(as described in section 1311 of the Patient Protection and Affordable Care Act (PPACA)) through a competitive marketplace established under section 1311(c) of PPACA (Marketplace), pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is cancelled.

Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Plan, or may not be modified with respect to the Medical Expense Reimbursement Plan if the Plan is being administered by a Recordkeeper other than the Employer, unless the Employer and the Recordkeeper otherwise agree in writing.

4.03 OTHER EXCEPTIONS TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes and apply to all qualified benefits except for Medical Expense Reimbursement Plans, as follows:

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

5.08 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.

6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement. Any individual policies purchased by the Employer for the Participant will be owned by the Participant.

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

c. Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

e. Forfeiture. Subject to Section 8.06 and 8.07, any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

f. COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of

desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

g. Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

h. Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan (increased by any Carryover to the Plan Year), shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

i. Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

j. Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

k. Continuation Coverage for Certain Dependent Children. In the event that benefits under the Medical Expense Reimbursement Plan does not qualify for the exception from the portability rules of HIPAA, then, effective for Plan Years beginning on or after October 9, 2009, notwithstanding the foregoing provisions, coverage for a Dependent child who is enrolled in the Medical Expense Reimbursement Plan as a student at a post-secondary educational institution will not terminate due to a medically necessary leave of absence before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the Plan.

For purposes of this paragraph, "medically necessary leave of absence" means a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that: (i) commences while the child is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) causes the child to lose student status for purposes of coverage under the terms of the Plan. A written certification must be provided by a treating physician of the dependent child to the Plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

8.04 ELIGIBLE MEDICAL EXPENSES:

(a) Eligible Medical Expense in General. The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his Dependents (subject to the restrictions in Sections 8.04(b) and (c)) during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, or from any other source. Notwithstanding the above, capital expenditures are not Eligible Medical Expenses under this Plan. Further, notwithstanding the above, effective January 1, 2011, only the following drugs or medicines will constitute Eligible Medical Expenses:

(i.) Drugs or medicines that require a prescription;
(ii.) Drugs or medicines that are available without a prescription ("over-the-counter drugs or medicines") and the Participant or Dependent obtains a prescription; and
(iii.) Insulin.

(b) Expenses Incurred After Commencement of Participation. Only medical care expenses incurred by a Participant or the Participant's Dependent(s) on or after the date such Participant commenced participation in the Medical Expense Reimbursement Plan shall constitute an Eligible Medical Expense.

(c) Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and (b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 8.04(b)).

(d) Health Savings Accounts. If the Employer has elected in Item F.8 of the Adoption Agreement to allow Eligible Employees to contribute to Health Savings Accounts under the Plan, then for a Participant who is eligible for and elects to contribute to a Health Savings Accounts, Eligible Medical Expenses shall be limited as set forth in Item F.8 of the Adoption Agreement.

8.05 USE OF DEBIT CARD: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses (other than over-the-counter drugs or medicines) under the Medical Expense Reimbursement Plan, the provisions described in this Section shall apply. However, beginning January 1, 2011, a Debit Card may not be used to purchase drugs or medicines over-the-counter.

a. Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.

(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

b. Status of Charges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

c. Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

(i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

d. Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of

such cards set forth in Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

8.06 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

8.07 CARRYOVER: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Carryover with respect to the Medical Reimbursement Plan, the provisions of this Section 8.07 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2013-71, the Carryover for a Participant who has an amount remaining unused as of the end of the run-off period for the Plan Year, may be used to pay or reimburse Eligible Medical Expenses during the following entire Plan Year. The Carryover does not count against or otherwise affect the Maximum benefit set forth in Section 8.03 (b). Eligible Medical Expenses incurred during a Plan Year shall be reimbursed first from unused contributions for the current Plan Year, and then from any Carryover carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run-off period, (b) must be counted against any Carryover amount from the prior Plan Year, and (c) cannot exceed the maximum Carryover from the prior Plan Year. If the Employer elects to apply Section 8.06 in Section F.7 of the Adoption Agreement, this Section 8.07 shall not apply.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.

For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

c. Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

e. Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.

f. Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

a. "Dependent" (for purposes of this Section IX) means any individual who is:

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

b. "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:

(i) provides care for more than six individuals (other than individuals who reside at the facility);
(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and
(iii) satisfies all applicable laws and regulations of a state or unit of local government.

c. "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;
(ii) paid or payable to a Dependent Care Service Provider; and
(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

d. "Dependent Care Service Provider" (for purposes of this Section IX) means:

(i) a Dependent Care Center, or
(ii) a person who provides care or other services described in Section 9.04(b) and who is not a related individual described in Section 129(c) of the Code.

SECTION X

HEALTH SAVINGS ACCOUNTS

10.01 PURPOSE: If elected by the Employer in Section F.8 of the Adoption Agreement, the Plan will permit pre-tax contributions to the Health Savings Account, and the provisions of this Article X shall apply.

10.02 BENEFITS: A Participant can elect benefits under the Health Savings Accounts portion of this Plan by electing to pay his or her Health Savings Account contributions on a pre-tax salary reduction basis. In addition, the Employer may make contributions to the Health Savings Account for the benefit of the Participant.

10.03 TERMS, CONDITIONS AND LIMITATION:

a. Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.

b. Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

10.04 RESTRICTIONS ON MEDICAL REIMBURSEMENT PLAN: If the Employer has elected in Section F.8 of the Adoption Agreement both Health Savings Accounts under this Plan and the Medical Expense Reimbursement Plan, then the Eligible Medical Expenses that may be reimbursed under the Medical Reimbursement Plan for Participants who are eligible for and elect to participate in Health Savings Accounts shall be limited as set forth in Section F.8 of the Adoption Agreement.

10.05 NO ESTABLISHMENT OF ERISA PLAN: It is the intent of the Employer that the establishment of Health Savings Accounts are completely voluntary on the part of Participants, and that, in accordance with Department of Labor Field Assistance Bulletin 2004-1, the Health Savings Accounts are not "employee welfare benefit plans" for purposes of Title I of ERISA.

SECTION XI

AMENDMENT AND TERMINATION

11.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

a. General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

b. Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

c. Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate.

The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

a. Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

b. Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and

shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

c. Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

12.10 SPECIAL CLAIMS REVIEW PROCEDURE: The provisions of this Section 12.10 shall be applicable to claims under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan, effective on the first day of the first Plan Year beginning on or after July 1, 2002, but in no event later than January 1, 2003, provided such plans are subject to ERISA.

a. Benefit Denials: The Administrator is responsible for evaluating all claims for reimbursement under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan.

The Administrator will decide a Participant's claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Participant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The Participant will be given 45 days in which to complete an incomplete claim. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Administrator denies the claim, in whole or in part, the Participant will be furnished with a written notice of adverse benefit determination setting forth:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

b. Appealing Denied Claims: If the Participant's claim is denied in whole or in part, he may appeal to the Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Administrator's initial notice of adverse benefit determination, or else the participant will lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Participant's written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant may also ask additional questions and make written comments, and may review (on request and at no charge) documents and other information relevant to his appeal. The Administrator will review all written comment the Participant submits with his appeal.

c. Review of Appeal: The Administrator will review and decide the Participant's appeal within a reasonable time not longer than 60 days after it is submitted and will notify the Participant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with the Participant's appeal will be provided.) If the decision on appeal affirms the initial denial of the Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

5. A statement of the Participant's right to bring suit under ERISA § 502(a).

12.11 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

12.12 PROTECTED HEALTH INFORMATION. The provisions of this Section will apply only to those portions of the Plan that are considered a group health plan for purposes of 45 CFR Parts 160 and 164. The Plan may disclose PHI to employees of the Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164. The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and use of, electronic PHI, in accordance with Subpart C of 45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Employer will:

- not use or disclose PHI other than as permitted or required by the plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the it on behalf of the Plan, in accordance with Subpart C of 45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents including a subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available PHI in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or his designee upon request for purposes of determining compliance with 45 CFR Section 164.504(f);
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and,
- ensure that the adequate separation required in paragraph (f)(2)(iii) of 45 CFR Section 164.504 is established.

For purposes of this Section, "PHI" is "Protected Health Information" as defined in 45 CFR Section 160.103, which means individually identifiable health information, except as provided in paragraph (2) of the definition of "Protected Health Information" in 45 CFR Section 160.103, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XIII

MISCELLANEOUS PROVISIONS

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

13.02 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent'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 or Dependent.

13.04 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

13.05 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.06 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

13.07 CONSTRUCTION:

a. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

b. Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

13.08 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.09 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Section 125 Flexible Benefit Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	Gresham Barlow School District
Address:	1331 NW Eastman Pky Gresham, OR 97030
Employer Identification Number:	93-6000831
Nature of Business:	Public School
Name of Plan:	Gresham Barlow School District Flexible Benefit Plan Voluntary Plan
Plan Number:	504

B. EFFECTIVE DATE

Original effective date of the Plan:	September 1, 1992
If Amendment to existing plan, effective date of amendment:	October 1, 2016

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item F.

Length of Service:	First of the following month
Retiree Wording:	N/A
Minimum Hours:	All employees with 15 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 19 years.

D. PLAN YEAR

The current plan year will begin on October 1, 2016 and end on September 30, 2017. Each subsequent plan year will begin on October 1 and end on September 30.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

The maximum amount available to each Participant for the purchase of elected benefits with non-elective contributions will be:

N/A

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will not be paid to the Participant as taxable cash.

Elective Contributions (Salary Reduction):

The maximum amount available to each Participant for the purchase of elected benefits through salary reduction will be:

100% of compensation per entire plan year.

Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

F. **AVAILABLE BENEFITS:** Each of the following components should be considered a plan that comprises this Plan.

1. **Group Medical Insurance** -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

American Fidelity Assurance Company
Accident and GAP

Eligibility Requirements for Participation, if different than Item C.

2. **Disability Income Insurance** -- The terms, conditions, and limitations for the Disability Income Insurance will be as set forth in the insurance policy or policies described below: (See Section VI of the Plan Document)

American Fidelity Assurance Company
017 Kind Series

Eligibility Requirements for Participation, if different than Item C.

3. **Cancer Coverage** -- The terms, conditions, and limitations for the Cancer Coverage will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

American Fidelity Assurance Company
C-12 and all subsequent plans

Eligibility Requirements for Participation, if different than Item C.

4. **Dental/Vision Insurance** -- The terms, conditions, and limitations for the Dental/Vision Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

N/A

Eligibility Requirements for Participation, if different than Item C.

5. **Group Life Insurance** which will be comprised of Group term life insurance and Individual term life insurance under Section 79 of the Code.

The terms, conditions, and limitations for the Group Life Insurance will be as set forth in the insurance policy or policies described below: (See Section VII of the Plan Document)

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, may not exceed $50,000.

Eligibility Requirements for Participation, if different than Item C.

6. **Dependent Care Assistance Plan** -- The terms, conditions, and limitations for the Dependent Care Assistance Plan will be as set forth in Section IX of the Plan Document and described below:

   Minimum Contribution - **$0.00** per Plan Year

   Maximum Contribution - **$5000.00** per Plan Year

   Recordkeeper: American Fidelity Assurance Company

Eligibility Requirements for Participation, if different than Item C.

N/A

7. **Medical Expense Reimbursement Plan** -- The terms, conditions, and limitations for the Medical Expense Reimbursement Plan will be as set forth in Section VIII of the Plan Document and described below:

   Minimum Coverage - **$0.00** per Plan Year or a Prorated Amount for a Short Plan Year.

   Maximum Coverage - **$2550.00** per Plan Year or a Prorated Amount for a Short Plan Year. In no event can the maximum exceed $2,550 as adjusted for inflation in accordance with the law.

   Recordkeeper: American Fidelity Assurance Company

   Restrictions: As outlined in Policy G-905/R1.

   Grace Period: The Provisions in Section 8.06 of the Plan to permit a Grace Period with respect to the Medical Expense Reimbursement Plan are not elected.

   Carryover: The Provisions in Section 8.07 of the Plan to permit a Carryover with respect to the Medical Expense Reimbursement Plan are elected.

Eligibility Requirements for Participation, if different than Item C.

8. **Health Savings Accounts** – The Plan permits contributions to be made to a Health Savings Account on a pretax basis in accordance with Section X of the Plan and the following provisions:

   HSA Trustee – **N/A**

Maximum Contribution – **N/A**

Limitation on Eligible Medical Expenses – For purposes of the Medical Reimbursement Plan, Eligible Medical Expenses of a Participant that is eligible for and elects to participate in a Health Savings Account shall be limited to expenses for:

N/A

Eligibility Requirements for Participation, if different than Item C.

a. An Employee must complete a Certification of Health Savings Account Eligibility which confirms that the Participant is an eligible individual who is entitled to establish a Health Savings Account in accordance with Code Section 223(c)(1).

b. Eligibility for the Health Savings Account shall begin on the later of (i) first day of the month coinciding with or next following the Employee's commencement of coverage under the High Deductible Health Plan, or (ii) the first day following the end of a Grace Period available to the Employee with respect to the Medical Reimbursement Accounts that are not limited to vision and dental expenses (unless the participant has a $0.00 balance on the last day of the plan year).

c. An Employee's eligibility for the Health Savings Account shall be determined monthly.

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of Oregon. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted this _____ day of _____, 20_____.

Gresham Barlow School District - 504
(Name of Employer)

Witness:_____ **By:_____**

Title:_____ **Title:_____**

APPENDIX A

Related Employers that have adopted this Plan

Name(s):

SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

The Employer is establishing this Flexible Benefit Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01 **Administrator** — The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).

2.02 **Beneficiary** — Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.02a **Carryover** — The amount equal to the lesser of (a) any unused amounts from the immediately preceding Plan Year or (b) five hundred dollars ($500), except that in no event may the Carryover be less than five dollars ($5).

2.03 **Code** — Internal Revenue Code of 1986, as amended.

2.04 **Dependent** Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom

Code Section 152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Student on a Medically Necessary Leave of Absence: With respect to any plan that is considered a group health plan under Michelle's Law (and not a HIPAA excepted benefit under Code Sections 9831(b), (c) and 9832(c)) and to the extent the Employer is required by Michelle's Law to provide continuation coverage, a Dependent includes a child who qualifies as a Tax Dependent (defined in Section 2.04(a)) because of his or her full-time student status, is enrolled in a group health plan, and is on a medically necessary leave of absence from school. The child will continue to be a Dependent if the medically necessary leave of absence commences while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the group health plan's benefits coverage. Written physician certification that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary is required at the Administrator's request. The child will no longer be considered a Dependent as of the earliest date that the child is no longer on a medically necessary leave of absence, the date that is one year after the first day of the medically necessary leave of absence, or the date benefits would otherwise terminate under either the group health plan or this Plan. Terms related to Michelle's Law, and not otherwise defined, will have the meaning provided under the Michelle's Law provisions of Code Section 9813.

(c) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30, 2010 (subject to any other limitations of the Plan).

Dependent for purposes of the Dependent Care Reimbursement Plan is defined in Section 9.04(a).

2.05 **Effective Date** The effective date of this Plan as shown in Item B of the Adoption Agreement.

2.06 **Elective Contribution** The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.

2.07	**Eligible Employee**	Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.
2.08	**Employee**	Any person employed by the Employer on or after the Effective Date.
2.09	**Employer**	The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 11.01 and 11.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
2.10	**Employer Contributions**	Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
2.11	**Entry Date**	The date that an Employee is eligible to participate in the Plan.
2.12	**ERISA**	The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
2.13	**Fiduciary**	The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
2.14	**Health Savings Account**	A "health savings account" as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
2.15	**HSA Trustee**	The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
2.16	**Highly Compensated**	Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
2.17	**High Deductible Health Plan**	A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).
2.18	**HIPAA**	The Health Insurance Portability and Accountability Act of 1996, as amended.
2.19	**Insurer**	Any insurance company that has issued a policy pursuant to the terms of this Plan.
2.20	**Key Employee**	Any Participant who is a "key employee" as defined in Section 416(i) of the Code.

2.21 **Non-Elective Contribution** — A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.

2.22 **Participant** — An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.

2.23 **Plan** — The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.

2.24 **Plan Year** — The Plan Year as specified in Item D of the Adoption Agreement.

2.25 **Policy** — An insurance policy issued as a part of this Plan.

2.26 **Preventative Care** — Medical expenses which meet the safe harbor definition of "preventative care" set forth in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.

2.27 **Recordkeeper** — The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.

2.28 **Related Employer** — Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent. Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and

shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder.

3.03 TERMINATION OF PARTICIPATION: A Participant shall continue to participate in the Plan until the earlier of the following dates:

a. The date the Participant terminates employment by death, disability, retirement or other separation from service; or
b. The date the Participant ceases to work for the Employer as an eligible Employee; or
c. The date of termination of the Plan; or
d. The first date a Participant fails to pay required contributions while on a leave of absence.

3.04 SEPARATION FROM SERVICE: The existing elections of an Employee who separates from the employment service of the Employer shall be deemed to be automatically terminated and the Employee will not receive benefits for the remaining portion of the Plan Year.

3.05 QUALIFYING LEAVE UNDER FAMILY LEAVE ACT: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's existing coverage under the Plan with respect to benefits under Section V and Section VIII of the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer

Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a

children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

(g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

(h) Cancellation due to reduction in hours of service. A Participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to

average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the cancellation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is cancelled.

(i) Cancellation due to enrollment in a Qualified Health Plan. A participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant is eligible for a Special Enrollment Period (as as defined in Code Section 9801(f)) to enroll in a Qualified Health Plan(as described in section 1311 of the Patient Protection and Affordable Care Act (PPACA)) through a competitive marketplace established under section 1311(c) of PPACA (Marketplace), pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is cancelled.

Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Plan, or may not be modified with respect to the Medical Expense Reimbursement Plan if the Plan is being administered by a Recordkeeper other than the Employer, unless the Employer and the Recordkeeper otherwise agree in writing.

4.03 OTHER EXCEPTIONS TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes and apply to all qualified benefits except for Medical Expense Reimbursement Plans, as follows:

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

5.08 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.

6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement. Any individual policies purchased by the Employer for the Participant will be owned by the Participant.

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

c. Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

e. Forfeiture. Subject to Section 8.06 and 8.07, any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

f. COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of

desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

g. Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

h. Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan (increased by any Carryover to the Plan Year), shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

i. Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

j. Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

k. Continuation Coverage for Certain Dependent Children. In the event that benefits under the Medical Expense Reimbursement Plan does not qualify for the exception from the portability rules of HIPAA, then, effective for Plan Years beginning on or after October 9, 2009, notwithstanding the foregoing provisions, coverage for a Dependent child who is enrolled in the Medical Expense Reimbursement Plan as a student at a post-secondary educational institution will not terminate due to a medically necessary leave of absence before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the Plan.

For purposes of this paragraph, "medically necessary leave of absence" means a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that: (i) commences while the child is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) causes the child to lose student status for purposes of coverage under the terms of the Plan. A written certification must be provided by a treating physician of the dependent child to the Plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

8.04 ELIGIBLE MEDICAL EXPENSES:

(a) Eligible Medical Expense in General. The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his Dependents (subject to the restrictions in Sections 8.04(b) and (c)) during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, or from any other source. Notwithstanding the above, capital expenditures are not Eligible Medical Expenses under this Plan. Further, notwithstanding the above, effective January 1, 2011, only the following drugs or medicines will constitute Eligible Medical Expenses:

(i.) Drugs or medicines that require a prescription;
(ii.) Drugs or medicines that are available without a prescription ("over-the-counter drugs or medicines") and the Participant or Dependent obtains a prescription; and
(iii.) Insulin.

(b) Expenses Incurred After Commencement of Participation. Only medical care expenses incurred by a Participant or the Participant's Dependent(s) on or after the date such Participant commenced participation in the Medical Expense Reimbursement Plan shall constitute an Eligible Medical Expense.

(c) Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and (b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 8.04(b)).

(d) Health Savings Accounts. If the Employer has elected in Item F.8 of the Adoption Agreement to allow Eligible Employees to contribute to Health Savings Accounts under the Plan, then for a Participant who is eligible for and elects to contribute to a Health Savings Accounts, Eligible Medical Expenses shall be limited as set forth in Item F.8 of the Adoption Agreement.

8.05 USE OF DEBIT CARD: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses (other than over-the-counter drugs or medicines) under the Medical Expense Reimbursement Plan, the provisions described in this Section shall apply. However, beginning January 1, 2011, a Debit Card may not be used to purchase drugs or medicines over-the-counter.

a. Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.

(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

b. Status of Charges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

c. Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

(i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

d. Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of

such cards set forth in Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

8.06 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

8.07 CARRYOVER: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Carryover with respect to the Medical Reimbursement Plan, the provisions of this Section 8.07 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2013-71, the Carryover for a Participant who has an amount remaining unused as of the end of the run-off period for the Plan Year, may be used to pay or reimburse Eligible Medical Expenses during the following entire Plan Year. The Carryover does not count against or otherwise affect the Maximum benefit set forth in Section 8.03 (b). Eligible Medical Expenses incurred during a Plan Year shall be reimbursed first from unused contributions for the current Plan Year, and then from any Carryover carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run-off period, (b) must be counted against any Carryover amount from the prior Plan Year, and (c) cannot exceed the maximum Carryover from the prior Plan Year. If the Employer elects to apply Section 8.06 in Section F.7 of the Adoption Agreement, this Section 8.07 shall not apply.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.

For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

c. Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

e. Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.

f. Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

a. "Dependent" (for purposes of this Section IX) means any individual who is:

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

b. "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:

(i) provides care for more than six individuals (other than individuals who reside at the facility);
(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and
(iii) satisfies all applicable laws and regulations of a state or unit of local government.

c. "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;
(ii) paid or payable to a Dependent Care Service Provider; and
(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

d. "Dependent Care Service Provider" (for purposes of this Section IX) means:

(i) a Dependent Care Center, or
(ii) a person who provides care or other services described in Section 9.04(b) and who is not a related individual described in Section 129(c) of the Code.

SECTION X

HEALTH SAVINGS ACCOUNTS

10.01 PURPOSE: If elected by the Employer in Section F.8 of the Adoption Agreement, the Plan will permit pre-tax contributions to the Health Savings Account, and the provisions of this Article X shall apply.

10.02 BENEFITS: A Participant can elect benefits under the Health Savings Accounts portion of this Plan by electing to pay his or her Health Savings Account contributions on a pre-tax salary reduction basis. In addition, the Employer may make contributions to the Health Savings Account for the benefit of the Participant.

10.03 TERMS, CONDITIONS AND LIMITATION:

a. Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.

b. Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

10.04 RESTRICTIONS ON MEDICAL REIMBURSEMENT PLAN: If the Employer has elected in Section F.8 of the Adoption Agreement both Health Savings Accounts under this Plan and the Medical Expense Reimbursement Plan, then the Eligible Medical Expenses that may be reimbursed under the Medical Reimbursement Plan for Participants who are eligible for and elect to participate in Health Savings Accounts shall be limited as set forth in Section F.8 of the Adoption Agreement.

10.05 NO ESTABLISHMENT OF ERISA PLAN: It is the intent of the Employer that the establishment of Health Savings Accounts are completely voluntary on the part of Participants, and that, in accordance with Department of Labor Field Assistance Bulletin 2004-1, the Health Savings Accounts are not "employee welfare benefit plans" for purposes of Title I of ERISA.

SECTION XI

AMENDMENT AND TERMINATION

11.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

a. General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

b. Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

c. Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate.

The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

a. Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

b. Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and

shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

c. Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

12.10 SPECIAL CLAIMS REVIEW PROCEDURE: The provisions of this Section 12.10 shall be applicable to claims under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan, effective on the first day of the first Plan Year beginning on or after July 1, 2002, but in no event later than January 1, 2003, provided such plans are subject to ERISA.

a. Benefit Denials: The Administrator is responsible for evaluating all claims for reimbursement under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan.

The Administrator will decide a Participant's claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Participant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The Participant will be given 45 days in which to complete an incomplete claim. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Administrator denies the claim, in whole or in part, the Participant will be furnished with a written notice of adverse benefit determination setting forth:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

b. Appealing Denied Claims: If the Participant's claim is denied in whole or in part, he may appeal to the Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Administrator's initial notice of adverse benefit determination, or else the participant will lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Participant's written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant may also ask additional questions and make written comments, and may review (on request and at no charge) documents and other information relevant to his appeal. The Administrator will review all written comment the Participant submits with his appeal.

c. Review of Appeal: The Administrator will review and decide the Participant's appeal within a reasonable time not longer than 60 days after it is submitted and will notify the Participant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with the Participant's appeal will be provided.) If the decision on appeal affirms the initial denial of the Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

5. A statement of the Participant's right to bring suit under ERISA § 502(a).

12.11 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

12.12 PROTECTED HEALTH INFORMATION. The provisions of this Section will apply only to those portions of the Plan that are considered a group health plan for purposes of 45 CFR Parts 160 and 164. The Plan may disclose PHI to employees of the Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164. The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and use of, electronic PHI, in accordance with Subpart C of 45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Employer will:

- not use or disclose PHI other than as permitted or required by the plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the it on behalf of the Plan, in accordance with Subpart C of 45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents including a subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available PHI in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or his designee upon request for purposes of determining compliance with 45 CFR Section 164.504(f);
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and,
- ensure that the adequate separation required in paragraph (f)(2)(iii) of 45 CFR Section 164.504 is established.

For purposes of this Section, "PHI" is "Protected Health Information" as defined in 45 CFR Section 160.103, which means individually identifiable health information, except as provided in paragraph (2) of the definition of "Protected Health Information" in 45 CFR Section 160.103, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XIII

MISCELLANEOUS PROVISIONS

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

13.02 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent'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 or Dependent.

13.04 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

13.05 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.06 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

13.07 CONSTRUCTION:

a. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

b. Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

13.08 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.09 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
James Hiu

DATE: October 6, 2016

RE: No. 7 – Community Care Day Honorees

EXPLANATION: For the past several years, volunteers from area churches have come together to prepare our school grounds for the start of school. This event is called "Community Care Day."

Throughout several weekends prior to the start of school, volunteers worked on several beautification projects, which included pulling weeds, raking, spreading bark dust, pruning, painting, and planting flowers. Tonight we will honor the churches that took the lead in coordinating this year's "Community Care Day."

The following churches led the effort to coordinate "Community Care Day" in the school district:

Cornerstone Church
East Hill Church
Good Shepherd Community Church
Grace Community Church
First Baptist Church
Gresham Bible Church
Mountain View Christian Church

PRESENTER: James Hiu

SUPPLEMENTARY MATERIALS: None

RECOMMENDATION: The administration recommends the school board present a certificate of recognition to representatives of these churches.

REQUESTED ACTION: No formal action is required.

PH:lc

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
Athena Vadnais

DATE: October 6, 2016

RE: No. 8 – Gresham-Barlow Education Foundation Update

EXPLANATION: The Gresham-Barlow Education Foundation has identified the following dates for 2016-17 reports to the school board:

September 1, 2016
November 3, 2016
February 2, 2017
April 6, 2017
June 8, 2017

Accordingly, there will not be a Foundation report this evening. The next update will be presented on November 3, 2016.

PRESENTER: Athena Vadnais

SUPPLEMENTARY MATERIALS: None

RECOMMENDATION: This report is being provided as information only.

REQUESTED ACTION: No action is required.

:lc

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
Mike Schofield

DATE: October 6, 2016

RE: No. 9 – Nutrition Services Annual Report

EXPLANATION: Keely Davidson will review the highlights of last year's Nutrition Services Program.

The food service management company (Sodexo) employs a staff of 90 plus to provide the nutrition services to approximately 12,000 students at 25 sites. Their main responsibility is preparing and serving meals and meal supplements (snacks) to students and participants in the National School Lunch and Breakfast Programs.

The program runs on a cost-effective basis. The total of all direct operating costs (including cost of food, supplies, wages, benefits, and other direct costs) must not exceed total program revenues.

Our goals for the Nutrition Services Program includes: providing nutritious, high-quality meals and snacks to students and participants; accommodating special diets where medically necessary; providing occasional catered food services; and, improving nutrition awareness.

PRESENTER: Mike Schofield

SUPPLEMENTARY MATERIALS: None

RECOMMENDATION: This report is being submitted as information only.

REQUESTED ACTION: No action required.

MS:lc

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
Athena Vadnais

DATE: October 6, 2016

RE: No. 10 – District Advisory Council (DAC) Report

EXPLANATION: The most recent DAC meeting was held on September 15, 2016, at North Gresham Elementary School. Board members present were Carla Piluso, Kris Howatt, Sharon Garner, and John Hartsock.

This evening, the board will hear a report concerning the DAC meeting.

PRESENTER: Athena Vadnais

SUPPLEMENTARY MATERIALS: Minutes of the September 15, 2016, DAC meeting

RECOMMENDATION: This report is being provided as information only.

REQUESTED ACTION: No action is required.

:lc

2016-17
District Advisory Council Meeting
September 15, 2016

North Gresham Elementary School

DAC Members present:

Deep Creek-Damascus	Stefanie Craft
East Gresham ES	Elsie Flowers
East Orient ES	Amy Buren
Hall ES	
Highland ES	Cary Barrett
Hogan Cedars ES	
Hollydale ES	Cyndi Smith Tom Sherman
Kelly Creek ES	Kathy Koch
North Gresham ES	Monika DeShazer Michelle Carter

Powell Valley ES	Kaleena Purdum
West Gresham ES	Trisha Knobbs Dori Moullet
Clear Creek MS	Cyndi Smith
Dexter McCarty MS	
Gordon Russell MS	
West Orient MS	Amy Buren
Gresham HS	Matt Wells Lance Hallberg
Sam Barlow HS	
Springwater Trail HS	Ron Rasmussen

School Board Members: Carla Piluso, Kris Howatt, Sharon Garner, and John Hartsock.

Administrators: Jim Schlachter, Athena Vadnais, James Hiu, Teresa Ketelsen, Sara Huston, Julie Evans, Randy Bryant, John Koch, Mike Schofield, and Tracy Klinger.

-MINUTES-

Called To Order

Chair Judy Davis called the meeting to order at approximately 7:05 p.m. and reviewed the evening's agenda.

District Introductions – Superintendent Jim Schlachter

Superintendent Jim Schlachter introduced the school board members. Members of his district-level administrative team were also introduced.

DAC Introductions – Community Engagement Director Athena Vadnais

Communications and Community Engagement Director Athena Vadnais led DAC member introductions. Each DAC member introduced themselves, shared which school(s) they

represented, and where their student(s) attend school.

Principal's Report – Tracy Klinger, North Gresham Elementary School

Principal Tracy Klinger shared with the group that North Gresham Elementary School is one of two schools participating in a technology grant/pilot. The TechSMART Initiative grant will fund teacher professional learning paired with technology at North Gresham Elementary and Kelly Creek Elementary. The goal of the grant is to significantly increase the number of students reading at grade level by the end of the third grade. The grant was awarded to the school district from the Mount Hood Cable Regulatory Commission (MHCRC). Principal Klinger also took the District Advisory Council members on a tour of the school. If the November school bond passes, North Gresham Elementary would be replaced.

School Bond Update - Superintendent Jim Schlachter

Superintendent Schlachter shared basic information about the school bond that will be on the November 2016 ballot. If passed, the $291.17 million school bond would:

- Expand Education Opportunities for Every Student
- Increase Safety & Security
- Upgrade and Update Existing Buildings
- Renovate and Replace Aging Schools

The school bond would cost taxpayers $1.89 per every $1000 of assessed value. The school bond would impact every school in the district. More information about the school bond and school specific project lists can be found on the district website at www.Gresham-BarlowBond.org

District Interaction with the Board – Board of Directors

Board members answered questions related to the school bond.

The board members spoke at length about the need to pass the bond, and the urgency in moving forward with needed repairs and upgrades to our facilities. They emphasized the educational benefit to the bond and the support it would give students and staff. They were unified in their support of the bond.

They encouraged parents to be informed; for further opportunities and to be involved as advocates in their community, they referred parents to the Yes For Student Success Political Action Committee.

Adjournment

The meeting was adjourned.

Minutes submitted by:
Athena Vadnais
Community Engagement Director

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
Mike Schofield

DATE: October 6, 2016

RE: No. 11 – Bond Oversight Committee

EXPLANATION: A key element of the effective implementation of a capital bond includes community involvement and transparency during the multi-year process of planning and implementing all aspects of the bond projects. Accordingly, the administration recommends that the board appoint an oversight committee to ensure that bond proceeds are spent properly and only on projects described in the bond explanatory statement.

Attached is a draft charter that outlines the responsibilities of a citizens oversight committee. Approval of the charter and appointment of the members will be made after the passage of the bond.

PRESENTER: Jim Schlachter
Mike Schofield

SUPPLEMENTARY MATERIALS: Bond Oversight Committee Charter

RECOMMENDATION: After passage of the bond, the administration will recommend the establishment of a bond oversight committee.

REQUESTED ACTION: No action is required at this time.

MS:lc

GRESHAM-BARLOW SCHOOL BOND OVERSIGHT COMMITTEE

September 21, 2016

- **Authorization:** The Gresham-Barlow School District School Bond Oversight Committee is established as a committee of the Board of Directors. (Oregon Public Meeting Laws Apply)

- **Purpose and Authority:** The purpose and authority of the Oversight Committee is to convene quarterly or as needed to review progress on the Gresham-Barlow School District Bond Measure 26-187. They will review project improvements, monitor spending (program progress), and monitor schedules. Further they will consider and recommend project modifications if inflationary increases in construction costs exceed current budget estimates. The Oversight Committee shall report quarterly to the Board of Directors regarding program progress.

- **Estimated Time to carry out oversight:** The oversight committee shall be dissolved on January 1, 2021, or upon issuance of a final report by the Committee after all projects authorized by the Gresham-Barlow School District Bond Measure 26-187 have been completed, whichever is earlier.

- **Frequency of Meetings:** The Oversight Committee shall meet no fewer than four times per year. Meetings shall be held at a time and location to be determined by the Committee Chair.

- **Membership:** The Oversight Committee shall be composed of no fewer than 7 and no more than 11 members, to be appointed by the Board Chair and approved by the Board. Members shall primarily be professionals with experience in construction, finance, auditing, public budgeting, banking and general business. The District's project manager and Chief Financial Officer shall serve as ex officio members.

- **Chair and Vice Chair:** The Board Chair shall designate one member to serve as Chair and one member to serve as Vice Chair of the Oversight Committee. The Chair shall preside over committee meetings and act as spokesperson for the committee.

- **Annual Report:** The Oversight Committee shall prepare and deliver quarterly meeting minutes as well as an annual report to the Board of Directors regarding project progress including an overall assessment of the projects, schedules, spending trends, cost projections and recommendations for budget changes for specific projects to ensure the purpose and promise of the Gresham-Barlow School District Bond Measure 26-187 is fully realized.

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter
James Hiu
Julie Evans

DATE: October 6, 2016

RE: No. 12 - Enrollment and Class Size Report

EXPLANATION: This report is intended to provide the board with a general overview of K-12 enrollment during the initial opening of school, and to identify staffing adjustments that have been made to accommodate enrollment numbers.

This year's district enrollment as of September 27 totaled 10,981 students, representing 170 below projections for 2016-17, overall. As always, there are needs at the primary level that have been met and will be shared at the board meeting.

In addition to the overall enrollment total, the attached enrollment data provides specific information, including class size averages and other staffing/enrollment information.

We will briefly share with the board some additional comments, and respond to any questions.

PRESENTERS: James Hiu and Julie Evans

SUPPLEMENTARY MATERIALS: Enrollment as of 9/27/16

RECOMMENDATION: None

REQUESTED ACTION: This report is being provided as information only; no formal action is required.

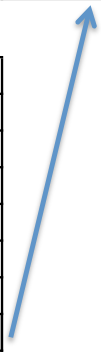
JH:pkh:lc

Gresham-Barlow School District 9/27/16

ENROLLMENT as of 9/27/16

	2013-14 9/24/13	2014-15 9/23/14	2015-16 9/22/15	2016-17 9/27/16	GBSD 2016-17 Projection	PSU 2016-17
Elementary						
K	783	771	812	800	812	927
1	846	831	783	811	830	912
2	840	847	785	797	819	880
3	791	865	827	810	837	919
4	778	822	864	864	866	933
5	842	804	831	866	901	943
	4,880	4940	4902	**4,948**	**5065**	**5514**
Middle School						
6	840	890	846	872	844	920
7	887	863	894	819	852	921
8	980	853	857	889	891	956
	2,707	2,606	2,597	**2,580**	**2587**	**2797**
High School						
9	1,034	891	891	891	924	953
10	960	890	890	890	890	936
11	874	815	815	815	840	957
12	856	857	857	857	845	1024
	3,724	3453	3453	**3453**	**3499**	**3870**
	11,311	10,999	10,952	**10,981**	**11,151**	12,181
			Below Projected	(170)		

REY Academy	40
Rosemary Anderson HS	70
L&C Montessori Charter	195
Arthur Academy	121
Metro East Web Academy	198
CAL**	265
ALP	29
	918



** CAL students are recorded in their home school

9/27/16

Middle Schools

School	6	7	8	Core Class Size Averages: Math	ELA	Sci	SS	Core Class Ave	Total	16-17 proj.	Over/ (Under)
Clear Creek	225	199	234	29.0	28.2	27.3	28.1	28.3	658	656	2
Damascus	63	46	53	26.8	26.6	27.0	27.0	26.7	162	159	3
Dexter McCarty	181	178	204	30.0	30.1	30.4	28.3	29.9	563	556	7
Gordon Russell	266	237	243	30.2	28.7	30.9	30.8	30.4	746	770	(24)
West Orient	137	159	155	29.2	29.7	30.1	29.5	29.9	451	446	5
Total	872	819	889				**MS Core Average**	**29.0**	2580	2587	(7)
2016-17 Ratio	29.1	29.3	25.0								
2015-16 Ratio	26.4	29.8	28.6								
2014-15 Ratio	30.7	28.8	28.4								
2013-14 Ratio	29.0	30.6	31.7								
2012-13 Ratio	29.2	30.2	29.8								

Elementary Schools

School	K	1	2	3	4	5	Total	16-17 proj.	Over/ (Under)
Deep Creek	46	51	33	44	53	43	270	281	(11)
East Gresham	59	59	62	63	84	59	386	442	(56)
East Orient	66	82	67	72	78	84	449	439	10
Hall	99	64	86	73	77	89	488	499	(11)
Highland	86	89	76	85	79	90	505	521	(16)
Hogan Cedars	84	84	100	91	123	114	596	581	15
Hollydale	72	75	71	70	66	53	407	411	(4)
Kelly Creek	83	87	87	88	93	94	532	528	4
North Gresham	84	94	88	96	99	91	552	564	(12)
Powell Valley	74	71	73	75	77	104	474	489	(15)
West Gresham	47	55	54	53	35	45	289	310	(21)
Total	**800**	**811**	**797**	**810**	**864**	**866**	**4948**	**5065**	**(117)**
2016-17 Ratio	23.2	25.7	27.5	30.0	31.4	32.7	28.1		
2015-16 Ratio	24.2	25.7	27.5	28.5	32.0	30.2	28.2		
2014-15 Ratio	26.6	27.7	28.7	29.8	30.4	32.8	30.0		
2013-14 Ratio	28.0	27.9	29.3	31.8	32.0	31.1	30.1		
2012-13 Ratio	26.0	29.1	31.4	30.6	31.9	30.4	29.7		

HIGH SCHOOLS - 9/27/16

School	9	10	11	12	Total	16-17 Proj	Over/ (Under)
GHS	396	403	372	401	1572	1591	(19)
SBHS	444	442	395	410	1691	1733	(42)
STHS	51	45	48	46	190	175	15
	891	890	815	857	3453	3499	(46)

GHS Core Class Average

	12-13	13-14	14-15	15-16	16-17
Math	35.8	33.0	28.2	31.6	31.6
Science	34.2	34.3	34.7	34.0	34.0
Social Studies	34.2	34.3	33.8	34.0	34.0
Language Arts	35.9	30.4	30.4	32.9	32.9

SBHS Core Class Average

	12-13	13-14	14-15	15-16	16-17
Math	30.2	30.9	29.8	33.0	31.6
Science	30.0	35.2	33.0	33.4	34.0
Social Studies	31.6	33.0	34.1	34.2	34.0
Language Arts	30.9	31.3	32.8	32.7	32.9

STHS Core Class Average

	12-13	13-14	14-15	15-16	16-17
Math	19.8	20.6	23.7	23.9	31.6
Science	18.0	17.3	20.8	22.3	34.0
Social Studies	19.4	19.5	21.0	21.7	34.0
Language Arts	18.0	16.6	19.0	24.1	32.9

GRESHAM-BARLOW SCHOOL DISTRICT
1331 NW Eastman Parkway
Gresham, OR 97030-3825

TO: Board of Directors

FROM: Jim Schlachter

DATE: October 6, 2016

RE: No. 13 – Bond Information Update

EXPLANATION:	The board will receive an update regarding the district's 2016 facilities bond measure, which will be on the November ballot.
PRESENTERS:	Jim Schlachter, Mike Schofield, Athena Vadnais
SUPPLEMENTARY MATERIALS:	None
RECOMMENDATION:	This report is being provided as information only.
REQUESTED ACTION:	No action is required.

:lc