Fort Worth Independent School District

Amended and Restated

FLEXIBLE BENEFITS PLAN

September 1, 2016

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FORT WORTH INDEPENDENT SCHOOL DISTRICT
AMENDED AND RESTATED FLEXIBLE BENEFITS PLAN

ARTICLE ONE
Introduction

1.1 Purpose of Plan. This Plan is established by the Fort Worth Independent School (hereinafter the "School District") as the Fort Worth Independent School District Amended and Restated Flexible Benefits Plan, effective September 1, 2016. The purpose of this Plan is to provide Participants with a choice between cash and Optional Benefit Coverages or some combination thereof. This is the exclusive means by which the School District offers its employees a choice between taxable and nontaxable benefits.

1.2 Flexible Benefits Plan Status. This Plan is intended to qualify as a "nondiscriminatory cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. It is to be maintained by the School District as the Administrator for the benefit of its employees and will be operated in compliance with the requirements of Section 125 and any regulations as well as the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148, as amended). Additionally, the Optional Benefit Coverage available hereunder are intended, respectively, to qualify as a self-insured medical reimbursement plan under Code Section 105, and as a dependent care assistance program under Code Section 129.

ARTICLE TWO
Definitions

Wherever used in this Plan, the singular includes the plural and the following terms have the following meanings, unless a different meaning is clearly required by the context:

2.1 "Administrator" means the Executive Director Benefits and Risk Management or such other person, committee or third party administrator as may be appointed from time to time by the School District to supervise the administration of the Plan or portions of the Plan.

2.2 "Benefit Eligible Employee" means an Employee of FWISD, an active contributing TRS member, employed as a regular, full-time, non-temporary employee.

2.3 "Code" or "Code Section" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section.

2.4 "Coverage Amount" means the amount of health care reimbursement coverage and/or dependent care reimbursement coverage elected by a Participant for a Plan Year under Article Five and/or Article Six

2.5 "Coverage Period" means the Plan Year.

2.6 "Debit Card" means a debit card, credit card or stored value card.

2.7 "Dependent" means a qualifying child or relative as defined in Code Section 152 of the Code.

2.8 "Dependent Care Expenses" mean expenses incurred during a Plan year by a Participant for the care of a Dependent of the Participant for related household services which would be considered employment-related expenses under Section 21(b)(2) of the Code, and which are eligible for reimbursement from a Participant's Dependent Care Flexible Spending Account in accordance with the requirements of Code section 129.

2.9 "Dependent Care Flexible Spending Account" means the account described in Article 6.

2.10 "Employee" means any individual who is employed by Ft. Worth Independent School District.

2.11 "Employer" means the Ft. Worth Independent School District.

2.12 "ERISA" means the Employee Retirement Income Security Act of 1974, as from time to time amended. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.13 "Experience gains" means unused amounts of contributions and benefits that are not used before the end of the Grace Period that are forfeited by the Participant.

2.14 "Grace Period" means that period of time ending on October 31, following the end of the preceding Plan Year.

2.15 "Health Flexible Spending Account" is the equivalent of "Medical Flexible Spending Account" and means the accounts described in Article 5.

2.16 "Key Employee" means any person who is a key employee, as defined in section 416(i)(1) of the Code, with respect to the School District.

2.17 "Qualified Benefits" means offered benefits that are excludible from an employee's gross income and do not defer compensation. In addition to the benefits set forth in the Summary Plan Description, FWISD offers a Medical Flexible Spending Account and a Dependent Care Flexible Spending Account.

2.18 "Participant" means any individual who participates in the Plan in accordance with Article 3. All participants in the plan must be employees of Ft. Worth Independent School District.

2. 19 "Plan" means the Ft. Worth Independent School District Amended and Restated Flexible Benefits Plan as set forth herein, together with any and all schedules, amendments and supplements hereto.

2.20 "Plan Year" means the twelve consecutive months between September 1 through August 31. It is the coverage period for benefits provided through the cafeteria plan to which annual elections for those benefits apply. Benefits elected may not be carried forward to subsequent plan years except in accordance with the Grace Period defined herein.

2.21 "Qualified Employee" any employee who is not a highly compensated or key employee and who is eligible to participate in the plan

2.22 "Qualifying Health Care Expense" means eligible medical expenses incurred by a Participant, or by the spouse or Dependent of such Participant, for medical care as defined in section 213(d) of the Code (including, without limitation, amounts paid for hospital bills, doctor and dental bills, and drugs), but only to the extent that the Participant or other person incurring the expense is not reimbursed or entitled to reimbursement for the expense through insurance or otherwise (other than under the Plan). "Qualifying Health Care Expense" does not include any premium paid for health coverage under any plan maintained by an Employer or any other employer or any expense incurred for qualified long-term care services as defined in Section 7702B(c) of the Code. Qualifying Health Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

2.23 "Required Premium" means the Participant's Coverage Amount for the Plan Year which shall be deducted from the Participant's compensation over a 12-month period beginning in September and ending August of the Plan Year. In the case of an Employee who first becomes a Participant after August of the Plan Year, the Required Premium shall be the Participant's Coverage Amount divided by the number of regular compensation payments remaining in the Plan Year. If the Participant changes his or her election under the Flexible Benefits Plan after January of the Plan Year to increase or decrease his or her Coverage Amount during the Plan Year, the Required Premium shall likewise be increased or decreased by the amount of such change divided by the number of regular compensation remaining in the Plan Year.

2.24 Run Out Period - The time period immediately following each Grace Period from November 1 and November 30 during which a Participant can submit a claim for reimbursement for a qualified health benefit incurred during the plan year or grace period.

2.25 "School District" means the Fort Worth Independent School District.

2.26 "Taxable Year" means the plan year of the cafeteria plan; the period for which salary reduction elections are made.

ARTICLE THREE
Rules Governing Eligibility for Participation

3.1 Participants. All participants in the plan must be employees of the Fort Worth Independent School District ("FWISD").

3.2 Commencement of Participation. Each FWISD Employee will become a Participant on the date he or she becomes a Benefit Eligible Employee. With respect to the Health Flexible Spending Arrangement and/or the Dependent Care Flexible Spending Arrangement, a Benefit Eligible Employee becomes a Participant upon the effective date of their election under this Plan to have the deductions made from their income and receive the applicable reimbursements available hereunder.

3.3 Cessation of Participation. A Participant will cease to be a Participant in this Plan as of the earlier of (a) the date on which the Plan terminates; (b) the last day of the Plan year date on which the Participant ceases to be a Benefit Eligible Employee;

3.4 Reinstatement of Former Participant. A former Participant will become a Participant again if and when he or she again becomes a Benefit Eligible Employee.

3.5 Participation of spouses or Dependents. A Participant's spouse or Dependent may receive benefits through a cafeteria plan although they cannot be a Participant in the Plan.

3.6 Terms of Plan. The terms of this plan apply uniformly to all participants. Discriminatory benefits will not be provided under the plan and inclusion of such benefits in gross income will occur in the event that discriminatory benefits are inadvertently provided to highly compensated participants and individuals and key employees.

ARTICLE FOUR
General Terms of Optional Benefit Coverages

4.1 Benefits Available Under this Plan. Each Participant may choose under this Plan to receive his or her full compensation in cash or to have all or a portion of it applied by FWISD toward the following optional benefits: Medical Insurance; Voluntary Supplemental Insurance; and Flexible Spending Accounts including Health Flexible Spending Arrangement; the Dependent Care Flexible Spending Arrangement; and Health Savings Accounts each described in detail herein. Voluntary Supplemental Insurance includes term life insurance and vision and dental coverage.

4.2 Description of Optional Benefit Coverages. This Plan is intended to allow the election between cash and one or more of the Optional Benefits. The types and amounts of benefits available under each are described herein, along with the terms of the applicable Flexible Spending Arrangements.

4.3 Election of Optional Benefit Coverages in Lieu of Cash. A Participant may elect under this Plan, in accordance with the procedures described in Sections 4.4, 4.5 and 4.6, to receive one or more Optional Benefits to the extent available to the Participant. If a Participant elects coverage for a Plan Year under the Health Flexible Spending Arrangement and/or the Dependent Care Flexible Spending Arrangement, the Participant's regular cash compensation for the Plan Year will be reduced by such amount as the Participant elects (subject to the limitations of those plans) and an amount equal to the reduction in compensation will be credited to the applicable flexible spending account in accordance with the plan terms.

4.4 Election Procedure. After initial enrollment by a Participant, re-enrollment each Plan Year is not required for Optional Benefit(s) with the exception of the Health Flexible Spending Arrangement and/or the Dependent Care Flexible Spending Arrangement unless the Participant intends to modify his or her Optional Benefit(s). Prior to the commencement of each Plan Year, the Administrator will make available a means of election for each Participant and for each other individual who is expected to become a Participant at the beginning of the applicable Plan Year. Each Participant who desires to modify his or her election of Optional Benefit(s) shall complete a new election form. The new election shall be effective as of the first day of the Plan Year.

4.5 New Participants. Before, or as soon as practicable after, an individual becomes a Participant in this Plan, the Administrator will provide the means of election described in Section 4.4 to the individual. If the individual desires one or more Optional Benefit(s) for the balance of the Plan Year, the individual shall so specify in his or her election. The Participant shall agree to a reduction in his or her compensation equal to the amount of the Optional Benefit(s) elected by the Participant. Each election must be completed and returned to the Administrator on or before such dates as the Administrator shall specify.

4.6 Failure to Make Election.

(a) For purposes of a new Participant's failure to make an election under Section 4.4 or 4.5 on or before the due date specified by the Administrator for the Plan Year in which he or she becomes a Participant shall constitute an election by the Participant to receive his or her full compensation in cash.

(b) For purposes of all Optional Benefit(s) except Health Flexible Spending Arrangement and/or the Dependent Care Flexible Spending Arrangement, an existing Participant's failure to make an election under Section 4.4 on or before the due date specified by the Administrator for

any Plan Year shall constitute an election by the Participant to continue with the Optional Benefits from the previous Plan Year.

(c) Participants must re-enroll in the Health Flexible Spending Arrangement and/or the Dependent Care Flexible Spending Arrangement each Plan Year and a failure to make an election to continue these Optional benefit(s) by an existing Participant will be treated as an election to discontinue coverage.

4.7 Revocation or Change of Election by the Participant During the Plan Year.

(a) Irrevocability - Any election made under the Plan (including an election made through inaction under Section 4.6) shall be irrevocable by the Participant during the Plan Year except as otherwise provided in (b) through (f) below.

(b) Revocation - A Participant may revoke an election in writing for the balance of the Plan Year and, if desired, file a new election in writing if, under the facts and circumstances, (1) a change in status occurs, and (2) the requested revocation and new election satisfy the consistency requirements in Section 4.8 below. For this purpose, a change in status includes the following events:

(1) Legal marital status. An event that changes a Participant's legal marital status includes marriage, death, death of spouse, divorce, legal separation or annulment.

(2) Number of dependents. An event that changes a Participant's number of dependents including birth, death, adoption or placement for adoption.

(3) Employment status. An event that changes the employment status of the Participant or the Participant's spouse or Participant's dependent, including termination or commencement of employment, a commencement or return from an unpaid leave of absence, and a change in worksite. Additionally, any other change in the employment status of the Participant or the Participant's spouse or Participant's dependent that results in that individual becoming (or ceasing to be) eligible under a cafeteria plan or other employee benefit plan will qualify as a change in status. The following changes are also permitted as change of status events:

(a) Reduction in Hours of Service – An employees whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week but for whom the reduction of hours does not render the employee ineligible for Medical Insurance under this plan qualifies to revoke that employee's Medical Insurance as a change of employment status if the revocation of the Medical Insurance corresponds to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage for new coverage that is effective no later that the first

day of the second month following the month that includes the date the original coverage is revoked.

(b) Enrollment in a Qualified Health Plan – The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and the revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in a Qualified Health Care Pan 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 revoked.

(4) Dependents. An event that causes a dependent to begin to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(5) Residence. A change in the place of residence of the Participant, his or her spouse or dependent.

(6) Other. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under regulations and rulings of the Internal Revenue Service.

(c) Dependent Care Significant Cost Change - In the case of the Dependent Care Flexible Spending Arrangement under Article Six, if the Participants' share of the cost of such coverage significantly increases or significantly decreases during the Plan Year, the Participants may make a corresponding change in election under the Plan for the balance of the Plan Year, which will include (but not be limited to) the following:

(1) For a significant cost increase, Participants electing such coverage for the Plan Year may revoke their election and either elect a similar coverage identified for the balance of the Plan Year, or drop such coverage if there is no similar coverage; or

(2) For a significant cost decrease, Participants may elect to commence participation with the significant cost decrease and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year.

This Section 4.7(c) shall apply only if the significant cost change is imposed by a Dependent Care Service Provider who is not a relative of the Participant. No election change may be made as to the Health Flexible Spending Arrangement on account of a significant cost change.

(d) Addition or Improvement of Benefit Package Option - If during the Plan Year a new Optional Benefit becomes available, or an existing Optional Benefit is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year, provided that no such election change may be made as to the Health Flexible Spending Arrangement. For purposes of this Section 4.7(d), a Participant's change in Dependent Care Service Provider shall be treated as a significant change in available coverage and a change is allowed to reflect the new dependent care costs.

(e) Spouses/Dependents - In the event that a Participant's spouse or Dependent makes an election change under a plan maintained by his or her employer, the Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the Plan Year that is on account of and corresponds with the election change made by the Participant's spouse or Dependent, if:

(1) the election change made by the Participant's spouse or Dependent under his or her employer's plan satisfies the regulations and rulings under Code section 125; or

(2) the period of coverage under the plan maintained by the employer of the Participant's spouse or Dependent does not correspond with the Plan Year of this Plan.

(f) Timelines - Any application for a revocation and new election under this Section 4.7 must be made within the time specified by the Administrator following the date of the actual event and shall be effective at such time as the Administrator shall prescribe, unless otherwise required by law.

4.8 Consistency Rule. A Participant's requested revocation and new election under Section 4.7(b) will be consistent with a change in status (1) if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a plan of the Employer or under a plan maintained by the employer of the Participant's spouse or Dependent, and (2) with respect to dependent care assistance, if the election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 (including employment related expenses as defined in Code Section 21(b)(2)). A change in status that affects the eligibility under an employer's plan shall include a change in status that results in an increase or decrease in the number of a Participant's family members or Dependents who may benefit from coverage under the plan.

4.9 Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such year any nondiscrimination or other requirement imposed by the Code or any limitation on benefits provided to Key Employees, the

Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

4.10 Automatic Termination of Election. Any election made under this Plan (including an election made through inaction under Section 4.6) shall automatically terminate on the date on which the Participant ceases to be a participant in the Plan, although Optional Benefits may continue if and to the extent provided herein or as otherwise provided by applicable law. In the event such a former Participant again becomes a Participant before the end of the same Plan Year, the elections previously in effect for the Participant shall be automatically reinstated for the balance of the Plan Year, except as otherwise elected by the Participant in accordance with Section 4.7. Additionally, any Employee who terminates employment and is rehired within thirty (30) days after terminating employment (or who returns to employment following an unpaid leave of absence of less than 30 days) is not a new Employee eligible for purposes of a new election under Section 4.7.

4.11 Maximum Elective Contributions. The maximum amount of elective contributions under the Plan for any Participant shall be the total cost to the Participant for the Plan Year.

4.12 Cessation of Required Contributions. Nothing in this Plan shall prevent the cessation of Optional Benefits by the Administrator because of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction or otherwise.

4.13 Elections Via Other Media. The Administrator may, in its discretion, use any telephonic, electronic or other alternative media form that it deems necessary or appropriate for the election of benefits under the Plan.

4.14 Coordination with FMLA. Notwithstanding any other provision of this Plan, the Administrator may (a) permit a Participant to revoke (and subsequently reinstate) his or her election of one or more Optional Benefits under the Plan, (b) adjust a Participant's compensation reduction as a result of a revocation or reinstatement and (c) permit payment of the Participant's share of the cost of an Optional Benefit during an unpaid leave with after-tax dollars, to the extent the Administrator deems necessary or appropriate to ensure the employer's compliance with the provisions of the Family and Medical Leave Act of 1993 ("FMLA") and its amendments and any regulations pertaining thereto.

ARTICLE FIVE
Health Flexible Spending Arrangement

5.1 Coverage Amount. In lieu of cash, a Participant may elect to receive payments or reimbursements of Qualifying Medical Care Expenses incurred in a taxable year up to any statutory maximum limits designated in federal law that are elected under the Plan by the

Participant. Participants will not be allowed to exceed the statutory maximum of salary reduction during any Taxable Year which was $2,500 (as indexed for inflation) for 2015. The 2016 statutory maximum has been published as $2,550.00. The maximum allowed under the Plan for future years will be the statutory maximum published by the Internal Revenue Service and the plan will not require amendment or revision to abide by such limitations. A Participant may, to the extent permitted under Article Four, change, his or her election by increasing or decreasing his Coverage Amount during the Plan Year within the respective limits for the respective Taxable Year.

5.2 Establishment of accounts. The Administrator will cause to be established and maintained a Health Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive reimbursements of Qualifying Medical Care Expenses incurred during the Plan Year.

5.3 Uniform Coverage Rule. A Participant's Health Flexible Spending Account for each Plan Year shall be credited at the beginning of the Plan Year, the total amount equal to the Participant's Coverage Amount for such Plan Year, and such amount shall be available to the Participant at all times during the Plan Year. Further, the payment schedule for the Participant's Coverage Amount for such Plan Year will not be based on the rate or amount of claims incurred during the Plan Year. Except as otherwise required by law, the amount credited for each Plan Year to each Health Flexible Spending Account shall be the property of FWISD until paid out pursuant to the terms hereof.

5.4 Debiting of accounts. A Participant's Health Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any payment to or for the benefit of the Participant for Qualifying Medical Care Expenses incurred during such Plan Year.

5.5 Experience Gains. The amount credited to a Participant's Health Care Spending Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Care Expenses incurred during the Plan Year and the subsequent Grace Period while the Employee was a Participant, and only if the Participant applies for reimbursement on or before November 30th following the end of the Grace Period. If any balance remains in the Participant's Health Flexible Spending Account for the Plan Year after all reimbursements are requested in a timely manner and provided, such balance shall not be carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner. Such balance shall be retained by FWISD and the Participant shall forfeit all rights with respect to such balance. No compensation will be deferred.

5.6 Grace Period Effect on Taxable Year Limit. In the event that an Participant uses unused salary reduction contributions remaining from the previous plan year during the designated Grace Period, such amounts do not count toward the statutory limit applicable for the subsequent plan year.

5.7 Substantiation by Third Party. To the extent required by federal regulations, all expenses will be substantiated by information from a third party that is independent of the employee and the employee's spouse and dependents.

(a) A Participant who has elected to receive health care reimbursements for a Plan Year may apply to the Administrator for reimbursement of Qualifying Medical Care Expenses incurred by the Participant while he or she was a Participant during the Plan Year by submitting a statement in writing to the Administrator, in such form as the Administrator may prescribe, setting forth:

(1) the amount, date and nature of each expense with respect to which a benefit is requested;

(2) the name of the person, organization or entity to which the expense was or is to be paid;

(3) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant;

(4) the amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense; and

(5) a statement that the expense (or the portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

(b) Such application shall be accompanied by a written statement from an independent third party with information describing the service or product, the date of the service or sale and the amount. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense. Self-substantiation or self-certification by an employee will not satisfy the federal substantiation requirements. The employee must also submit any bills, invoices, receipts, cancelled checks or other statements or documents that the Administrator may request. An explanation of benefits written by an insurance company indicating the date of the qualifying health care and the employees responsibility for payment of that care combined with an employee's certificate that any expense paid through the Health Flexible Spending Account has not been reimbursed and that the employee will not seek reimbursement from any other plan covering health benefits, the claim will be fully substantiated without the need for submission of a receipt by the employee.

5.8 Reimbursement or Payment of Expense. The Administrator shall reimburse the Participant from the Participant's Health Care Spending Account, at such time and in such manner as the Administrator may prescribe, for Qualifying Medical Care Expenses incurred during the Plan Year for which the Participant makes written application and provides documentation in accordance with Section 5.8. The Administrator may, at its option, pay any such Qualifying Medical Care Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant. No reimbursement or payment under this Section 5.9 shall be made if the claim submitted by the Participant is for an amount less than the minimum reimbursable amount established by the Administrator or if the expense cannot be substantiated. The amount of any Qualifying Medical Care Expenses not reimbursed or paid as a result of the minimum reimbursable amount

shall be carried over and reimbursed or paid only if and when the Participant's unreimbursed claims equal or exceed such minimum. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year that are submitted for reimbursement after the last day of the Plan Year and on or before November 30th following the close of the Plan Year shall be paid regardless of whether they equal or exceed the minimum reimbursable amount. Expenses incurred before or after the period of coverage may not be reimbursed.

5.9 Limited Purpose Health Flexible Spending Account. A Participant who has elected to participate in both a Health Flexible Spending Account and a Health Savings Account is limited to reimbursement for eligible dental and vision expenses through the Health Flexible Spending Account. The statutory maximum for salary reductions set forth in § 125(i) apply. An otherwise eligible Participant must be covered by a high deductible health plan in order to be eligible to contribute to a Health Savings Plan; however, such a Participant will not fail to qualify for a Health Savings Plan merely because the individual is also covered by a limited purpose Health Flexible Savings Accounts. The substantiation rules set forth in 5.7 apply to limited purpose Health Flexible Savings Accounts.

5.10 Debit Card Program. The Administrator may pay or reimburse Qualifying Medical Care Expenses, in accordance with the substantiation rules contained in Proposed Treasury Regulation Section 1.125-6(e) and/or (f), through the use of a debit card program. However, if such program is undertaken, the Administrator must satisfy all of the following requirements:

(a) Before any Participant receives the debit card, the Participant agrees in writing that he or she will only use the card to pay for Qualifying Medical Care Expenses of the Participant or his or her spouse or dependents, that he or she will not use the debit card for any medical expense that has already been reimbursed, that he or she will not seek reimbursement under any other health plan for any expense paid for with a debit card, and that he or she will acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the debit card.

(b) The debit card includes a statement providing that the agreements in Section 5.10 (a) are reaffirmed each time the Participant uses the card.

(c) The amount available through the debit card equals the Coverage Amount elected by the Participant for the Health FSA for Plan Year, and is reduced by amounts paid or reimbursed for Qualifying Medical Care Expenses incurred during the plan year.

(d) The debit card is automatically cancelled when the Employee ceases to be a Participant in the Health FSA.

(e) The Administrator limits use of the debit card to:

(1) Physicians, dentists, vision care offices, hospitals, other medical care providers (as identified by the merchant category code);

(2) Stores with the merchant category code for Drugstores and Pharmacies if, on a location by location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as Qualified Medical Care expenses; and

(3) Stores that implemented the inventory information approval system under Proposed Treasury Regulation Section 1.125-6(f).

(f) The Administrator substantiates claims based on payments to medical care providers and stores described in paragraphs (e)(1) and (2) of this Section 5.10 in accordance with either Proposed Treasury Regulation Section 1.125-6(e) or (f).

(g) The Administrator follows all of the following correction procedures for any improper payments using the debit card:

(1) Until the amount of the improper payment is recovered, the debit card must be de-activated and the Participant must request payments or reimbursements of Qualifying Medical Care Expenses from the Health HSA through other methods outlined in Section 5.8;

(2) The Administrator will demand that the Participant repay the Plan an amount equal to the improper payment;

(3) If, after the demand for repayment of improper payment is made by the Administrator, the Participant fails to repay the amount of the improper charge, the Administrator will withhold the amount of the improper charge from the Participant's pay or other compensation, to the full extent allowed by applicable law;

(4) If any portion of the improper payment remains outstanding after attempts to recover the amount are made by the Administrator, the Administrator will apply a claims substitution or offset to resolve improper payments, such as a reimbursement for a later substantiated expense claim being reduced by the amount of the improper payment; and

(5) If, after applying all the procedures described herein, the Participant remains indebted to the Administrator for improper payments, the Administrator, consistent with its business practice, treats the improper payment as it would any other business indebtedness.

5.11 Limitation on reimbursement or payments with respect to certain Participants. Notwithstanding any other provision of this Plan, the Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (within the meaning of Code section 105(h)(5) or 125(e)) to the extent the Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in forfeiture under Section 5.5.

5.12 Cessation of Coverage.

(a) Cessation of participation. In the event that a Participant ceases to be a Participant in this Plan for any reason during a Plan Year, the Participant's salary reduction agreement relating to this Plan shall terminate. Except as provided in subsection (b) of this Section 5.12, the Participant shall be entitled to reimbursement only for Qualifying Health Care Expenses incurred within the same Plan Year and before he or she ceased to be a Participant.

(b) Continuation of coverage. If and to the extent required by law (including, without limitation, Code Sections 105, 125, and 4980B and the regulations thereunder), in the event that a Participant ceases to be an Employee and undertakes to pay Required Premiums to the Administrator on a monthly basis (or within such other time limit as may be provided for by law), coverage under the Plan shall continue so long as such Required Premiums are paid, but not beyond the end of the period for which such coverage is required by law. In addition, the former Participant shall be treated as a Participant under the Plan to such extent as is required by law, and shall be entitled to reimbursement for Qualifying Health Care Expenses incurred during such period of continued coverage, subject to subsection (c) of this Section 5.12.

(c) Limits on time and amount of reimbursement. Reimbursement shall be made for any Plan Year under this Section 5.12 only if the Participant applies for such reimbursement in accordance with Section 5.7 before the end of the Run Out Period (November 30th). In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursement permitted under this Article Five. No reimbursement under this Article Five shall exceed the remaining balance, if any, in the Participant's Health Care Spending Account for the Plan Year in which the expenses were incurred.

5.13 Coordination with FMLA. In the event that a Participant goes on unpaid leave in accordance with the Family and Medical Leave Act (hereinafter "FMLA"), options are available for continued Plan coverage as well as payment.

(a) Participant Options. Notwithstanding any other provision of this Plan, a Participant on unpaid Family and Medical Leave Act (hereinafter "FMLA") leave, in accordance with the provisions of 29 U.S.C. §2601 et seq., may either revoke coverage under the Health Flexible Spending Arrangement or elect to continue such coverage. If a Participant elects to continue such coverage, the Participant must continue his or her payment of the Required Premium(s) during the period of such FMLA leave. Additionally, a Participant whose coverage under the Health Flexible Spending Arrangement terminated while such Participant was on FMLA leave, shall be entitled to have that coverage reinstated upon his or her return from such FMLA leave.

(b) Pay-as-You-Go Payment Option. If a Participant taking FMLA leave elects to continue coverage under the Health Flexible Spending Arrangement while taking such leave, the

Participant shall be responsible for the Required Premiums that would be allocable to such Participant if not otherwise on FMLA leave. For this purpose, the Administrator offers the pay-as-you-go payment option. A Participant may pay his or her share of the Required Premium on the same schedule as payments would have been made if the Participant were not on leave. Such payments are generally made by the Participant on an after-tax basis except to the extent taxable compensation may be paid by FWISD to such Participant while on leave. Additionally, the payments by the Participant shall be made on such terms as are applicable generally to payments by employees on unpaid leave or as may otherwise be agreed by the Participant and FWISD. If a Participant fails to make the required payments while on leave, FWISD will assume the responsibility of advancing payment of required premiums on the Participant's behalf during the remainder of the FMLA leave and will recoup the Participant's share of Required Premiums directly from the Participant.

5.14 Nondiscrimination. Health Flexible Spending Arrangements will be administered in a nondiscriminatory manner with respect to contribution and benefits as well as benefit availability and benefit utilization. The Plan will provide all similarly situated participants a uniform coverage opportunity to elect qualified benefits, and the actual election of qualified benefits through the plan will not be disproportionate by highly compensated participants.

ARTICLE SIX
Dependent Care Flexible Spending Arrangement

6.1 Maximum Dependent Care Reimbursement. The maximum amount which the Participant may receive in any calendar year in the form of dependent care assistance under this Plan shall be the least of (a) the Participant's earned income for the calendar year (after all reductions in compensation including the reduction related to dependent care assistance), (b) the actual or deemed earned income of the Participant's spouse for the calendar year, or (c) $5,000 (or, $2,500 for those married Participants filing separate returns. If a Participant does not certify to the Administrator's satisfaction that he or she either is unmarried or will file a joint federal income tax return for the year, the maximum dependent care reimbursement will be $2,500 for that Participant. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable for caring for himself or herself, such spouse shall be deemed to have earned income of not less than $250 per month if the Participant has one Dependent and $500 per month if the Participant has two or more Dependents. In the case of two Participants who are married to each other and who file a joint federal income tax return for the calendar year, the $5,000 limit in (c) above shall be reduced for each such Participant by the amount received for the calendar year under the Plan by the Participant's spouse. For purposes of this Section 6.1, "earned income" shall have the meaning given it by Code Section 32(c)(2), and a Participant shall be treated as not married if the Participant is not considered as married under the special rules of Code Section 21(e)(3) and (4).

6.2 Establishment of Accounts. FWISD will cause to be established and maintained a Dependent Care Spending Account for each Plan Year with respect to each Participant who has

elected to receive reimbursements of Dependent Care Expenses incurred during the Plan Year.

6.3 Crediting of Accounts. There shall be credited to a Participant's Dependent Care Spending Account for each Plan Year, as of each pay period for the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in the Participant's compensation for such pay period in accordance with the Participant's dependent care election and salary reduction agreement under the Plan. All amounts credited to each such Dependent Care Spending Account shall be the property of FWISD until paid out pursuant to the terms hereof.

6.4 Debiting of Accounts. A Participant's Dependent Care Spending Account for each Plan Year shall be debited from time to time in the amount of any payment to or for the benefit of the Participant for Dependent Care Expenses incurred during such Plan Year.

6.5 Use-or-Lose Rule. The amount credited to a Participant's Dependent Care Spending Account for any Plan Year shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Plan Year, and only if the Participant applies for reimbursement on or before the end of the Run Out Period. If any balance remains in the Participant's Dependent Care Spending Account for a Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner. Such balance shall be disposed of by FWISD in accordance with the provisions of 6.6, and the Participant shall forfeit all rights with respect to such balance.

6.6 Experience Gains. If, at the conclusion of the Plan Year and the Run Out period provided in Section 6.5, there remains in FWISD's possession, excess employer contributions, including salary reduction contributions, such amount, referred to as "experience gains" will be retained by FWISD.

6.7 Claims for Reimbursement. A Participant who has elected to receive dependent care assistance for a Plan Year may apply to the Administrator for reimbursement of Dependent Care Expenses incurred by the Participant during the Plan Year by submitting a statement in writing to the Administrator, in such form as the Administrator may prescribe, setting forth:

(a) the amount, date and nature of each expense with respect to which a benefit is requested;

(b) the name of the person, organization or entity to which the expense was or is to be paid;

(c) a statement that the expense (or the portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other dependent care plan coverage; and

(d) such other information as the Administrator shall from time to time require.

6.8 Substantiation. The application described in 6.7 shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, cancelled checks or other statements or documents showing the amounts of such expenses, together with any additional documentation the Administrator may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

6.9 Reimbursement or Payment of Expense. The Administrator shall reimburse the Participant from the Participant's Dependent Care Spending Account, at such time and in such manner as the Administrator may prescribe, for Dependent Care Expenses incurred during the Plan Year for which the Participant makes written application and provides documentation in accordance with Section 6.7 and 6.8. No reimbursement or payment shall, at any time, exceed the Balance of the Participant's Dependent Care Spending Account for the Plan Year at the time of the reimbursement of payment, nor shall any payment or reimbursement be made if the Participant's claim is for an amount less than the minimum claim amount established by the Administrator. The amount of any Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence shall be carried over and reimbursed or paid only if and when the Participant's claim equals or exceeds such minimum and the balance in the Participant's Dependent Care Spending Account permits such reimbursement or payment. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year that are submitted for reimbursement after the last day of the Plan Year and on or before the Run Out Period shall be paid regardless of whether they equal or exceed the minimum claim amount, provided the Participant's Dependent Care Spending Account permits such reimbursement or payment.

6.10 Annual Report to Participants. The Administrator shall furnish to each participant (or former Participant) who has elected dependent care assistance under this Plan for the prior year a written statement showing the amount of such assistance paid or payable during such year with respect to Dependent Care Expenses incurred by the Participant (or former Participant). If the amount of such Dependent Care Expenses is not known to the Administrator by January 31st, the written statement shall show the amount of dependent care assistance elected by the Participant (or former Participant) for such year.

6.11 Debit Card Program.

(a) The Administrator may pay or reimburse Dependent Care Expenses, in accordance with the rules contained in Proposed Treasury Regulations Section 1.125-6(g) and related guidance, through the use of a debit card program. However, in no event shall Dependent Care Expenses be reimbursed before the expenses are incurred.

(b) The Administrator may adopt the following method to provide reimbursements for Dependent Care Expenses through a debit card:

(i) At the beginning of the Plan Year or upon enrollment in the dependent care assistance program, the Participant pays initial expenses to the Dependent Care

Provider and substantiates the initial expenses by submitting to the Administrator a statement from the Dependent Care Service Provider substantiating the dates and amounts for the services provided.

(ii) After the Administrator receives the substantiation (but not before the date the services are provided as indicated by the statement provided by the Dependent Care Service Provider), the Plan makes available through the debit card an amount equal to the lesser of:

(A) The previously incurred and substantiated Dependent Care Expense; or

(B) The Participant's total salary reduction amount to date.

(iii) The debit card may be used to pay for subsequently incurred Dependent Care Expenses.

(iv) The amount available through the debit card may be increased in the amount of any additional Dependent Care Expenses only after the additional Dependent Care Expenses have been incurred.

6.12 Limitation on Reimbursement or Payments with Respect to Certain Participants. Notwithstanding any other provision of the Plan, the Administrator may limit the amounts contributed, reimbursed or paid with respect to any Participant who is a highly compensated employee (within the meaning of Code Section 414(q)), to the extent that the Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section 6.5.

6.13 Cessation of Coverage. In the event that a Participant ceases to be a Participant in the Plan during a Plan Year for any reason, the Participant's salary reduction agreement related to dependent care assistance shall terminate immediately.

ARTICLE SEVEN
Health Savings Account

7.1 Purpose. A Health Savings Account (HSA) is an account established exclusively for the purpose of paying qualified medical expenses incurred by the account beneficiary (eligible individual). The Plan Administrator shall establish an HSA to separately account for contributions/payments used to fund Health Savings Accounts. Each Participant's HSA will be credited with amounts withheld from the Participant's Compensation and amounts paid by the employer. A Participant in an HSA must otherwise qualify as set forth in 7.2.

7.2 High Deductible Health Plan Requirement. A Participant must first be enrolled in a high-deductible health plan. A high deductible health plan is offered as benefit under this plan. A Participant cannot be covered under any other health plan in order to qualify for an HSA. The high deductible health plan annual minimum deduction figures are established by the Internal Revenue Service.

7.3 HSA Allowances. The following prohibitions do not apply to an HSA:

(a) The prohibition against a benefit that defers compensation by permitting employees to carry over unused elective contributions or plan benefits from one plan year to another (the Use-It-Or-Lose-It rule);
(b) The mandatory 12-month period of coverage. Although it is best to coordinate the addition of the HSA with the plan year, this is not a mandate. Participants adding an HSA mid-year who also have a Health Flexible Spending Account must modify their Health Flexible Spending Account to a Limited Purpose Health Flexible Spending Account as set forth in Section 5.9. A mid-year addition or deletion of an HSA or mid-year changes to the contributions to an HSA are not a qualifying event for purposes of a change in election to a Health Flexible Spending Account in accordance with Section 4.6(b).
(c) Change-in-status rules. Changes in future elections can be made to an HSA at any time without the need to experience a change in status. Such changes in future elections would include starting or stopping HSA contributions.

7.4 Maximum Contributions. Participants are limited in the amounts that can be contributed to an HSA by the Internal Revenue Service's determination of the annual contribution limitation published for each calendar year.

ARTICLE EIGHT
Administration of Plan

8.1 Plan Administrator. Fort Worth Independent School District, as the Plan Administrator, has the principal duty to see that this Plan is carried out in accordance with its terms for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan;

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

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

(e) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing.

(f) To amend the Plan at any time including during the Plan year.

Any determination by the Administrator, or any authorized delegate, shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously.

8.2 Examination of Records. The Administrator will make available, to each Participant, records under the Plan that pertain to the Participant, for examination at a reasonable time and location during normal business hours; provided, however, that the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

8.3 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Administrator.

8.4 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.5 Claims and Review Procedures. Any claim for benefits under the Plan shall be filed in accordance with the provisions hereof and such other claim procedures as may be established by the Administrator from time to time. Notice of the decision on such claim and any appeal will be provided by the Administrator, or its authorized delegate, in accordance with the provisions of the Plan, Sections 503 of ERISA and any and all regulations then in effect at the time the claim is made under the Plan.

ARTICLE NINE
Amendment and Termination of Plan

9.1 Amendment of Plan. The Administrator reserves the power to amend provisions of the Plan at any time or times, to any extent that it may deem advisable. Any amendment to the Plan shall be effected by a written instrument signed by the Superintendent of Fort Worth Independent School District, or his or her authorized delegate, and delivered to the Third Party Administrator. Unless otherwise provided, any such amendment will be effective for all Participants, whether or not employed by FWISD at the time of the amendment.

(a) Amendments will only be effective for periods after the later of the adoption date or effective date of the amendment.

(b) For amendments adding new benefits, the Plan will only pay or reimburse those expenses for new benefits incurred after the later of the amendment's adoption date or effective date.

9.2 Termination of Plan. FWISD has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but has no obligation whatsoever to maintain the Plan for any given length of time. FWISD may discontinue or terminate the Plan at any time without liability, by a written instrument signed by the Superintendent of Fort Worth Independent School District, or his or her authorized delegate, and delivered to the Administrator.

9.3 Affordable Care Act. For purposes of federal regulations, this Flexible Benefits Plan is intended to constitute an eligible employer-sponsored plan offering affordable minimum essential coverage ("MEC") for purposes of the Pension Excise Tax Regulations (26 CFR part 54) under Section 4980H added to the Internal Revenue Code by section 1513 of the Patient Protection and Affordable Coverage Act, as amended.

9.4 Nondiscrimination. This Flexible Benefits Plan does not discriminate in favor of highly compensated employees.

ARTICLE TEN
Miscellaneous Provisions

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

10.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment hereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against FWISD or the Administrator, except as provided herein.

10.3 Employment Not Guaranteed. Nothing contained in this Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Employee any right to be retained in the employ of the Employer.

10.4 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of FWISD. Nothing herein will be construed to require FWISD or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of FWISD from which any payment under the Plan may be made.

10.5 Non-assignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by this or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.6 No Guarantee of Tax Consequences. Neither the Administrator nor FWISD makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax or Social Security tax purposes, or that any other federal or state tax or Social Security tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and

state income tax and Social Security tax purposes, and to notify FWISD if the Participant has reason to believe that any such payment is not so excludable.

10.7 Indemnification of School District by Participants. If any Participant receives one or more payments or reimbursements under the Plan that are not for proper expenses as established by this Plan, such Participant shall indemnify and reimburse FWISD for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.8 Governing Law. Except to the extent federal law applies, this Plan shall be construed, administered and enforced according to the laws of the State of Texas.

IN WITNESS WHEREOF, the Ft. Worth Independent School District has caused this Plan to be executed this the 23rd day of August, 2016.

FT. WORTH INDEPENDENT SCHOOL DISTRICT

By: _____
Jacinto Ramos, President
Board of Education

Date: 8-23-16