LOS ANGELES COMMUNITY COLLEGE DISTRICT

HEALTH REIMBURSEMENT ARRANGEMENT

Effective January 1, 2010

Rev. 12/2020

STATEMENT OF PURPOSE

The Los Angeles Community College District (LACCD) hereby establishes the LACCD Health Reimbursement Arrangement (HRA) effective January 1, 2010.

This Plan is intended to qualify as a health reimbursement arrangement plan under Code sections 105 and 106 of the Internal Revenue Code of 1986, as amended, and IRS Notice 2002-45, and is to be interpreted in a manner consistent with all relevant provisions of the Code.

The purpose of the Plan is to provide Participants with reimbursement for Qualified Health Care Expenses, as that term is defined in Article I herein, and exclude said reimbursements from Participants' gross income under Code Section 105(b).

ARTICLE I

DEFINITIONS

Definitions. The following items when used in this Plan shall have the following meanings, unless a different meaning is clearly required by the context:

1.1. Code. Code shall mean the Internal Revenue Code of 1986, as amended from time to time. Reference to a specific provision of the Code shall include such provision, any valid regulations promulgated thereunder, and any comparable provision of future legislation that amends, supplements or supersedes such provision.

1.2. Early Retiree. Early Retiree shall mean an LACCD employee who retires from employment with the Employer in accordance with the rules of the California Public Employees Retirement System (CalPERS), the California State Teachers Retirement System (CalSTRS), or the Public Agency Retirement System (PARS), who is receiving a retirement allowance and who is not eligible for Medicare due to age or disability.

1.3. Effective Date. Effective Date shall mean the date that this Plan becomes effective, which is January 1, 2010.

1.4. Employee. Employee shall mean an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee (including individuals who perform services for the Employer but who is paid by a temporary or other employment or staffing agency), or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer.

1.5. Employer. Employer shall mean Los Angeles Community College District (LACCD).

1.6. Health Flexible Spending Account. Health Flexible Spending Account, "Health FSA" shall mean a health flexible spending arrangement as defined in Code Section 106(c) (2) and IRS Prop. Treas. Reg. 1.125-5.

1.7. Health Reimbursement Arrangement. Health Reimbursement Arrangement "HRA Account" shall mean the individual account that each Participant shall receive once eligibility provisions are satisfied in accordance with Section 3.1.

The HRA Account shall be funded on an annual basis until the Participant fails to satisfy the eligibility requirements defined in Section 2.2.

1.8. Participant. Participant shall mean all benefited, active LACCD Employees and Early Retirees. The benefitted active Employee or Early Retiree of LACCD shall be enrolled in the Public Employees Medical and Hospital Care Act (PEMHCA), hereby referred to as the CalPERS Health Care Program, based on their current employment or former employment with LACCD. If the Employee or Early Retiree is not enrolled in the CalPERS Health Care Program as a subscriber, the Employee or Early Retiree must be enrolled as a dependent of a subscriber, and the subscriber must also be an Employee, an Early Retiree, or a Retiree of LACCD. A Participant shall not include Employees who are not fully benefitted as that term is defined by the Employer; Employees and Early Retirees who waive coverage under the CalPERS Health Care Program who do not satisfy the requirements of this Section 1.8, and retirees who do not satisfy the definition of an Early Retiree of Section 1.2.

1.9. Period of Coverage. Period of Coverage means the Plan Year, with the following exceptions: (a) for eligible Employees who first become Participants, it shall mean the portion of the Plan Year following the date participation commences; and (b) for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates.

1.10. Plan. Plan shall mean the Los Angeles Community College District (LACCD) Health Reimbursement Arrangement (HRA), as described herein.

1.11. Plan Administrator. Plan Administrator shall be the Employer or the person(s) appointed by the Employer to act as Plan Administrator on its behalf.

1.12. Plan Year. Plan Year shall mean the twelve month period beginning January 1 and ending December 31.

1.13. Qualified Dependent. Qualified Dependent shall mean any individual who is a tax dependent of the Participant as defined in Code section 105 (b) who is eligible for coverage under the CalPERS Health Care Program.

1.14. Qualified Health Care Expense. Qualified Health Care Expense shall mean a healthcare expense incurred by a Participant or Qualified Dependent that is authorized under Code section 213 (d),as amended from time to time, including, but not limited to, deductibles, copayments, coinsurance, prescription drug expenses, dental and vision expenses, over-the-counter drugs, qualified long term care premiums, and Medicare premiums.

ARTICLE II

PARTICIPATION

2.1 Plan Participation. Every Employee and Early Retiree of the Employer who satisfies the requirements of a Participant shall be covered under the Plan. Participants shall not be required to make any contributions to the Plan.

(A) Once an Early Retiree reaches the age of 65, they will not receive future annual District contributions to their Plan balance.

2.2 Cessation of Participation. A Participant in the Plan shall cease to be a Participant in the Plan upon the occurrence of any of the following events:

(A) the date that he or she ceases to satisfy any of the requirements for being a Participant;
(B) the date the Plan is terminated;
(C) the date of the Participant's death

- Upon Participant's death, Participant's Qualified Dependents will not receive future annual District contributions to the deceased Participant's Plan balance.

2.3 Participation of former Participants and Qualified Dependents: To the extent required by law (including, without limitation Section 4980B of the Code and regulations thereunder), a former Participant shall be eligible to receive reimbursement from the Plan as defined in Section 4.1, if the individual elects continuation coverage under COBRA or as an Early Retiree elects in lieu of COBRA to receive reimbursement as described in Section 4.3. Qualified Dependents of Early Retirees and Retirees who are age 65 and older shall be eligible to continue to receive reimbursements for coverage under the Plan in the event of a Participant's death, until all benefits in the deceased Participant's account have been depleted.

ARTICLE III

TIMING OF ELIGIBILITY AND BENEFIT ENTITLEMENT

3.1. Date of Eligibility and Benefit Entitlement.

Any Employee who becomes eligible for the Plan, by way of initial hire or reinstatement, on or before March 1 of any calendar year shall be entitled to receive benefits under the Plan, as outlined in Article IV, during that calendar year. Any Employee who becomes eligible for the Plan, by way of initial hire or reinstatement, after March 1 of any calendar year shall be entitled to benefits under the Plan beginning January 1 of the following calendar year.

An employee retiring from LACCD who satisfies the definition of an Early Retiree in Section 1.2, who enrolls in the CalPERS Health Care Program shall be treated as a Participant as of their retirement date. If an Early Retiree receives a contribution as defined in Section 4.1 from the Plan while the Early Retiree is an Employee, the Early Retiree shall not be eligible to receive an additional contribution under Section 4.1., until the beginning of the next Plan Year.

ARTICLE IV

REIMBURSEMENTS

4.1 Plan Benefits. The Plan provides reimbursement of Qualified Health Care Expenses incurred by Participants and their Qualified Dependents while covered under the Plan. Each Participant shall receive a single, contribution of $1500 per Plan Year. The Plan Benefits shall be determined by the Employer on an annual basis and are subject to change pursuant to the LACCD Master Benefits Agreement hereby incorporated by reference.

4.2 Carryover of Accounts. If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for that Period of Coverage, such balance shall be carried over to reimburse the Participant and Qualified Dependents for Qualified Health Care Expenses incurred during a subsequent period of coverage. There shall be no limit as to the maximum benefit that a Participant can carryover from one year to the next or the maximum benefit a Participant can accumulate in their HRA Account.

4.3 Benefit Cessation and Right to Reimbursement. The benefits under Section 4.1 shall cease to be available to a Participant on the date of the occurrence of one of events described in Section 2.2. When applicable, a former Participant shall be eligible to continue participation in the Plan as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA). If a Participant fails to elect COBRA coverage, the former Participant shall have the option of submitting expenses for reimbursement under the Plan, in accordance with 4.5 and 7.1. Upon expiration of the timeframes described in Section 4.5 any amounts remaining in a former Participant's HRA Account shall be forfeited.

An Early Retiree who ceases to be a Participant, and/or the Early Retiree's Qualified surviving Dependent(s), who do not elect COBRA, shall be entitled to receive reimbursements for qualified health care expenses incurred after the Early Retiree ceases to be a Participant. The reimbursement under the HRA shall be equal to the unused benefit amounts available in the Early Retiree's HRA account at the time the Early Retiree ceased to be a Participant, and until such time as those amounts are exhausted.

4.4 Eligible Health Care Expenses

Under the Plan, a Participant may receive reimbursement for Health Care Expenses incurred during a Period of Coverage. For purposes of this section the following terms shall mean:

(A) *Incurred.* A Health Care Expense is incurred at the time the health care service is delivered or the health care expense is incurred, not when the individual incurring the expense is formally billed for, is charged for, or

pays for the health care expense. Health Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible.

(B) *Health Care Expenses Generally.* "Health Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for health care, as defined in Code § 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs) and health insurance premiums for long term care insurance, individual health and dental insurance policies, Medicare Part B and TEFRA, but shall not include expenses that are deemed to be cosmetic as defined by the IRS or as defined in subsection 4.4 (d). Reimbursements due for Health Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account.

(C) *Health Care Expenses Exclusions.* "Health Care Expenses" shall not include the expenses not recognized by the IRS as qualified health care expenses or expenses that are reimbursable under another plan or source.

(D) *Cannot Be Reimbursed or Reimbursable from Another Source.* Health Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance, or any other accident or health plan including the Health FSA as described in Section 4.6 . If only a portion of a Health Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), the Plan can reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article IV.

4.5 Limits on Time and Amount of Reimbursement. Reimbursements shall be made for any Plan Year only if the Participant or former Participant applies for such reimbursement within 90 days after the end of the Plan Year. In the event of the Participant's death, the Participant's Qualified Dependent (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements under the Plan.

4.6 Coordination of Benefits. Benefits under this Plan are solely intended to reimburse Qualified Health Care Expenses not previously reimbursed. If the Participant's Qualified Health Care Expenses are covered by both this Plan and by a Health FSA, the expenses shall be reimbursed first under this Plan and until such time as the total HRA balance has been exhausted, at which point, the Participant may then seek reimbursement for Qualified Health Care Expenses under the Health FSA.

ARTICLE V

PAYMENT OF CLAIMS

5.1 General. A claim is a request for a Plan benefit made by a Participant or authorized representative, in accordance with the Plan's procedure for filing benefit claims. The claimant or authorized representative may file a claim by contacting the Plan Administrator. A claim must be received by the person or organizational unit designated by the Plan Administrator for handling benefit matters on behalf of the Plan, in order for the Plan's review and determination process to begin. The claimant or authorized representative is required to provide information sufficient to determine whether, and to what extent, the claim is covered under the Plan.

5.2 Initial Determination of Claim. In the case of a claim, the Plan shall notify the claimant or authorized representative of the Plan's benefit determination not later than 30 days after the Plan's receipt of the claim. This period may be extended one time only by the Plan for up to 15 days, provided that (i) the Plan determines that the extension is necessary due to matters beyond the control of the Plan, and (ii) the Plan notifies the claimant or authorized representative, before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to make its determination. If the extension is necessary because of the failure of the claimant or authorized representative to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant or authorized representative will have 45 days from receipt of the notice to provide the specified information.

5.3 Denial of Claim. If a claim is denied (in whole or in part), the Plan will provide the claimant or authorized representative with written notification of the adverse benefit determination. The notification will set forth, in a manner calculated to be understood by the claimant or authorized representative

(A) The specific reason or reasons for the adverse benefit determination;
(B) Reference to the specific Plan provisions on which the determination is based;
(C) A description of any additional material or information necessary for the claimant or authorized representative to perfect the claim, and an explanation of why such material or information is necessary; and
(D) A description of the Plan's review procedures and the time limits applicable to such procedures (including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review);
(E) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule,

guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant or authorized representative upon request.

5.4 Appeal. The claimant or authorized representative may obtain a full and fair review by the Plan of the claim and adverse benefit determination by submitting an appeal to the Plan within 180 days following receipt by the claimant or authorized representative of an adverse benefit determination. The claimant or authorized representative may submit written comments, documents, records, and/or other information relating to the claim for benefits, as part of the appeal. The Plan will provide the claimant or authorized representative, upon request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits.

5.5 Review on Appeal. The Plan's review of the adverse benefit determination on a timely appeal shall take into account all comments, documents, records, and other information submitted by the claimant or authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. The Plan's review shall not give any deference to the initial adverse benefit determination, and shall be conducted by an individual (i) who is not the individual who made the initial adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of such individual.

5.6 Benefit Determination on Review. The Plan shall notify the claimant or authorized representative of the Plan's benefit determination on review within 60 days after receipt of a timely appeal. The Plan's benefit determination on review (for pre-service or post-service claims) shall be provided in writing to the claimant or authorized representative. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant or authorized representative:

(A) The specific reason or reasons for the adverse benefit determination on review;
(B) Reference to the specific Plan provisions on which the determination is based;
(C) A statement that the claimant or authorized representative is entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits;
(D) A statement describing any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring a civil action following an adverse benefit determination on review;

(E) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on review, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on review and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant or authorized representative upon request.

ARTICLE VI

SOURCE OF REIMBURSEMENTS

6.1 Reimbursements. Reimbursement of Qualified Health Care Expenses under this Plan shall be from the general assets of the Employer. Participants shall have no rights to any particular assets of the Employer, except as provided by the Plan. A Participant's right to reimbursement under the Plan shall be limited to the amount determined by the Plan Administrator to be payable under the Plan

6.2 Rights of Participants. Any bookkeeping account established under the Plan for purposes of tracking Plan benefits received by a Participant shall be for the administrative convenience of the Plan Administrator and the Employer. Nothing in this Plan shall require the Employer to segregate or set aside any portion of its assets for purposes of the Plan. Nor shall the establishment of any bookkeeping account hereunder or of any other administrative practice vest any Participant with title in any assets of the Employer, or entitle the Participant to benefits, except as expressly provided for in the Plan.

ARTICLE VII

CESSATION OF COVERAGE

7.1. Cessation of Participation. In the event a Participant ceases to satisfy the requirements for being a Participant during the Plan Year, such individual shall be entitled to receive reimbursement under the Plan for Qualified Health Care Expenses incurred prior to the date the Participant ceases to be eligible under the Plan as described in Section 2.2. The maximum reimbursement shall be limited to the unused amount in the HRA remaining at the time the Participant ceases to be a Participant as described in Section 2.2. Early Retirees who cease to be Participants shall be eligible to receive reimbursements under the Plan as described in Section 4.3.

7.2. COBRA. The Participant and his or her Qualified Dependent whose coverage terminates under the HRA account because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the HRA account on the day before the qualifying event for the periods prescribed by COBRA. However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, the Participant and his or her spouse or Dependents shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA participants. A premium for COBRA continuation coverage shall be charged to Qualified Beneficiaries in such amount and made payable at such times as are established by the Employer and permitted by COBRA.

ARTICLE VIII

HIPAA PRIVACY AND SECURITY

8.1 Employer's Certification of Compliance. The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 CFR § 164.504(f) (2) (ii), and that Employer agrees to conditions of disclosure set forth in this Article VIII.

8.2 Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Employer or the Administrator information on whether the individual is participating in the Plan.

8.3 Permitted Uses and Disclosures of Summary Health Information. The Plan may disclose Summary Health Information to the Employer or the Administrator, provided that the Employer or the Administrator requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan. "Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 CFR § 164.51 4(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.51 4(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

8.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article VIII (including, but not limited to the restrictions on Employer's use and disclosure described in 8.5) and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64.

8.5 Restrictions on Employer's Use and Disclosure of Protected Health Information

(A) Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.

(B) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to Protected Health Information.

(C) Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.

(D) Employer will report to the Plan any use or disclosure of a Covered individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.

(E) Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 C.F.R. § 164.524.

(F) Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 C.F.R. § 164.526.

(G) Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(H) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 C.F.R. Part 164, Subpart E.

(I) Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived there from that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the

Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(J) Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 CFR § 504(f) (2) (iii), is satisfied.

8.6 Adequate Separation Between Employer and the Plan

(A) Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Covered Individual's Protected Health Information received from the Plan or a business associate servicing the Plan:

1. Privacy Official;
2. Employees in the Employer's Human Resources Department;
3. Employees in the Employer's Office of General Counsel; and
4. Any other class of employees designated in writing by the Privacy Official.

(B) The employees, classes of employees or other workforce members identified in Section 8.4(a), above, will have access to a Covered Individual's Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 8.2(a), above.

(C) The employees, classes of employees or other workforce members identified in Section 8.4(a),above, will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information in breach or violation of or noncompliance with the provisions of this Article

ARTICLE IX

ADMINISTRATION

9.1 Appointment of Plan Administrator. The Plan shall be administered by the Plan Administrator.

9.2 Powers and Authority of the Plan Administrator. Except as otherwise expressly provided in the Plan:

(A) The Plan Administrator shall have all powers necessary or helpful for the carrying out its responsibilities under the Plan, and its decisions or actions in respect to any matter hereunder shall be conclusive and binding upon all parties concerned.

(B) Without limiting the generality of the foregoing, the Plan Administrator shall have the power and authority to make rules for administration of the Plan which are not inconsistent with the terms and provisions of the Plan; to construe all terms, provisions, conditions and limitations of the Plan; and to determine all questions arising out of or in connection with the provisions of the Plan or its administration in any and all cases in which the Plan Administrator deems such a determination advisable.

The foregoing list of powers is not intended to be complete or exhaustive. The Plan Administrator shall, in addition, have such powers as it may determine to be necessary for the performance of its duties under the Plan.

9.3 Liability Limited. Except as otherwise provided by law, the Plan Administrator shall not incur any liability whatsoever on account of any matter connected with or related to the Plan or the administration of the Plan, unless the Plan Administrator has acted in bad faith, or has willfully neglected its duties, in respect to the Plan.

9.4 Counsel and Agents. The Plan Administrator may employ counsel (including legal counsel, who may be counsel for the Employer), agents, and clerical and other services as it may require in carrying out the provisions of the Plan. The Plan Administrator shall be fully protected in acting or refraining to act in accordance with the advice of legal or other counsel.

9.5 Reliance on Information. The Plan Administrator, the Employer and any of their employees, officers, and directors shall be entitled to rely upon any tables, valuations, certificates, opinions and reports furnished by any accountant, trustee, insurance company, counsel, physician, dentist or other expert who is

engaged by the Plan Administrator or the Employer. The Plan Administrator and the Employer shall be fully protected in respect to any action taken or suffered by them in good faith reliance thereon.

9.6 Genuineness of Documents. The Plan Administrator, the Employer and their officers, directors and employees shall entitled to rely upon any notice, request, consent, letter, telegram or other paper or document believed by them or any of them to be genuine, and to have been signed or sent by the proper person, and shall be fully protected in respect of any action taken or suffered by them in good faith reliance thereon.

9.7 Proper Proof. In any case in which the Employer or the Plan Administrator is required under the Plan to take action upon the occurrence of any event, they shall be under no obligation to take such action unless and until proper satisfactory evidence of such occurrence has been received by them.

9.8 Fiduciary. The Plan Administrator shall have the authority to control the operations and administration of the Plan and shall act as a fiduciary of the Plan.

9.9 Delegates. The Plan Administrator may designate other persons to carry out fiduciary and other responsibilities under the Plan, and shall not be liable for the acts or omissions of such persons except as provided by law.

ARTICLE X

AMENDMENT OR TERMINATION

10.1 Amendment. The Employer may amend the Plan in writing at any time, and from time to time.

10.2 Termination. The Employer reserves the right to terminate the Plan at any time. If the Plan is terminated, claims incurred by Participants and Qualified Dependents prior to the date of such termination shall be payable under the terms of the Plan.

ARTICLE XI

MISCELLANEOUS

11.1 Nonalienation Clause. Any rights or benefits under the Plan may not be anticipated, assigned (either at law or equity), transferred or alienated by the Participant or Qualified Dependent in any manner. Such prohibition on alienation shall be a precondition for the receipt of benefits under the Plan.

11.2 Reliance. The Employer and the Plan Administrator may rely upon any certificate, statement or other representation made by any Participant or Qualified Dependent with respect to any fact required to be determined under any provisions of the Plan, and shall not be liable on account of the payment of any benefits or the doing of any act in reliance upon such certificate, statement or other representation. Any such certificate, statement or other representation made by a Participant or Qualified Dependent shall be conclusively binding upon the Participant and his or her Qualified Dependents, and the Participant and Qualified Dependents shall thereafter and forever be estopped from disputing the truth and correctness of such certificate, statement or other representation.

113 Limitation of Liability. No liability shall attach to or be incurred by any employee, officer or director of the Employer, under or by reason of the terms, conditions and provisions contained in the Plan, or for the acts or decisions taken or made thereunder or in connection therewith.

11.4 Usage. Whenever applicable, the masculine gender, when used in the Plan, will include the feminine or neuter gender, and the singular shall include the plural.

11.5 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or its inability to be enforced shall not affect other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included therein.

11.6 Governing Law. The Plan shall be construed in accordance with the laws of the state of California, to the extent not preempted by federal law.

11.7 Service in Multiple Capacities. Any fiduciary under the Plan may serve in more than one fiduciary capacity for the Employer with respect to the Plan.

11.8 Captions. The captions contained herein are inserted only as a matter of convenience and for reference, and in no way shall they define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall they affect the Plan or the construction of any provision thereof.

IN WITNESS WHEREOF, the Employer has caused the Plan to be executed on the _____ day of [month], 2009.

LOS ANGELES COMMUNITY COLLEGE DISTRICT

_____

Name (print):_____