PLAN DESCRIPTION

LOS ANGELES COMMUNITY COLLEGE DISTRICT
TEMPORARY FACULTY MEMBER
PREMIUM-ONLY PLAN

PURPOSE

Through the collective bargaining process, the Los Angeles Community College District ("District") has agreed to pay a fixed dollar amount per month, as specified in the Master Benefits Agreement between the District and the exclusive representatives of the District's employees, towards medical insurance premiums for part-time temporary faculty members and temporary adjunct faculty members if the employee meets certain requirements. The same employees are permitted to participate in District-sponsored vision and dental plans if they pay the full premium required for such coverage. This Premium Only Plan ("Plan") is effective with the Plan Year that begins January 1, 2006. The Plan is effective March 1, 2006. The purpose of this Plan is to allow the District to pay a share of the medical insurance premiums for part-time temporary faculty members and temporary adjunct faculty members and allow these employees to pay the remainder of the premiums on a pre-tax basis through payroll deduction. This Plan will also endeavor to allow part-time temporary faculty members and temporary adjunct faculty members to pay the full premium required for vision and/or dental coverage on a pre-tax basis. The District intends that this Plan qualify under Section 125 of the Internal Revenue Code of 1986 ("Code") as amended, and that the District's premium contribution and benefits that an employee receives under this Plan be eligible for exclusion from the employee's income under the Code. If any provision in this Plan conflicts with, or is in any way inconsistent with, any provision in any insurance or benefits plan offered herein, the provisions in the insurance or benefits plan shall control.

ARTICLE I
DEFINITIONS

The words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context, and pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

"Beneficiary" means the person, persons or trust designated by written revocable designation filed with the Plan Administrator by the Participant to receive benefits under this Plan, including the Participant and his or her Dependents.

"Benefit Package Option(s)" means the District-sponsored hospital/medical, dental and/or vision group insurance plans, and the level of coverage (number of individuals to be covered), selected by a Participant in the Plan.

"Change in Status" has the meaning described in Section 4.3.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended, and the same as may be amended from time to time.

"Dependent" means a person as defined in the most recent Master Benefits Agreement in effect between the District and its collective bargaining units.

"District" means the Los Angeles Community College District.

"Effective Date" means January 1, 2006 for the Plan Year and March 1, 2006 for the Plan.

"Eligible Employee" has the meaning described in Section 2.1.

"Employee" means any part-time temporary faculty member or temporary adjunct faculty member employed by the Employer.

"Employer" means the Los Angeles Community College District and any other organization that succeeds to its business and elects to continue this Plan.

"Enrollment Period" means the period designated when newly eligible Employees can enroll and current Participants' eligibility is verified for the next fall semester.

"ERISA" means the Employment Retirement Income Security Act of 1974, and the same as may be amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Health Insurance" means hospital/medical, dental and vision group insurance coverage sponsored by the Employer, from which Eligible Employees may make their elections.

"Highly Compensated Employee" means any Employee defined as such in Section 414(q) in the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HMO" means Health Maintenance Organization, a form of managed care health plan.

"Hospital/Medical Group Coverage" means insurance plans sponsored by the Employer covering hospital inpatient and outpatient services, physician services, and prescription drug benefits.

"Open Enrollment" means the period designated annually by the District for enrollment in the Plan and for making plan changes before the beginning of the Plan Year.

"Participant" means any Eligible Employee who has met the conditions for participation in the Plan as set forth in Article II.

"Period of Coverage" means the time following an Eligible Employee's enrollment in the Plan during which the Participant's Health Insurance is in effect.

"Plan" means the Employer's Premium-Only Plan which is described herein and as amended from time to time, and which is intended to constitute a separate written Plan for the exclusive benefit of Eligible Employees.

"Plan Election Form/Salary Reduction Agreement" means the form that must be completed by an Eligible Employee, and submitted to the District, specifying the Employee's selected Benefit Package Option(s) and agreeing to a reduction of taxable income on the Employee's salary warrant through payroll deduction to pay the Employee's share of Plan premiums.

"Plan Sponsor" means the Employer.

"Plan Year" means the 12-month period designated by the Employer as the annual duration of the health insurance plans, currently January 1 through the following December 31.

"PPO" means Preferred Provider Organization, a form of managed care health plan.

"QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

"Salary Reduction Agreement" means a voluntary agreement whereby an Eligible Employee agrees to reduce his or her salary for the next Period of Coverage for the purpose of participating in the Plan.

"Spouse" means a person as defined in the most recent Master Benefits Agreement in effect between the District and its collective bargaining units.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.1 Eligibility. A part-time temporary faculty member or temporary adjunct faculty member ("Employee") is eligible to receive access to, and a District contribution toward, District-sponsored hospital/medical group coverage and access to District-sponsored vision and dental group coverage under this Plan if the Employee has been assigned and is employed as a part-time

temporary faculty member or a temporary adjunct faculty member with the District and meets the eligibility requirements in Sections 2.1.1. through 2.1.4 below:

2.1.1. The Employee is assigned to a .33 (or higher) full-time equivalent (FTE) temporary (limited or long-term substitute) or adjunct faculty load in the District. Open but inactive assignments (i.e., no work, no pay) do not constitute employment and cannot be considered in determining eligibility for hospital/medical, vision or dental group coverage with the District.

2.1.2. The Employee has completed at least a .2 FTE part-time temporary faculty member or temporary adjunct faculty position in the District during three or more semesters out of the previous eight consecutive semesters.

2.1.3. By the start of each academic year, the Employee has submitted a signed affidavit (provided by the District) that affirms that the Employee is not eligible for hospital/medical coverage through another employer.

2.1.4. The Employee participates in this Plan under the terms of Internal Revenue Code Section 125 so that the Employee's contribution to insurance premiums for District-sponsored hospital/medical, vision or dental group coverage will be deducted, pre-tax, from salary warrants. The amount of the Employee's contribution toward the premiums for group coverage, plus any other payroll deductions, shall not exceed the Employee's gross pay each month; otherwise, the Employee is not eligible to participate in or continue to participate in this Plan.

2.2 Participation and Election of Benefits. An Employee who meets the eligibility requirements of Article II ("Eligible Employee") shall become a Participant in the Plan for a Period of Coverage when he or she properly files the required Plan Election Form/Salary Reduction Agreement before the close of the Open Enrollment or during the Enrollment Period. A Participant who becomes ineligible or terminates participation cannot reenroll until the Open Enrollment for the next Plan Year. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment period, unless an event occurs that would justify an interim election change, as described under Section 4.4.

2.3 Term and Conditions of Coverage. A Participant who has prepaid the premium(s) via this Plan for an entire semester and enrolls, or remains enrolled, in the Plan for the next semester shall remain eligible for coverage during the time between the end of the first semester and the beginning of the next semester contingent upon verification of continued eligibility. The premium payments shall equate to 12 months coverage and shall be deducted from 10 monthly pay periods for each 12-month coverage period.

2.4 Termination of Participation. Except as provided in Sections 2.5 and 2.6, participation during a Plan Year shall terminate on the date a Participant ceases to be an employee with the District, takes any unpaid leave of absence, fails to meet the Plan eligibility requirements of this Article (Article II), or affirmatively terminates his or her participation. Participation in the Plan shall cease immediately upon a Participant's failure to pay the balance of the required medical or other insurance premium(s) in accordance with District procedures.

2.5 Participation During FMLA Leaves of Absence. If a Participant who meets the eligibility requirements in Article II takes a qualifying leave of absence under the FMLA (Family and Medical Leave Act of 1993, as amended), the District will continue to provide benefits as described in Article III, to the extent required under the FMLA.

2.6 Participation During Uniformed Service Leaves of Absence Under USERRA. A Participant who is absent from employment with the District as a result of being in "Uniformed Service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in this Plan for up to 24 months, measured from the first day of the Participant's leave of absence for duty in the Uniformed Service. While on leave of absence for duty in the Uniformed Service, the Participant shall continue making his or her required contributions towards insurance premiums as set forth in Article III. Following completion of Uniformed Service and upon meeting the eligibility requirements of this Plan, the Eligible Employee is entitled to reinstatement in this Plan in accordance with USERRA requirements.

2.7 Participation During Other Unpaid Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the contributions due for the Participant will be paid as set forth in Article III. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 4.4.4 will apply.

ARTICLE III
BENEFITS

3.1 Hospital/Medical Group Coverage. Under this Plan, the District will contribute a fixed dollar amount towards the monthly cost of a Participant's medical insurance premium for District sponsored hospital/medical group coverage. To receive the District contribution and District-sponsored hospital/medical group coverage, an Employee must: 1) meet the eligibility requirements of Article II; 2) become a Participant in this Plan under Section 2.2 for the required Period of Coverage, contingent upon verification of continued eligibility; and 3) pay, in advance as required by the District, the monthly balance of all required premiums, minus the District's contribution towards the medical insurance premium.

3.2 Vision and Dental Coverage. Under this Plan, Eligible Employees may participate in District-sponsored vision and/or dental coverage. To receive District-sponsored vision and/or dental coverage, an Employee must: 1) meet the eligibility requirements of Article II; 2) become a participant in this Plan under Section 2.2 for the required Period of Coverage, contingent upon verification of continued eligibility; and 3) pay, in advance as required by the District, 100% of the monthly premiums, as determined by the District, for the vision and/or dental coverage.

3.3 Insurance Contracts. The District shall have the right to enter into contracts with one or more insurers or providers for the purpose of providing benefits under this Plan. The District has the right to amend, renew, or cancel any contract, plan or agreement, or replace any insurer or

provider as the District may deem necessary. Such action may result in an increase, or decrease, in the amount of premiums a Participant may be required to pay. Any dividend, credit, or refund which may be payable under any agreement with an insurer or provider shall be the sole property of the District and shall be retained by the District.

3.4 Premium Payments for Hospital/Medical Group Coverage. Upon filing the required Plan Election Form/Salary Reduction Agreement with the District and becoming a Participant in this Plan pursuant to Article II, the Participant shall have his or her taxable wages reduced by an amount equal to the medical insurance premiums required for coverage under the selected District-sponsored hospital/medical group plan, less the District contribution. The District shall forward the Participant's required share of the medical insurance premium to the appropriate hospital/medical group coverage insurer or provider.

3.5 Premium Payments for Vision and Dental Coverage. Upon filing the Plan Election Form/Salary Reduction Agreement with the District and becoming a Participant in this Plan pursuant to Article II, the Participant shall have his or her taxable wages reduced by an amount equal to the premiums required for coverage under the selected District-sponsored vision and/or dental plan. The District shall forward the Participant's premium payments to the appropriate insurer or provider.

3.6 Premium Payments by Employees on FMLA Leave of Absence. Any Participant who elects to continue participation in this Plan while on qualifying FMLA leave of absence shall continue to make the premium payments required under this Plan. If the Participant elects to continue participation in the District-sponsored hospital/medical group coverage while on FMLA leave, the District will continue to pay its contribution towards the Participant's medical insurance premium. If the Participant is entitled to receive salary or other compensation while on FMLA leave, the Participant may continue to pay his/her required share of the medical insurance premiums on a pre-tax basis under this Plan. If the Participant is also participating in District-sponsored vision and/or dental coverage, the Participant may continue to pay his or her required premiums for vision and/or dental coverage on a pre-tax basis under this Plan. If the Participant's net salary or compensation on paid FMLA leave is not sufficient to pay his or her premiums, or if a Participant is on unpaid FMLA leave, the Participant may pay his or her share of the medical insurance premium, and/or his or her premiums for vision and/or dental coverage, with after-tax contributions by sending monthly premium payments to the District by the due date established by the District. The Participant may prepay any amounts that will become due during the leave of absence.

3.7 Premium Payments by Employees on Uniformed Service Leave of Absence. Any Participant who elects to continue participation in this Plan while on Uniformed Service leave of absence shall continue to make the premium payments required under this Plan. If the Participant elects to continue participation in the District- sponsored hospital/medical group coverage while on USERRA leave, the District will continue to pay its contribution towards the Participant's medical insurance premium. If the Participant is entitled to receive salary or other compensation while on Uniformed Service leave, the Participant may continue to pay his or her required share of the medical insurance premiums on a pre-tax basis under this Plan. If the Participant is also participating in District-sponsored vision and/or dental coverage, the

Participant may continue to pay his or her required premiums for vision and/or dental coverage on a pre-tax basis under this Plan. If the Participant's net salary or compensation on paid Uniformed Service leave is not sufficient to pay his or her premiums, or if the Participant is not receiving pay while on Uniformed Service leave, the Participant may pay his or her share of the medical insurance premium, and/or his or her premiums for vision and/or dental coverage, with after-tax contributions by sending monthly premium payments to the District by the due date established by the District. The Participant may prepay any amounts that will become due during the leave of absence.

3.8 Premium Payments by Employees on Other Unpaid Leave. A Participant on an unpaid leave of absence that does not affect eligibility may continue to participate in the Plan and make contributions by pre-payment before going on leave, if authorized by the Plan Administrator.

3.9 Nondiscrimination. Contributions and benefits under the Plan shall not discriminate in favor of Highly Compensated Employees. The Employer may limit, deny or require modification of any Participant's Salary Reduction Agreement to the extent necessary to avoid any such discrimination.

3.10 Medical Insurance Benefits Provided Under the Medical Insurance Plan.
Hospital/medical, dental and vision group benefits are provided by the corresponding insurance plans, not by this Plan. The types and amounts of insurance benefits, the requirements for participating in the insurance plans, and the other terms and conditions of coverage and benefits of the insurance plans are set forth in those plans. All claims to receive benefits under the insurance plans shall be subject to and governed by the terms and conditions of the insurance plans and the rules, regulations, policies and procedures adopted in accordance therewith, as may be amended from time to time. If any provision in this Plan conflicts with, or is in any way inconsistent with, any provision in any insurance or benefits plan offered herein, the provisions in the insurance or benefits plan shall control.

ARTICLE IV
IRREVOCABILITY OF ELECTIONS AND EXCEPTIONS

4.1 Irrevocability of Elections. Except as described in this Article IV, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. That is, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding: participation in this Plan, salary reduction amounts, or election of particular Benefit Package Options.

4.2 Procedure for Making New Election if Exception to Irrevocability Applies.

4.2.1 Timeframe for Making New Election. A Participant (or an Eligible Employee who, when first eligible under Section 2.1 or during the Open Enrollment period or Enrollment Period under Section 2.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.4, as applicable, but only if the election

under the new Plan Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.4(d) through 4.4(i), within 30 days after the events described in such Sections). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a Dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the hospital/medical plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

4.2.2 Effective Date of New Election. Elections made pursuant to this Section 4.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later or if a new Plan Election Form is filed late in the month).

4.3 Changes in Status Defined. A Participant may make a new election upon the occurrence of certain events as described in Section 4.4, including a Change in Status, for the applicable coverage. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to IRC Section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan.

4.3.1 Legal Marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

4.3.2 Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

4.3.3 Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: 1) a termination or commencement of employment; 2) a strike or lockout; 3) a commencement of or return from an unpaid leave of absence; 4) a change in worksite; and 5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan;

4.3.4 Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

4.3.5 Change in Residence. A change in the place of residence of the Participant or his or her Spouse or Dependents.

4.4 Events Permitting Exception to Irrevocability Rule for All Benefits. A Participant may change an election as described below upon the occurrence of the stated events for the applicable coverage under this Plan. A Participant entitled to change an election as described in this Section 4.4 must do so in accordance with the procedures described in Section 4.2.

4.4.1 Open Enrollment Period. A Participant may change an election during the Open Enrollment Period in accordance with Section 2.2.

4.4.2 Termination of Employment. A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 2.3 and 2.4, as applicable.

4.4.3 Leaves of Absence. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 2.5 and upon USERRA leave in accordance with Section 2.6.

4.4.4 Change in Status. A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.3) but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

4.4.4.1 Loss of Spouse or Dependent Eligiblity; Special COBRA Rules. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 2.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

4.4.4.2 Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as result of a change in martial status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

4.4.5 HIPAA Special Enrollment Rights. If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

4.4.5.1 a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or

4.4.5.2 a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

4.4.6. Certain Judgments, Decrees and Orders. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires health plan coverage for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may 1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or 2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

4.4.7 Medicare and Medicaid (Medi-Cal). If a Participant or his or her Spouse or Dependent who is enrolled in a health plan under this Plan becomes enrolled in Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the Plan coverage of the person becoming entitled to Medicare or Medicaid coverage.

Furthermore, if a Participant or his or her Spouse or Dependent who has been enrolled in Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the Plan coverage of the individual who loses Medicare or Medicaid eligibility.

4.4.8 Change in Cost. For purposes of this Section 4.4.8 and Section 4.4.9, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, 1) a health flexible spending account (FSA) is not similar coverage with respect to a health plan that is not a health FSA; 2) an HMO and a PPO are considered to be similar coverage; and 3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

4.4.8.1 Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

4.4.8.2 Significant Cost Increases. If the Plan Administrator determines that the cost charged for a Participant's Benefit Package Option(s) (such as a PPO for the hospital/medical plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in her or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

4.4.8.3 Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the hospital/medical plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the one that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the hospital/medical plan); and (b) Employees who are otherwise eligible under Section 2.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole

discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

4.4.9 Change in Coverage.

4.4.9.1 Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

4.4.9.2 Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for Period of Coverage that is different from the plan year under the other plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of an corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

4.5 Election Modifications Required by Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to:

4.5.1 satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other plan;

4.5.2 prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized;

4.5.3 maintain the qualified status of benefits received under this Plan; or

4.5.4 satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary

Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE V
CONTINUATION COVERAGE

5.1 Continuation Coverage. A Participant, Spouse or Dependent who loses eligibility under this Plan and loses District-sponsored hospital/medical group, vision, or dental insurance coverage, may have the opportunity to elect to continue hospital/medical group, vision, or dental insurance coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The applicable COBRA rights, if any, are described in the COBRA provisions contained in the relevant hospital/medical group, vision, or dental insurance plans.

ARTICLE VI
PLAN ADMINISTRATION

6.1 Plan Administration. The District, as Plan Administrator, shall establish rules for the administration of this Plan and the transaction of business. The Plan Administrator shall have the exclusive right to interpret this Plan and to decide all matters arising under this Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations made by the Plan Administrator as to any matter under this Plan shall be conclusive and binding on all persons.

6.2 Powers and Duties. The Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish information that the Plan Administrator may request for the purpose of the proper administration of this Plan and as a condition to receiving any benefits under this Plan;

(b) To make and enforce rules and regulations and prescribe the use of forms that the Plan Administrator deems necessary for the efficient administration of this Plan;

(c) To decide questions concerning this Plan and the eligibility of any Employee or any other person to participate in this Plan;

(d) To determine the cost of benefits available to any Employee under the provisions of this Plan and to provide a full and fair review to any Employee whose claim for Benefits has been denied in whole or in part; and

(e) To designate persons to carry out any duty or power.

(f) To modify elections made by Participants, and take such other actions, as required to enable the Plan to satisfy the requirements of Section 125 of the Code.

6.3 Reliance on Participant and Other Parties. The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys other experts employed or engaged by the Plan Administrator.

6.4 Provision for Third-Party Plan Service Providers. The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the operation of this Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

6.4 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own willful misconduct or gross negligence.

ARTICLE VII
AMENDMENT OR TERMINATION OF PLAN

7.1 Plan Amendment or Modification. The District reserves the right and power to modify or amend this Plan, and/or any and all provisions of this Plan, in whole or in part, without notice, at any time and retroactively. The District reserves the right and power to amend or modify this Plan as necessary or appropriate to meet the requirements of the Code or of the Employment Retirement Income Security Act of 1974 (ERISA) if applicable.

7.2 Plan Termination. The District reserves the right and power to discontinue or terminate this Plan at any time.

7.3 Effective Date of Amendment or Termination. Any amendment, discontinuance, or termination of this Plan shall be effective as of the date that the District determines.

ARTICLE VIII
GENERAL INFORMATION

8.1 Right to Continued Employment. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue in the employ of the District or any campus, department, or office thereof.

8.2 Assignment. No benefit under this Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so shall be void.

8.3 Written Communications. All communications in connection with this Plan made by an Employee shall become effective only when duly executed and filed with the District, as required by the District.

8.4 Governing Laws. The provisions of this Plan shall be construed, administered, and enforced according to applicable Federal law and the laws of the State of California.

8.5 Status of Benefits. The District believes that this Plan is in compliance with Section 125 of the Code and that it provides certain benefits to Participants which are tax-free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting benefits under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest and penalties as may be imposed.

8.6 Source of Benefits. The Employer and any insurance company contracts purchased or held by the Employer shall be the sole sources of benefits under the Plan. No Employee or Beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or Beneficiary.