PLANO INDEPENDENT SCHOOL DISTRICT

FLEXIBLE BENEFIT PLAN

(As Amended and Restated
Effective September 1, 2024)

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P R E A M B L E

The purpose of this document is to set forth the terms of the Plano Independent School District Flexible Benefit Plan. The Plan is intended to be a qualified "cafeteria plan" under Section 125 of the Code with a flexible spending account arrangement offering optional employee welfare benefits for selection by Participants as described herein. Optional benefits offered under the Plan for individual selection consist only of a choice between cash and certain Qualified Benefits.

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ARTICLE I

DEFINITIONS

As used in this Plan, the following words and phrases have the meanings set forth below unless the context clearly indicates otherwise; and wherever appropriate in the Plan, the Dependent Care Assistance Plan, and the Medical Reimbursement Plan, the singular shall include the plural, the plural shall include the singular and the use of any gender shall include the other gender.

Section 1.01 - Account means the Dependent Care Assistance Account (as defined by the Dependent Care Assistance Plan) and/or the Medical Reimbursement Account (as defined by the Medical Reimbursement Plan) of a Participant.

Section 1.02 - Administrator means the District or such other person or committee as may be appointed from time to time by the District to supervise the administration of the Plan.

Section 1.03 - Affiliated Employer means any employer which, together with the Employer maintaining this Plan, has adopted the provisions of this Plan with the consent of the District.

Section 1.04 - Change in Status shall be defined as in Treasury Regulation Section 1.125-4, which includes a change in the Participant's:

(a) *Legal marital status with a Spouse* including marriage, death of Spouse, divorce, legal separation, or annulment;

(b) *Number of dependents* including birth, adoption, placement for adoption, death of a Dependent, or an event that causes a Participant's Spouse or Dependent to satisfy or cease to satisfy the requirements for coverage under a Qualified Benefit due to attainment of age, student status, or any similar circumstance as provided in the Qualified Benefit;

(c) *Employment status* including a termination or commencement of employment by the Participant or the Participant's Spouse or Dependent; or

(d) *Work schedule* including a reduction or increase in hours of employment by the Participant or the Participant's Spouse or Dependent, including a switch

between part-time and full-time employment, a strike or lockout, or commencement or return from an unpaid leave of absence.

Section 1.05 - Code means the Internal Revenue Code of 1986, as amended from time to time and any applicable regulations promulgated thereunder.

Section 1.06 - Compensation means a Participant's pay (before any Compensation reduction pursuant to Section 4.01) including commissions, bonuses, overtime pay and extra allowances, as determined by the District, for personal services rendered in the course of employment with the Employer.

Section 1.07 - Dependent means an individual who qualifies as a "dependent" of a Participant for purposes of the provisions of the Code applicable to the Qualified Benefit for which dependent status is relevant. For example, (a) for purposes of an optional benefit that is accident or health coverage (including the Medical Reimbursement Plan), "Dependent" means a child or other qualifying individual with respect to the Participant for whom reimbursements under the accident or health coverage are excludable from the Participant's income under Code section 105(b) and (b) for purposes of the Dependent Care Assistance Plan, "Dependent" means a Qualifying Individual (as defined by the Dependent Care Assistance Plan) with respect to a Participant. For purposes of Section 4.06 hereof, a "Dependent" means a "dependent" as defined by Treasury regulation section 1.125-4(h)(i)(3), as amended.

Section 1.08 - Dependent Care Assistance Plan means the separate plan under Section 129 of the Code designed to provide payment or reimbursement for dependent care expenses as described in Article VI hereof.

Section 1.09 - District means the Plano, Texas, Independent School District.

Section 1.10 - Effective Date of this amendment and restatement of the Plan is September 1, 2024, except as otherwise specified herein. The original effective date of the Plan was June 1, 1986.

Section 1.11 - Eligible Employee means an Employee of the Employer who has satisfied the conditions for eligibility to participate in the Plan in accordance with Article II and, to the extent necessary, a retired or terminated Employee who is entitled to continue to pay for Qualified Benefits under the Plan.

Section 1.12 - Employee means a person who is classified by the Employer as a common-law Employee of the Employer, notwithstanding such person's classification or reclassification for tax or other purposes.

Section 1.13 - Employer means the District, any successor organization of the District or any Affiliated Employer which assumes or adopts the obligations of the Plan.

Section 1.14 - Entry Date means the first day of the Plan Year, except for an Employee who first satisfies the requirements for eligibility during the Plan Year (including rehired Employees), in which case the Entry Date shall be the first day the requirements for eligibility are satisfied.

Section 1.15 - FMLA means the Family Medical Leave Act of 1993, as amended.

Section 1.16 - Health Savings Account means an individual trust account that qualifies under Code section 223 and that is established through the bank or other custodian designated by the Administrator from time to time. The Plan permits contributions to Health Savings Accounts by eligible Participants, but the Employer does not maintain such accounts. A Participant who contributes to a Health Savings Account is solely responsible for the maintenance and utilization of such account and for ensuring compliance with applicable requirements of the Code.

Section 1.17 - Highly Compensated Participant means an individual who is a "highly compensated participant" or a "highly compensated individual" as such terms are defined in Section 125(e) of the Code.

Section 1.18 - Key Employee means any Employee or former Employee (and the Spouse and Dependents of such an Employee) who is a "key employee" as defined in Section 416(i)(1) of the Code.

Section 1.19 - Medical Reimbursement Plan means the separate plan designed to provide medical and dental care expense reimbursement under Section 105(b) of the Code as described in Article VII hereof.

Section 1.20 - Other Plan means a group term life insurance plan or an accident or health plan of the employer of the Participant's Dependent or Spouse.

Section 1.21 - Participant means an Eligible Employee who has elected to participate in the Plan for a Period of Coverage and who has not ceased participation pursuant to Section 2.03 and Section 2.04.

Section 1.22 - Period of Coverage means the Plan Year during which coverage of benefits under the Plan is available to and elected by a Participant, provided, however, that an Employee (including an eligible rehired Employee to the extent provided in Section 2.05) who becomes eligible to participate during a Period of Coverage may elect to participate for a period lasting until the end of the current Period of Coverage. In such case, the interval commencing on such Employee's Entry Date and ending as of the last day of the current Plan Year shall be deemed to be such Participant's Period of Coverage.

Section 1.23 - Plan means the Plano Independent School District Flexible Benefit Plan established by the Employer by means of this document, any and all exhibits or documents which are incorporated and made a part hereof by reference, including separate written plans of the Employer, any adoption agreements between the Plan and the Employer, and any amendments which may be made to the Plan from time to time.

Section 1.24 - Plan Year means the 12-month period beginning September 1 and ending August 31.

Section 1.25 - Qualified Benefit means a benefit plan, program, or contract, the cost or premium for which may be paid by a Participant under the Plan without being includable in the Participant's gross income as provided in Code Section 125(f). For a Participant eligible to make contributions to a Health Savings Account, the term "Qualified Benefit" also includes a Health Savings Account.

Section 1.26 - Salary Reduction Agreement means a written agreement of a Participant entered into prior to an applicable Period of Coverage in which the Participant agrees to a reduction in Compensation for purposes of purchasing benefits under the Plan and which for all purposes hereunder are deemed to be Employer contributions.

Section 1.27 - Spouse means the "spouse" of a Participant within the meaning of the Code.

ARTICLE II
ELIGIBILITY FOR PARTICIPATION

Section 2.01 - Requirements for Eligibility and Entry Date: An Employee who is eligible to participate in one or more Qualified Benefits shall be eligible to commence participation in this Plan as of the first day as of which the Employee meets the eligibility requirements of any such Qualified Benefit. Subject to Section 2.05, a rehired Employee shall be treated as a new Employee for purposes of eligibility to participate hereunder.

Section 2.02 - Application for Participation: Once an Employee satisfies the requirements for eligibility, the Administrator shall furnish to such Eligible Employee information regarding the Plan including available benefits hereunder and an application to participate in the Plan which must be completed by the Employee and returned to the Administrator prior to the applicable Entry Date upon which the Employee would be eligible to commence participation. Such application to participate shall include a Salary Reduction Agreement, designation of beneficiary, if applicable, and election of benefit coverage. The Employee shall also be required to furnish to the Administrator such information and documentation as may be deemed necessary by the Administrator for the proper administration of the Plan. An Employee, upon executing such application for participation, shall be deemed to have consented to and be bound by all the terms, conditions and limitations of the Plan and any decision or determinations made by the Administrator with respect to the Participant's rights and entitlement of benefits under the Plan.

Section 2.03 - Termination of Participation: A Participant will cease participation in the Plan as of the earliest of the following events: the last day of the month in which the Participant terminates employment with the Employer (provided, however, that if employment ends on or after the last day of the instructional year, participation in the Plan shall continue through the last day of the month in which the Employee receives his or her final paycheck for regular pay (excluding pay for vacation or other leave)), the date on which the Participant ceases to be eligible to participate in any Qualified Benefit, the date the Participant fails to make a required contribution, or the date of termination of the Plan. Participation shall not cease due to a failure to make a contribution for a period if no contribution is required for that period (for example, if no contribution is required

during the summer because the cost of coverage has been allocated over pay period during the school year during which a Participant receives regular Compensation from the Employer).

Section 2.04 - Continued Participation: Notwithstanding anything herein to the contrary, a Participant or former Participant and/or the qualified beneficiary (as defined by the applicable law relating to continuation coverage) of a Participant or former Participant who terminated employment but continues health plan coverage under applicable law regarding continuation coverage or who is otherwise eligible or required to pay the cost of a Qualified Benefit on an after-tax basis (such as the cost of Qualified Benefit coverage for an individual who is eligible for such coverage under the terms of the Qualified Benefit but who does not qualify as Spouse or Dependent hereunder), shall be deemed to contribute such cost to the Plan on an after-tax basis.

Section 2.05 - Reinstatement of Former Participant: A former Participant will become a Participant again if and when he meets the eligibility requirements of Section 2.01; provided, however, that:

(a) A former Participant may not make a new benefit election within the same Plan Year in which the Participant ceases participation due to a failure to make required contributions;

(b) A Participant whose election terminates due to the Participant's termination of employment

  (i) shall have such election automatically reinstated if the Participant resumes employment within 30 days of such termination of employment, without any other intervening event that would permit a change in election, and

  (ii) may make a new benefit election under this Plan with respect to any eligible Qualified Benefits if the Participant resumes employment later than 30 days after termination of employment; and

(c) A Participant who takes FMLA leave and revokes his election with respect to a Qualified Benefit providing group health benefits may reinstate such election upon returning from FMLA leave; provided that such a Participant shall not be entitled to greater benefits relative to a Participant who has not taken leave during the Plan Year.

Section 2.06 - Compliance with FMLA and USERRA: Notwithstanding anything herein to the contrary, the Plan shall be administered in accordance with the mandatory provisions of the FMLA and the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III

OPTIONAL BENEFITS

Section 3.01 - Benefits Available for Selection by Participant: A Participant may elect, in accordance with the procedure set forth in Section 4.01, one or more of the following Qualified Benefits offered by an Employer and for which the Participant is otherwise eligible:

(a) The conversion of the employee portion of the premium or other cost of benefits available to the Participant to a pre-tax Compensation reduction for the TRS-ActiveCare option elected or deemed elected by the Participant.

(b) The conversion of the employee portion of the premium or other cost of benefits available to the Participant to a pre-tax Compensation reduction for the other plans (and optional benefits under those plans) listed in the Appendix, as amended from time to time.

(c) Dependent care reimbursement pursuant to the Dependent Care Assistance Plan.

(d) Medical expense reimbursement pursuant to either (but not both) the general purpose option or the limited-purpose/post-deductible option of the Medical Reimbursement Plan.

(e) Contributions to a Health Savings Account if the Participant elects coverage under a Qualified Benefit that is a high deductible health plan as defined by Code section 223(c)(2) and does not elect coverage under the general purpose Medical Reimbursement Plan option.

(f) Such other Qualified Benefits as may be adopted by the District as optional benefits hereunder.

Section 3.02 - Reference to Other Documents: To the extent any optional benefits described in Section 3.01 are provided under a separate plan or contract, such plan or contract is hereby incorporated by reference and made a part hereof to the extent required for the administration of the Plan. Notwithstanding the foregoing, the Plan only provides a mechanism for paying for or contributing to the optional benefits elected by a Participant, and the entitlement of each Participant (and the Participant's Spouse and Dependents) to benefits under a component plan or contract

providing optional benefits shall be determined solely by the terms of such component plan or contract.

ARTICLE IV
BENEFIT ELECTIONS AND CONTRIBUTION

Section 4.01 - Election of Optional Benefits and Salary Reduction Agreement: An Eligible Employee may elect under this Plan, prior to the first day of an applicable Period of Coverage, coverage under one or more of the optional benefits described in Section 3.01. Such election shall be made at the time and in the manner specified by the Administrator and shall be subject to such administrative rules as are established by the Administrator from time to time and applied to Participants on a uniform and nondiscriminatory basis. In any event, the Eligible Employee shall be required to sign and return the election form to the Administrator prior to the applicable Entry Date into the Plan and the first pay period during the Period of Coverage for which the Salary Reduction Agreement is to apply. The District shall provide to Eligible Employees prior to an applicable Period of Coverage the necessary election forms for electing such coverage, which shall include a Salary Reduction Agreement whereby the Participant shall agree to a reduction in Compensation equal to the Participant's share of the cost or premium for each optional benefit selected under Section 3.01 plus any administrative fees charged to the Participant pursuant to Section 8.03.

(a) The Employer in its sole discretion shall determine the manner in which the Participant's share of the cost of selected optional benefits shall be allocated and deducted from the Participant's Compensation during the Plan Year. Without limiting the foregoing, the Employer may require allocation of such cost over fewer than all of the pay periods during the year.

(b) To the extent a Participant's Compensation for a pay period is less than the allocated cost for that pay period (determined after taking into account any Compensation reserves required by the Employer in its sole discretion and any other legally required or higher priority deductions as determined by the Employer in its sole discretion), the remaining cost shall be paid by the Participant on an after-tax basis in such manner and at such time as is required by the Employer in its sole discretion. In any event, the Eligible Employee shall be required to sign and return the election form to the Administrator prior to the applicable Entry Date into the Plan and the first pay period during the Period of Coverage for which the Salary Reduction Agreement is to apply.

Section 4.02 - Effect of Failure to Elect: If an Eligible Employee who has not previously elected to participate under the Plan fails to return the election form described in Section 4.01 to the Administrator by the due date established by the Administrator, the Employee shall be deemed to have elected a Compensation reduction under Section 3.01(a) to the extent he is enrolled in TRS-ActiveCare, and no benefits under Sections 3.01(b)-(e) or Section 3.01(f).

Section 4.03 - Subsequent Failure to Elect: If a Participant fails to return an election form to the Administrator prior to the due date for the next ensuing Period of Coverage the Participant shall be deemed to have elected no coverage or contributions for that next Period of Coverage for the benefits described in Sections 3.01(b)-(e) and Section 3.01(f), but shall be deemed to have elected to receive the same benefits and same level of coverages as in effect under Section 3.01(a) pursuant to the election form (or deemed election under Section 4.02) currently on file and in effect with the Administrator.

Section 4.04 - Contributions During Leave of Absence: If the Participant takes an approved, unpaid leave of absence or unpaid FMLA leave, such cost shall be paid on a "prepay basis" before the Participant takes such leave, on a "catch-up basis" after the Participant takes such leave, or an a "pay-as-you-go basis" while the Participant takes such leave (provided that payment on a "prepay basis" or "catch-up basis" must be approved in advance by the District in its sole discretion). If the Participant or a former Participant (or qualified beneficiary) is deemed to continue participation under Section 2.04, such cost shall be paid on a "pay-as-you-go basis."

Section 4.05 - Maximum Contributions: The maximum contributions under the Plan for any Participant shall be the sum of the costs from time to time of the most expensive benefits available to the Participant under the available optional benefits under Section 3.01 (including the portion of such costs payable with non-elective District contributions, if any). Aggregate contributions to a Health Savings Account shall not exceed the maximum applicable amount allowed under section 223 of the Code.

Section 4.06 - Benefit Election Irrevocable/Exceptions: Except as otherwise provided in this Section, a Participant's election of benefits made in accordance with Section 4.01 shall be irrevocable with regard to any benefit or portion of benefit elected hereunder for the Period of Coverage to which such election pertains, and no conversion from one type of benefit to another or modification of the Salary Reduction Agreement shall be permitted during the applicable Period of Coverage.

Notwithstanding the foregoing, a Participant shall be entitled to revoke a benefit election after the Period of Coverage has commenced for which the election applies and shall be entitled to make a new election with respect to the remainder of the current Period of Coverage:

(a) With respect to a Qualified Benefit that is not a group term life insurance plan or an accident or health plan, if the revocation and new election are on account of and consistent with a Change in Status.

(b) With respect to a Qualified Benefit that is a group term life insurance plan or an accident or health plan, if a Change in Status occurs and results in

(i) the Participant, Spouse, or Dependent gaining or losing eligibility for coverage under the Qualified Benefit in question (and the Participant, Spouse, and/or Dependent, as applicable, elects or becomes ineligible for coverage under such plan); or

(ii) the Participant, Spouse, or Dependent gaining or losing eligibility for coverage under an Other Plan;

and such change in election corresponds with such gain or loss in eligibility or coverage.

(c) In the case of a Qualified Benefit that is group-term life insurance, if a Change in Status is due to a marriage, birth, adoption, or placement for adoption, the Plan may allow an election change to increase (but not to reduce) the amount of the Participant's life insurance coverage. In the case of divorce, a legal separation, annulment, or death of a Spouse or Dependent, the Plan may allow an election change to reduce (but not to increase) the amount of the Participant's life insurance coverage.

(d) In the case of a Qualified Benefit that is an accident or health plan, if the Participant, Spouse, or Dependent becomes eligible for continuation coverage under a health plan of the Employer under applicable law, the Participant may elect to increase payments under the Plan to pay for such continuation coverage;

(e) If a Participant, Spouse, or Dependent becomes entitled to coverage under Part A, B, or C of Title XVIII of the Social Security Act (Medicare) or Title XVIV of the Social Security Act (Medicaid) (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act) or becomes eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Plan (CHIP), the Participant may make an election change to cancel coverage of the Participant, Spouse or Dependent, as applicable, under any Qualified Benefit that is an accident or health plan and that permits such cancellation of coverage. In addition, if a Participant, Spouse, or Dependent who has been entitled to such coverage under Medicare, Medicaid, or CHIP loses eligibility for such coverage, the Participant may make an election change to commence or increase coverage for that Participant, Spouse, or Dependent under such plan to the extent permitted by the terms of such plan.

(f) If the Administrator receives a qualified medical child support order that requires accident or health coverage for a Participant's child, the Administrator or the Participant may change the Participant's election under this Plan to elect coverage under a Qualified Benefit that is an accident or health plan. Likewise, the Participant may change his or her election under this Plan to cancel coverage for the child if the qualified medical child support order requires the Participant's former Spouse to provide such coverage for the child.

(g) If a Participant qualifies for the special enrollment rights provided under applicable provisions of the Health Insurance Portability and Accountability Act, as amended, such Participant may revoke an election for a Qualified Benefit that constitutes accident or health coverage and make a new election that corresponds with such special enrollment rights.

(h) If a Participant takes FMLA leave, such Participant may revoke his or her election for the remainder of the Plan Year with respect to Qualified Benefits providing group health benefits.

(i) With respect to a Qualified Benefit other than benefits under the Medical Reimbursement Plan, if the cost of such benefit increases or decreases (other than, with respect to the Dependent Care Assistance Plan, a cost change imposed by a dependent care service provider who is a relative of the Employee) during the Plan Year, an automatic corresponding change shall be made to the Participant's election. An Eligible Employee's completion of a Salary Reduction Agreement shall constitute agreement and consent to such automatic adjustment in the amount of contribution. If such a cost increase is significant, the Administrator may permit each Participant electing such benefit for the Plan Year either (i) to make a corresponding change in his election or (ii) to revoke his election for the remainder of the Plan Year and elect similar coverage (if any) under another optional Qualified Benefit under Section 3.01 for the remainder of the Plan Year.

(j) In the event that coverage under an optional Qualified Benefit offered under Section 3.01 (other than the Medical Reimbursement Plan) is significantly curtailed or ceases during a Plan Year, the Administrator may permit each affected Participant to revoke his election for the remainder of the Plan Year. In such event, the Participant may elect similar coverage (if any) under another optional Qualified Benefit under Section 3.01 for the remainder of the Plan Year. If a new optional Qualified Benefit (other than the Medical Reimbursement Plan) providing coverage similar to one or more existing optional Qualified Benefits is added during a Plan Year, the Administrator may permit each affected Participant to elect the new optional Qualified Benefit on a prospective basis and to make a corresponding change in his election. If an optional Qualified Benefit (other than the Medical Reimbursement Plan) is eliminated during a Plan Year, the Administrator may allow each affected Participant to elect another optional benefit on a prospective basis and to make a corresponding change in his election.

(k) A Participant may revoke an election for the remainder of a Plan Year and file a new election on account of and corresponding with a change made under an Other

Plan, if the Other Plan permits participants to make an election change that would be permitted under subsections (a) through (j) above or if the period of coverage under the Plan is different from the period of coverage under the Other Plan and if the underlying component plan providing the Qualified Benefit permits such election.

(l) In the case of a Qualified Benefit that is an accident or health plan (other than the Medical Reimbursement Plan) a Participant may revoke his or her election for the balance of the Plan Year, consistent with the Participant's election to obtain coverage through an exchange under the Affordable Care Act during a special enrollment period or open enrollment period for such exchange.

(m) At any time an eligible Participant may revoke an existing election to contribute to a Health Savings Account and make a new election for the remaining portion of the Plan Year. Any such election shall be effective on or as soon as administratively practicable after (i) the effective date designated in the election or (ii) if no effective date is designated, the date of the election.

Notwithstanding the foregoing, a Participant shall not in any event be eligible to revoke or reduce the Participant's annual election for Medical Reimbursement Plan benefits to an amount less than the dollar amount of any reimbursable expenses incurred prior to the effective date of any change of election. If a Participant changes such an election and subsequently submits a claim for expenses incurred prior to the effective date of such change and if the aggregate expenses exceed the new election, the excess expenses shall not be eligible for reimbursement under the Medical Reimbursement Plan. Any new election under this Section 4.06 shall be made at the time and in the manner specified by the Administrator for such elections and shall be effective at such time as the Administrator shall prescribe, which time periods may be different for different Qualified Benefits and different Changes in Status and special enrollment events. The Participant shall furnish the Administrator with information relative to a Change in Status sufficient for the Administrator to determine that the criteria for a change in benefit election meets the criteria hereunder and is in accordance with applicable law. The Administrator's decision regarding the Participant's ability to revoke or make a new election shall be final, conclusive, and binding on the Participant and all other interested parties.

ARTICLE V
NONDISCRIMINATION

Section 5.01 - Nondiscrimination Not Guaranteed: Neither the Employer nor any agent or representative thereof represents that this Plan, the benefits provided hereunder or under any Qualified Benefit, or contributions made hereunder are at any particular point in time nondiscriminatory as determined in accordance with applicable provisions of the Code. The Employer and any agent or representative thereof shall be held harmless by any Employee, Participant, their agent or representatives, heirs, beneficiaries, administrators or assigns from any and all tax liability of whatsoever nature might arise by reason of the Plan's being deemed discriminatory at any time and in any regard.

Section 5.02 - Inclusion in Income: In the event any portion or all of a contribution or benefit becomes taxable hereunder by reason of the Plan's being deemed discriminatory under Section 125(b) or other applicable sections of the Code, such contribution or benefit shall be treated as received or accrued in the taxable year of the applicable Participant, Highly Compensated Participant or Key Employee in which the Plan Year ends unless applicable law requires inclusion in income at some other point in time in which case such law shall be controlling.

ARTICLE VI

DEPENDENT CARE ASSISTANCE PLAN

Section 6.01 - Introduction: Pursuant to this Article, the Employer establishes a dependent care assistance plan under which a Participant may elect to have payments made or receive reimbursement for Dependent Care Expenses. The Plan is intended to be qualified under Section 129 of the Code, and is an optional Qualified Benefit under the Flexible Benefit Plan. This Plan constitutes a separate written employee benefit plan as contemplated by Section 129(d)(1) of the Code.

Section 6.02 - Definitions: Except as otherwise defined in this Article, capitalized words shall have the meaning specified in Article I of the Flexible Benefit Plan, except that references to the "Plan" in such definitions shall be construed to refer to the Plan as defined in this Section. For purposes of this Plan, the following special definitions shall apply:

(a) Dependent Care Assistance Account means the bookkeeping account maintained by the Administrator used for crediting contributions and deducting Dependent Care Expense payments and reimbursements.

(b) Dependent Care Expenses means expenses incurred by a Participant which (i) are incurred for the care of a Qualifying Individual or for related household services, (ii) are paid or payable to a Dependent Care Service Provider (or as reimbursement to the Participant for such expenses) and (iii) are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Individuals with respect to the Participant. Dependent Care Expenses shall not include expenses incurred for the care of a Qualifying Individual unless such expenses qualify as an employment-related expense under Section 21(b)(2) of the Code.

(c) Dependent Care Service Provider means a person who provides care or other services contemplated in subsection (b) above, but shall not include (i) a dependent care center (as defined in Section 21(b)(2)(D) of the Code) unless the requirements of Section 21(b) of the Code are satisfied or (ii) certain related individuals described in Section 129(c) of the Code.

(d) Eligible Employee means an Employee of the Employer who has satisfied the conditions for eligibility to participate in this Plan pursuant to Section 6.03.

(e) Flexible Benefit Plan means the Plano Independent School District Flexible Benefit Plan, as amended.

(f) Highly Compensated Employee means an Employee (and the Spouse and Dependents of such Employee) who is a "highly compensated employee" as such term is defined in Code Section 129(d)(2).

(g) Plan means the dependent care assistance plan established by the District by means of this Article VI, as amended from time to time.

(h) Qualifying Individual means a Participant's qualifying child, relative, or Spouse who meets the requirements of Section 21(b)(1) of the Code.

Section 6.03 - Requirements for Eligibility: An Employee who is in a permanent status (as defined by the Employer) and who is regularly scheduled to work at least 25 hours per week shall be eligible to participate in this Plan.

(a) The Entry Date for a newly eligible Employee is either the first day that the Employee satisfies the eligibility requirements set forth above or the first day of the month following such date, as elected or deemed elected by the Employee on the participation application.

(b) Subject to Section 2.05, a rehired Employee shall be treated as a new Employee for purposes of eligibility to participate hereunder.

(c) An Eligible Employee may elect to participate in the Plan by completing an application for participation in accordance with Section 2.02.

(d) An individual who terminates participation in the Flexible Benefit Plan pursuant to Section 2.03 shall cease to be eligible to participate in this Plan at the same time.

Section 6.04 - Maximum Contributions and Benefits Available:

(a) The maximum amount which a Participant may elect under the Flexible Benefit Plan to contribute to his or her Dependent Care Assistance Account with respect to any calendar month shall be $205 in the case of a married Participant who files a separate Federal income tax return and $413 in the case of all other Participants.

The maximum amount is determined by the applicable dollar limit set forth in subsection (b) below reduced by annual Plan administrative fees for the Dependent Care Assistance Plan that are payable by a Participant in accordance with Section 8.03, with the result divided by twelve (12) and then rounded down to the next lowest whole dollar amount. For example, for the Plan Year beginning in 2024, if annual administrative fees are $36, then the maximum contribution per month would be either $205 (($2,500 - $36) / 12 = $205.33, rounded down to $205) or $413 (($5,000 - $36) / 12 = $413.66, rounded down to $413). By electing to contribute more than $205 per month to his or her Dependent Care Assistance Account, a Participant is certifying to the Administrator that he or she is unmarried or will file a joint Federal income tax return for each applicable taxable year of the Participant during which such election is in effect. The foregoing limitations may be annualized and then prorated for Eligible Employees who are not paid during the summer or whose contributions are processed more frequently than once per month.

(b) Subject to the limitations set forth in subsection (d) below, the maximum amount which a Participant may receive from the Plan on a pre-tax basis in payment or reimbursement of Dependent Care Expenses incurred in any single calendar year shall be $2,500 in the case of a married Participant who files a separate Federal income tax return and $5,000 in the case of all other Participants.

(c) Subject to the limitations set forth in subsection (d) below, the maximum amount which a Participant may receive from the Plan on a pre-tax basis during any single calendar year in payment or reimbursement of Dependent Care Expenses (whenever incurred) shall be the lesser of (i) the Participant's Compensation for the calendar year (after all pre-tax reductions in Compensation including the reduction related to Dependent Care Expenses), (ii) the earned income of the Participant's Spouse for the calendar year. In the case of a Spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself, such Spouse shall be deemed to have earned income of not less than $250 per month if the Participant has one Qualifying Individual and $500 per month if the Participant has two or more Qualifying Individuals.

(d) No benefit shall be provided under the Plan to Highly Compensated Employees to the extent that the average of benefits provided under this Plan to Employees who are not Highly Compensated Employees would fail to satisfy any applicable requirements of Code Section 129(d)(8).

Section 6.05 - Dependent Care Assistance Account: The Administrator shall establish for each Participant a Dependent Care Assistance Account for each Period of Coverage. Each Dependent Care Assistance Account shall initially contain zero dollars ($0). A Participant's Dependent Care Assistance Account for a Period of Coverage shall be credited with the portion of the Participant's Salary Reduction Agreement dollars for that Period of Coverage that he has elected to apply toward such account and that he actually contributes to such account. A Participant's Dependent Care Assistance Account for a Period of Coverage shall be reduced by the amount of any Dependent Care Expenses paid to or on behalf of a Participant.

Section 6.06 - Claims for Reimbursement: A Participant who has elected to participate in the Plan shall apply in writing to the Administrator for payment or reimbursement of Dependent Care Expenses incurred by the Participant during the Period of Coverage. The claim, which shall be made in a manner and using such forms (if any) as are required by the District, shall include the following:

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

(b) The name of the person, organization or entity to which the expense was paid and the appropriate taxpayer identification or Social Security number; and

(c) Such other information as the Administrator may from time to time require.

To the extent required by the Administrator, such claim shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amount of such expenses, together with any additional documentation which the Administrator may request or the Code may require.

Section 6.07 - Reimbursement or Payment of Dependent Care Expenses: Subject to limitations contained in this Article, the Administrator shall pay or reimburse the Participant from the

Participant's Dependent Care Assistance Account for Dependent Care Expenses incurred during the Period of Coverage for which the Participant submits a claim in accordance with Section 6.06.

(a) No reimbursement or payment of Dependent Care Expenses incurred during a Period of Coverage shall at any time exceed the lesser of the balance of the Participant's Dependent Care Assistance Account at the time such payment or reimbursement is requested and the balance of the Participant's Dependent Care Assistance Account for the Period of Coverage during which such Dependent Care Expenses were incurred. The amount of any Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence during a Period of Coverage shall be reimbursed or paid only if and when the balance in such Account permits such reimbursement or payment.

(b) Participants shall be reimbursed for such expenses on a monthly or more frequent basis determined by the Administrator. The minimum reimbursement amount is $25 or such other amount as is determined by the Administrator from time to time, provided that the final payment of benefits for any Period of Coverage may be made following the close of such Period of Coverage based on accepted claims filed with the District no later than three months following the close of such Period of Coverage.

(c) If a Participant ceases to be a Participant, such Participant shall be entitled to continue receiving benefits pursuant to this Article to the extent of the amount remaining in the Participant's Dependent Care Assistance Account for the expenses incurred during the Period of Coverage prior to the time termination of participation occurs.

Section 6.08 - Forfeiture of Unused Benefits: Amounts remaining in a Participant's Dependent Care Assistance Account following final payment of all Dependent Care Expenses incurred during the applicable Period of Coverage and timely claimed under Section 6.07 shall be forfeited.

Section 6.09 - Report to Participants: On or before January 31 of each year or at such other time as may be specified by applicable law, the Administrator shall furnish to each Participant who has

received dependent care assistance during the prior calendar year a written statement showing the amount of such assistance paid during such year with respect to the Participant.

Section 6.10 - Plan Administrator: The Plan shall be administered by the Administrator under the terms of the Flexible Benefit Plan and subject to the provisions thereof.

Section 6.11 - Other Governing Provisions: Other matters, including but not limited to contributions, elections, Compensation reduction and payment of contributions, claims procedures, amendment of the Plan and termination of the Plan, shall be governed by the general provisions of the Flexible Benefit Plan, incorporated herein by reference.

Section 6.12 - Reduction of Benefits for Highly Compensated Employees: If the Administrator determines that by the end of the Plan Year the average benefits for the non-Highly Compensated Employees will fail to satisfy the requirements of Code Section 129(d)(8), benefits for the Highly Compensated Employees will be reduced so that they do not exceed the applicable limit. This reduction will be accomplished by the Plan Administrator's determining a date after which no Highly Compensated Employees will be permitted to contribute to the Plan. Despite any cessation of contributions for a Highly Compensated Employee, he may continue to incur and to submit eligible claims following such cessation for amounts previously contributed, up to his Dependent Care Assistance Account balance. Once contributions for Highly Compensated Employees have been discontinued by the Plan Administrator, they may not be resumed during that Period of Coverage.

ARTICLE VII

MEDICAL REIMBURSEMENT PLAN

Section 7.01 - Introduction: Pursuant to this Article, the Employer establishes a medical reimbursement plan under which a Participant may elect to receive payments or reimbursements of eligible Medical Care Expenses under either of two options: a general purpose option and a limited-purpose/post-deductible option for Participants who intend to contribute to a health savings account under Section 223 of the Code. Both options under the Plan are intended to be qualified under Section 105(b) of the Code, and are optional Qualified Benefits under the Flexible Benefit Plan. This Plan constitutes a separate written benefit plan as contemplated by section 105 of the Code.

Section 7.02 - Definitions: Except as otherwise defined in this Article, capitalized words shall have the meaning specified in Article I of the Flexible Benefit Plan, except that references to the "Plan" in such definitions shall be construed to refer to the Plan as defined in this Section. For purposes of this Plan the following special definitions shall apply:

(a) Eligible Employee means an Employee of the Employer who has satisfied the conditions for eligibility to participate in the Plan pursuant to Section 7.03.

(b) Flexible Benefit Plan means the Plano Independent School District Flexible Benefit Plan, as amended.

(c) Highly Compensated Individual means an Employee (and the Spouse and Dependents of such Employee) who is a "highly compensated individual" as such term is defined in Code Section 105(h)(5).

(d) Medical Care Expenses means, effective January 1, 2020, any expenses incurred by a Participant or by a Spouse or Dependent of such Participant for Medical Care, but including menstrual care products (as defined in Code section 223(d)(2)(D)) and excluding

(i) expenses reimbursed through insurance or otherwise (other than under the Plan) and

(ii) any premium paid for medical, dental, accident, disability, or long-term care insurance benefits, including any such premiums under a plan (whether insured or self-insured) maintained by the Employer or any other employer.

(e) Medical Care means

(i) For the general purpose option under the Plan, Medical Care has the meaning specified by Section 213(d) of the Code.

(ii) For the limited-purpose/post-deductible option under the Plan, Medical Care has the meaning specified by Section 213(d) of the Code but excluding all care other than (A) coverage that is disregarded under Code Section 223(c)(1)(B), (B) preventive care within the meaning of Code Section 223(2)(C), and (C) medical care for expenses incurred after the minimum annual deductible under Code Section 223(c)(2)(A)(i) is satisfied (regardless of whether the related high deductible health plan covers the expense or whether the deductible is later satisfied).

(e) Medical Reimbursement Account means the bookkeeping account maintained by the Administrator used for crediting contributions to the Plan and accounting for benefit payments from the Plan.

(f) Plan means the medical reimbursement plan established by the District by means of this Article VII, as amended from time to time.

Section 7.03 - Requirements for Eligibility: An Employee who is in a permanent status (as defined by the Employer) and who is regularly scheduled to work at least 25 hours per week shall be eligible to participate in this Plan. An Employee is not considered to be in permanent status if the Employee is classified by the Employer as a substitute, adult temp, student worker, volunteer, contractor, or other classification that does not have permanent status under the Employer's personnel policies.

(a) The Entry Date for a newly eligible Employee is either the first day that the Employee satisfies the eligibility requirements set forth above or the first day of the month following such date, as elected or deemed elected by the Employee on the participation application.

(b) Subject to Section 2.05, a rehired Employee shall be treated as a new Employee for purposes of eligibility to participate hereunder.

(c) An Eligible Employee may elect to participate in the Plan by completing an application for participation in accordance with Section 2.02. An election to participate in this Plan for a Period of Coverage must specify whether the Participant is participating under the general purpose option or the limited-purpose/post-deductible option of the Plan.

(d) An individual who terminates participation in the Flexible Benefit Plan pursuant to Section 2.03 shall cease to be eligible to participate in this Plan at the same time; provided, however, that to the extent required by applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, a former Eligible Employee may elect to continue participation in the Plan for the remainder of the Period of Coverage in which he or she terminates employment with the Employer.

Section 7.04 - Maximum Contributions and Benefits Available: Subject to the limitations set forth herein to avoid discrimination, the maximum amount which a Participant may elect under the Flexible Benefit Plan to contribute to his Medical Reimbursement Account with respect to any calendar month during the Plan Year shall be an amount determined in accordance with the provisions of this Section. The maximum amount is determined by the applicable annual dollar limit under Code section 125(i) for the applicable "taxable year" ($2,500 as adjusted for inflation pursuant to Code section 125(i)(2)) reduced by annual Plan administrative fees for the Medical Reimbursement Plan that are payable by a Participant in accordance with Section 8.03, with the result divided by twelve (12) and then rounded down to the next lowest whole dollar amount. For example, for the Plan Year beginning in 2024, if annual administrative fees are $36, then the maximum contribution per month would be $251 (($3,200 - $36) / 12 = $263.66, rounded down to $263). The foregoing limitations may be annualized and then prorated for Eligible Employees who are not paid during the summer or whose contributions are processed more frequently than once per month.

Section 7.05 - Nondiscrimination: The Plan shall not discriminate in favor of Highly Compensated Individuals as to either eligibility to participate or benefits provided hereunder.

Section 7.06 - Medical Care Reimbursement Account: The Administrator shall establish for each Participant a Medical Reimbursement Account for each Period of Coverage. A Participant's Medical Reimbursement Account for a Period of Coverage shall reflect a balance equal to the full amount elected by the Participant in the Salary Reduction Agreement for a given Period of Coverage reduced (but never below zero dollars ($0)) by the amount of any Medical Care Expenses paid to or on behalf of a Participant.

Section 7.07 - Claims for Reimbursement: A Participant who has elected to participate in the Plan shall apply in writing to the Administrator for payment or reimbursement of Medical Care Expenses incurred by the Participant during the Period of Coverage. The claim, which shall be made in a manner and using such forms (if any) as are required by the District, shall include the following:

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

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

(c) Such other information as the District may from time to time require, which may include additional substantiation information for Participants enrolled in the limited-purpose/post-deductible option under the Plan.

To the extent required by the Administrator, such claim shall be accompanied by bills, invoices, receipts, canceled checks or other statement showing the amounts of such expenses, together with any additional documentation which the Administrator may request.

Section 7.08 - Reimbursement or Payment of Medical Care Expense: Subject to limitations contained in other provisions of the Plan, the Administrator shall pay or reimburse the Participant from the Participant's Medical Reimbursement Account for Medical Care Expenses incurred during the Period of Coverage for which the Participant submits a claim in accordance with Section 7.07.

(a) Participants shall be reimbursed for Medical Care Expenses on a monthly or more frequent basis determined by the District. No reimbursement or payment of Medical Care Expenses incurred during a Period of Coverage shall at any time exceed the balance of the Participant's Medical Care Reimbursement Account for the Period of Coverage during which such Medical Care Expenses were incurred. The minimum reimbursement amount is zero dollars ($0) or such other amount as is determined by the Administrator from time to time, provided that the final payment of benefits for any Period of Coverage may be made following the close of such Period of Coverage based on accepted claims filed with the Administrator no later than three months following the close of such Period of Coverage.

(b) If a Participant ceases Plan participation, such Participant shall be entitled to continue receiving benefits pursuant to this Article to the extent of the amount remaining in the Participant's Medical Reimbursement Account for the expenses incurred during the Period of Coverage prior to the time termination of participation occurs.

Section 7.09 - Forfeiture of Unused Benefits: Amounts remaining in a Participant's Medical Reimbursement Account following final payment of all Medical Care Expenses incurred during the applicable Period of Coverage and timely claimed under Section 7.08 shall be forfeited.

Section 7.10 - Plan Administrator: The Plan shall be administered by the Administrator under the terms of the Flexible Benefit Plan and subject to the provisions thereof.

Section 7.11 - Other Governing Provisions: Other matters including, but not limited to, contributions, elections, Compensation reduction and payment of contributions, claims procedures, amendment of the Plan and termination of the Plan shall be governed by the general provisions of the Flexible Benefit Plan, incorporated herein by reference.

Section 7.12 - HIPAA Privacy Rules:

(a) Scope. The following provisions regarding protected health information and electronic protected health information apply solely to the extent the Plan (or any

relevant portion thereof) is a "health plan" covered by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and shall not be effective until the applicable "compliance date" for such plan as defined by such regulations. For purposes of this Section, the terms "protected health information" and "electronic protected health information" shall have the meaning specified by the privacy and security regulations under HIPAA.

The following provisions are intended to comply with the privacy regulations under HIPAA and shall be construed solely for that purpose. Such provisions shall not be construed to provide or mean that the Plan is a health care provider, practices medicine, or makes medical treatment decisions. The Plan reimburses or pays for a portion of the cost of eligible Medical Care Expenses and does not directly provide health care or practice medicine.

(b) Permitted Uses and Disclosures. The Plan may use protected health information to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the privacy regulations thereunder. Without limiting the foregoing, the Plan may use and disclose protected health information for "payment", "treatment", and "health care operations" purposes as such terms are defined by the HIPAA privacy regulations. In addition to using protected health information for such purposes, protected health information may be disclosed by the Plan to the Employer, and the Employer may use and disclose protected health information, for plan administration purposes, for enrollment purposes, and for any other purposes consistent with an individual's authorization or permitted by the HIPAA privacy regulations. In addition, "summary health information" may be disclosed by the Plan to the Employer and may be used and disclosed by the Employer for purposes of obtaining premium bids for health insurance coverage under the Pan or modifying, amending, or terminating the Plan. However, protected health information that is genetic information cannot be used for underwriting purposes.

(c) Employer Certification. The Plan will not disclose protected health information to the Employer for plan administration purposes unless the Plan receives from the Employer a certification that the applicable Plan documents have been amended to incorporate the following provisions. Therefore, the Employer certifies and agrees that it will:

(i) not use or further disclose protected health information other than as permitted or required by the Plan document or as required by law;

(ii) ensure that any agents to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(iii) not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer (unless authorized by the individual and/or permitted by the HIPAA privacy regulations);

(iv) report to the Plan any use or disclosure of the protected health information that is inconsistent with the uses and disclosures provided for and of which it becomes aware;

(v) make available protected health information to the affected individual in accordance with section 164.524 of the HIPAA privacy regulations;

(vi) make available protected health information for amendment at the request of the affected individual and incorporate any amendments to protected health information in accordance with section 164.526 of the HIPAA privacy regulations;

(vii) make available the information required to provide an accounting of disclosures to an affected individual in accordance with section 164.528 of the HIPAA privacy regulations;

(viii) make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the applicable requirements of the HIPAA privacy regulations;

(ix) if feasible, return or destroy all protected health information 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 purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) ensure that the adequate separation described below in subsection (d) is established.

(d) With respect to protected health information disclosed by the Plan to the Employer for use and/or disclosure by the Employer for plan administration purposes:

(i) such information may be disclosed to employees in the Benefits and Risk Management department and other departments and positions with oversight responsibility for the Plans, including employees with oversight responsibility for claims payment and third party claims administration;

(ii) such information may be used by the persons described above only for purposes of the plan administration functions that the Employer performs for the Plan; and

(iii) compliance with the provisions above relating to disclosure for plan administration purposes shall be monitored and enforced by the Administrator. The Administrator shall establish rules for effectively resolving any instances of noncompliance. Such rules are incorporated herein by this reference.

(e) Security Requirements. The following provisions of this subsection (e) do not apply to the extent the only electronic protected health information disclosed to the Employer for plan administration purposes (i) is disclosed pursuant to an individual's authorization; (ii) is summary health information disclosed for the purpose of obtaining premium bids or modifying, amending, or terminating the Plan; or (iii) is enrollment, disenrollment, or participation information. The Employer or its delegate will implement administrative, physical, and technical

safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes. With respect to electronic protected health information, the Employer will ensure that the requirements of subsection (d) above are supported by reasonable and appropriate security measures. With respect to electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes, the Employer will ensure that any agent to whom the Employer provides such information agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any "security incident" (as such term is defined by the HIPAA security regulations) of which it becomes aware with respect to electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes.

(f) Notifications of A Breach. The Plan shall make such notifications of a breach of unsecured protected health information as may be required under the HIPAA privacy regulations.

ARTICLE VIII
PLAN ADMINISTRATION

Section 8.01 - Plan Administrator: The administration of the Plan shall be under the supervision of the Administrator. The Administrator will have full power to administer the Plan in all of its details subject, however, to the requirements of the Code and other applicable law. For this purpose, the Administrator's power will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To construe and interpret the provisions of the Plan and make rules and regulations under the Plan;

(b) To decide all questions as to eligibility to become a Participant in the Plan and as to the rights of Participants under the Plan;

(c) To file or cause to be filed all such annual reports, returns, schedules, descriptions, financial statements and other information as may be required by applicable law;

(d) To determine and to authorize the amount, manner and time of payment of benefits hereunder;

(e) To contract with such insurance carriers or other suppliers as may be necessary to provide for benefits;

(f) To communicate to any insurer or other contract supplier of benefits under this Plan, in writing, all information required to carry out the provisions of the Plan;

(g) To notify the Participants of the Plan in writing of any amendment or termination of the Plan or of a change in any benefit available under the Plan;

(h) To prescribe such forms as may be required for Eligible Employees to make elections under the Plan;

(i) To do other such acts necessary to administer the Plan in accordance with the provisions hereof, or as may be provided for or required by law;

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

(k) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be by written instrument and in accordance with applicable law.

Section 8.02 - Claims Procedure:

(a) Notice of Claim: In the event a Participant has a claim for any benefits under this Plan, such Participant shall file a claim with the Administrator on a form or forms provided for such purpose by the Administrator which shall be available at the Employer's administrative office. If the Participant fails to file a claim for benefits, then the Administrator may take whatever steps are necessary and proper to dispose of the Participant's potential benefits under this Plan and shall be held harmless in performance of same.

Prior to making any payment of benefits hereunder, the Administrator and District may require the Participant to provide such information and to complete any appropriate documents or forms necessary for the proper administration of this Plan, including filing of all appropriate claims and requests for payment from any other plan or plans maintained by the Employer. The Administrator shall make all determinations as to the right of any Participant to a benefit under this Plan.

(b) Claims Procedure: If any person believes he is being denied any rights or benefits under the Plan, such person may file a claim in writing with the Administrator. If any such claim is wholly or partially denied, the Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary for such person to perfect such claim and an explanation of why such material or information is necessary and (iv)

information as to the steps to be taken if the person wishes to submit a request for review. Such notification will be given within 90 days after the claim is received by the Administrator (or within 180 days, if special circumstances require an extension of time for processing the claim and if written notice of such extension and circumstances is given by the Administrator to such person within the initial 90-day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period, and such person may request a review of his claim.

Within 60 days after the date on which a person receives a written notice of a denied claim (or, if applicable, within 60 days after the date on which such denial is considered to have occurred), such person (or his duly authorized representative) may (i) file a written request with the Administrator for a review of his denied claim and of pertinent documents and (ii) submit written issues and comments to the Administrator. The Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain specific reasons for the decision as well as specific references to pertinent Plan provisions. The decision on review will be made within 60 days after the request for review is received by the Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Administrator to hold a hearing, and if written notice of such extension and circumstances is given to such person within the initial 60-day period). If the decision on review is not made within such period, the claim will be considered denied.

Section 8.03 - Administrative Expenses; Forfeitures: The Administrator may establish reasonable administrative fee(s) to be paid by Participants as a condition of participation in the Plan, a Health Savings Account, the Dependent Care Assistance Plan, and/or the Medical Reimbursement Plan. Such fees shall be added to the costs of the optional benefits elected by a Participant and shall be deducted from the Participant's Compensation pursuant to a Salary Reduction Agreement in accordance with Section 4.01. Any expenses of administration of the Plan, a Health Savings Account, the Dependent Care Assistance Plan, and the Medical Reimbursement Plan that are not

charged to Participants shall be paid from forfeitures arising under Section 6.08 and Section 7.09. Any such forfeitures remaining after the payment of such expenses shall be retained by the Employer.

ARTICLE IX
AMENDMENT AND TERMINATION

Section 9.01 - Amendment of the Plan: The District may amend any or all provisions of this Plan at any time by written instrument identified as an amendment of the Plan effective as of a date specified therein.

Section 9.02 - Termination of Plan: This Plan may be terminated for any reason in whole or in part at any time by the District.

Section 9.03 - Preservation of Rights: Termination or amendment of the Plan shall not affect the rights of any Participant in his or her Accounts or the right to claim reimbursement for expenses incurred prior to such termination or amendment as the case may be to the extent such amount is payable under the terms of the Plan prior to the effective date of such termination or amendment.

ARTICLE X
MISCELLANEOUS

Section 10.01 - Facility of Payment: If the Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing same by reason of legal incapacity, the Administrator may, at its discretion, take any one or more of the following actions:

(a) Apply such amount directly for the comfort, support and maintenance of such person;

(b) Reimburse any person for any such support theretofore supplied to the person entitled to receive any such payment;

(c) Pay such amount to a legal representative or guardian or any other person selected by the Administrator for such comfort, support and maintenance, including without limitation, any relative who has undertaken, wholly or partially, the expense of such person's comfort, care and maintenance or any institution in whose care or custody the person entitled to the amount may be. The Administrator may, in its discretion, deposit any amount due to a minor to his or her credit in any savings or commercial bank of the Administrator's choice.

Section 10.02 - Lost Payee: Any amount due and payable to a Participant or beneficiary shall be forfeited if the Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due. However, any such forfeited amount will be reinstated through a special contribution to the Plan by the Employer and become payable if a valid claim is made by the Participant or beneficiary. The Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

Section 10.03 - Indemnification: To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom the Employer has delegated duties under the Plan, against any and all claims, losses, damages, expenses and liabilities arising from any act or failure to act that constitutes or is alleged to constitute a breach of such person's responsibilities in

connection with the Plan under applicable law, unless the same is determined to be due to gross negligence, willful misconduct or willful failure to act.

Section 10.04 - Plan Not a Contract of Employment: Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any Employee or Participant or as a right of any Employee or Participant to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee or Participant with or without cause.

Section 10.05 - 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 under the Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under or contribution with respect to the Plan is excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Administrator if the Participant has reason to believe that any such payment is not so excludable. Each Participant is solely responsible for determining eligibility to make Participant contributions and receive Employer contributions (if any) to a Health Savings Account and for withdrawing any ineligible contributions to such an account.

Section 10.06 - Rights to Employer's Assets: No Employee, Participant, Spouse, Dependent or beneficiary of an Employee or Participant nor their heirs, successors or assigns shall have any right to, or interest in, any assets of the Employer upon termination of a Participant's employment or otherwise, except as provided from time to time under this Plan and then only to the extent of the benefits payable under the Plan to such Employee, Participant, Spouse, Dependent or beneficiary.

Section 10.07 - Nonalienation of Benefits: Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse or

for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Employer and Administrator shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Section 10.08 - Severability: If any provision of the Plan, including instruments incorporated herein by reference, shall be held illegal, invalid or disqualifying for any reason, said illegality or invalidity shall not affect the remaining provisions hereof with such illegal, invalid or disqualifying provision being fully severable form the contents of the Plan, and the Plan shall be construed and enforced as if such illegal, invalid or disqualifying provision had not been included herein.

Section 10.09 - Titles and Headings: The headings of this Plan have been inserted for ease of reference only and are not to be interpreted as part of the construction of the provisions hereof.

Section 10.10 - Governing Law: The provisions of this Plan shall be construed according to the internal laws of the State of Texas, except as superseded by federal law, and in accordance with the Code to the extent such law applies to this Plan. The Plan is intended to be a cafeteria plan under Section 125(c) of the Code, containing a medical expense reimbursement plan under Section 105 of the Code and a dependent care assistance program under Section 129 of the Code, and shall be construed accordingly.

Section 10.11 - Multiple Copies: This Plan may be executed in any number of counterparts, each of which shall be deemed an original and constitute but one and the same document. Any xerox, photostatic or similarly reproduced copy of this Plan shall also be deemed an original for all purposes.

APPENDIX TO THE PLANO INDEPENDENT SCHOOL DISTRICT
FLEXIBLE BENEFIT PLAN

As provided in Section 3.01(a) of the Flexible Benefit Plan and subject to Section 4.01 of such Plan, conversion of the employee portion of the cost of benefits to a pre-tax Compensation reduction is available with respect to the following plans:

1. Vision Insurance Plan (all options)
2. TRS-ActiveCare (all options)
3. Dental Insurance Plan (all options)