THIS DOCUMENT IS THE

EMPLOYER-FUNDED

MEDICAL REIMBURSEMENT PLAN

FOR

BEAL CITY PUBLIC SCHOOLS

Effective Date of Plan:

July 1, 2012

Group Number: G-940

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ARTICLE I: ESTABLISHMENT OF THE PLAN

BEAL CITY PUBLIC SCHOOLS establishes the Beal City Public Schools Employer-Funded Medical Reimbursement Plan as of July 1, 2012, for the purpose of providing eligible Employees with tax-free medical reimbursement benefits. The Plan is intended to qualify as a medical reimbursement plan under Section 105(h) of the Code and is to be interpreted in a manner consistent with the requirements of that Section. The Plan is also intended to be a health reimbursement arrangement with no rollover feature, as permitted by IRS Notice 2002-45.

ARTICLE II: BASIC INFORMATION ABOUT THE PLAN

1.	*Plan Name*:	Beal City Public Schools Employer-Funded Medical Reimbursement Plan
2.	*Employer/Plan Sponsor/ Plan Administrator:*	Beal City Public Schools 3117 Elias Road Mt. Pleasant, Michigan 48858 (989) 644-3901
3.	*Taxpayer Identification No.:*	38-6001811
4.	*Group Number:*	G-940
5.	*Type of Plan:*	Welfare Benefit Plan
6.	*Claim Administrator:*	Administration Systems Research Corporation International (ASR) P.O. Box 6392 Grand Rapids, Michigan 49516-6392 (616) 957-1751 or (800) 968-2449
7.	*Type of Administration:*	The Claim Administrator administers claims for benefits pursuant to a contract with the Plan Administrator.
8.	*Agent for Service of Legal Process:*	Superintendent Beal City Public Schools 3117 Elias Road Mt. Pleasant, Michigan 48858 Service of process may be made upon the Plan Administrator.
9.	*Effective Date of Plan:*	July 1, 2012
10.	*Benefit Year:*	July 1 through June 30

ARTICLE III: FILING A CLAIM

To file a claim under this Plan, a Participant must first file a claim for health care expenses with the Employer's group health plan. **Any eligible expenses not covered under this claim by the Employer's plan will automatically be paid to the provider from the Employer-Funded Medical Reimbursement Plan. The Participant does not need to take further action to obtain reimbursement nor send the EOB from the Employer's group health plan back to ASR.**

Complete and proper claims for benefits made by Participants will be promptly processed, but in the event there are delays in processing claims, Participants shall have no greater rights to interest or other remedies against the Claim Administrator than as otherwise afforded by law. All information will be reviewed promptly. The Employer or ASR may request missing or additional data if needed. The Employer or ASR reserves the right to require an original claim form or billing statement.

ASR shall examine each claim for reimbursement and determine whether the claim is for expenses covered by this Plan. Generally, the Claim Administrator will automatically reimburse the provider of services unless the Participant submits proof of prior payment when filing the claim. The Employer reserves the right to pay the approved portion directly to the Participant.

All claims for reimbursement must be filed with the Claim Administrator no later than 12 months from the date of service. If a claim is not timely filed, it shall be denied. Eligible claims shall be paid up to the limit described in the Limit on Benefits section.

The Plan Administrator reserves the right to establish additional procedures for the submission of claims for reimbursement.

The Participant should keep a copy of the claim form and EOB statement(s) for each reimbursement request for his or her own records. Any questions can be directed to the Employer or ASR.

ARTICLE IV: BENEFITS

4.1 Covered Medical Expenses

For each Benefit Year, the Plan Administrator shall reimburse a Participant for Medical Expenses incurred during the Benefit Year by the Participant or the Participant's Dependent. For purposes of the Plan, a Medical Expense shall be incurred on the date the service or supply is provided. A Medical Expense is eligible for reimbursement only if all of the following circumstances apply:

(a) The Medical Expense was incurred as the result of a Participant's or the Participant's Dependent's treatment by an individual or entity designated as a participating (in-network) provider under the Employer's group health plan.

(b) The Medical Expense was eligible for payment under the Employer's group health plan on behalf of the Participant or one of his or her enrolled Dependents but for the application of that plan's in-network deductible provisions.

(c) The Medical Expense is ineligible to be paid or reimbursed by health insurance or any other source. However, if the Participant or his or her enrolled Dependents have health plan coverage other than through the Employer, this Plan shall pay before the other coverage.

(d) The Medical Expense was incurred while the Employee or former Employee was a Participant.

(e) The Medical Expense is not a premium paid to obtain health insurance.

4.2 Limit on Benefits

The maximum amount per Benefit Year that may be reimbursed to a Participant for Medical Expenses incurred is $1,400 for amounts applied toward the satisfaction of each Covered Person's in-network deductible under the Employer's group health plan (maximum $2,800 per family). **The Covered Person must satisfy the first $100 and the family must satisfy the first $200 of the in-network deductible under the Employer's group health plan.**

If a Participant has a change in status during the Benefit Year and adds or drops Dependents, causing the Participant to go from single to family coverage or vice versa under the Employer's group health plan, the Participant's maximum benefit for that Benefit Year shall be adjusted accordingly.

ARTICLE V: PARTICIPATION

5.1 Eligibility

Each Employee of the Employer who is eligible for and has elected coverage under the Employer's group health plan shall be eligible to participate in this Plan.

5.2 Participation

An Employee eligible under the Eligibility section on the effective date of the Plan is deemed to be a Participant as of that date. Any other eligible Employee shall be deemed to be a Participant on the date on which the Employee becomes a participant in the Employer's group health plan. The Employer's group health plan complies with the special enrollment rights requirements of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). As a result, because the participation provisions of this Plan are tied to the participation requirements of the Employer's group health plan, this Plan shall comply with the special enrollment rights requirements of HIPAA.

5.3 Termination of Participation

An individual who stops participating in the Employer's group health plan shall be considered to have terminated participation in this Plan as of that date. The individual shall be ineligible to receive reimbursement under the Plan for Medical Expenses incurred after the date the individual's participation in the Plan terminated, except to the extent the individual continues to participate in the Plan as described in the Continuation Coverage section.

5.4 Continuation of Coverage

During any time period in which the Plan is subject to the Public Health Service Act (PHSA), an individual whose participation in the Plan terminates under the Termination of Participation section has the option of continuing to participate in the Plan to the extent required by the continuation coverage provisions of PHSA. This Plan shall be considered a part of the Employer's group health plan for purposes of PHSA.

If an individual is eligible to elect PHSA, the individual may continue participation by making after-tax contributions on a monthly basis in an amount equal to 102% of the cost of identical coverage for similarly situated enrollees. This option of continuing to participate is generally available for the 18-month period immediately following the date when the individual's participation terminated and shall continue for any longer period as may be required by PHSA. However, the continuation coverage provided under this section shall terminate immediately upon the occurrence of any of the following events:

(a) The Plan Sponsor and its related employers within the meaning of Section 414 of the Code no longer offer any group health coverage for its Employees.

(b) The individual fails to timely make the required payments for the continuation coverage.

(c) The individual becomes, after the date of election of PHSA continuation coverage, covered under another group health plan. However, this provision does not apply during any time period the other group health plan contains any exclusion or limitation with regard to any pre-existing conditions other than an exclusion or limitation that does not apply to the individual or is satisfied by the individual owing to HIPAA.

(d) The individual becomes entitled to Medicare benefits (Part A or Part B) after the date of election of PHSA continuation coverage.

(e) The individual's continuation coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of active Employees (e.g., for fraud or misrepresentation in a claim for benefits).

Further, if an Employee ceases to be eligible to participate in the Plan because of service in the U.S. Military, the Plan shall comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 with respect to the Plan. However, these requirements shall only apply to the extent they provide the Employee with more favorable coverage than under PHSA.

5.5 Certificates of Creditable Coverage

The Plan shall comply with HIPAA by issuing any required Certificates of Creditable Coverage upon termination of participation. Such Certificates may be issued on a combined basis with the Certificates of Creditable Coverage for the Employer's group health plan.

ARTICLE VI: HIPAA PRIVACY AND SECURITY RULES

The provisions of this Article shall apply to the extent the Plan Sponsor is subject to HIPAA's privacy rules. For any time period where the Employer has fewer than 50 employees who are eligible to participate in the Plan and the Plan Sponsor administers the Plan without the assistance of a third-party administrator, the provisions of this Article shall not apply.

6.1 Permitted and Required Uses and Disclosure of Protected Health Information (PHI)

Subject to the Certification of Plan Sponsor section, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such PHI except for the following purposes:

(a) To perform Plan Administrative Functions that the Plan Sponsor does for the Plan.

(b) To obtain premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan.

(c) To modify, amend, or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

6.2 Conditions of Disclosure

The Plan Sponsor agrees to the following stipulations with respect to any PHI:

(a) To not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(b) To ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(c) To not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) To report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

(e) To make a Participant's or the Participant's Dependent's PHI available when he or she requests access in accordance with 45 CFR §164.524.

(f) To make a Participant's or the Participant's Dependent's PHI available when he or she requests an amendment and incorporate any amendments to that PHI in accordance with 45 CFR §164.526.

(g) To make available the information required to provide an accounting of disclosures of PHI to a Participant or the Participant's Dependent upon request in accordance with 45 CFR §164.528.

(h) To make its internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services in order to determine compliance by the Plan with the HIPAA privacy rules.

(i) To return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, if feasible, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made; if such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) To ensure that the adequate separation between the Plan and the Plan Sponsor, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that the terms set forth in the Adequate Separation between Plan and Plan Sponsor section below are followed.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/termination information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, the Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. The Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

6.3 Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in the Conditions of Disclosure section.

6.4 Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor provided that the Plan Sponsor uses such Summary Health Information only for the following purposes:

(a) To obtain premium bids from health plan providers to provide health coverage under the Plan.

(b) To modify, amend, or terminate the Plan.

6.5 Adequate Separation between Plan and Plan Sponsor

The Plan Sponsor will provide access to PHI to the Employees or classes of Employees listed in its HIPAA privacy policies and procedures for its group health plans. The Plan Sponsor will restrict the access to and use of PHI by these individuals to the Administrative Functions that the Plan Sponsor performs for the Plan. In the event any of these individuals do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Sponsor will impose

reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. The Plan Sponsor will impose such sanctions progressively (e.g., an oral warning, a written warning, time off without pay, and termination), if appropriate, and commensurate with the severity of the violation.

To comply with the HIPAA security rule on the required effective date, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

6.6 Disclosure of Certain Enrollment Information to Plan Sponsor

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in, or has terminated from, any health insurance issuer or health maintenance organization offered by the Plan.

6.7 Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

6.8 Participant Notification

Participants shall be notified of the provisions of this Article in a Notice of Privacy Practices.

ARTICLE VII: ADMINISTRATION

7.1 Powers of Plan Administrator

The Plan Administrator shall have the discretionary authority and power necessary to administer and meet its obligations under the Plan, including, without limitation, the following:

(a) Interpret the terms and provisions of the Plan.

(b) Decide all questions of eligibility for participation in the Plan.

(c) Make and enforce rules and regulations it deems necessary for the efficient administration of the Plan.

(d) Establish procedures by which Participants may apply for reimbursement under the Plan.

(e) Determine the rights under the Plan of any Participant applying for or receiving reimbursement.

(f) Reimburse all Participants entitled to reimbursement under the Plan in a timely manner.

(g) Administer the claim procedures provided for in this Article.

(h) Delegate specific responsibilities for the operation and administration of the Plan to any Employees or agents as it deems advisable.

(i) Maintain records pertaining to the Plan.

(j) Correct administrative and operational errors and omissions.

7.2 Administrative Services

The Plan Administrator shall enter into an administration agreement with the Claim Administrator, under which the Claim Administrator shall be given broad authority by the Plan Administrator to administer claims for reimbursement under the Plan and to render other administrative services on behalf of the Plan. The Claim Administrator shall review, interpret, and evaluate all claims for reimbursement under the Plan. However, the Claim Administrator shall have no power to modify any terms of the Plan or any benefit provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan. The Plan Administrator shall have the sole and final discretion regarding whether any expense is eligible for reimbursement under the Plan.

To the extent that these administrative responsibilities are assumed by the Claim Administrator under an administration agreement, the Employer and the Plan Administrator shall have no responsibility for these functions. The Plan Administrator may periodically amend the administration agreement or enter into similar agreements with any other Claim Administrator as the Plan Administrator shall in its discretion select.

7.3 Claim for Reimbursement

Claimants shall submit a claim for reimbursement to the Claim Administrator. The Claim Administrator shall evaluate the claim and notify the claimant of the approval or disapproval, in accordance with the provisions of the Plan.

(a) Claims Evaluation. Any claimant whose claim for reimbursement under the Plan is denied, in whole or in part, shall be given notice of the denial within 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan Administrator both determines that such an extension is necessary owing to matters beyond the control of the Plan Administrator and notifies the claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary owing to the failure of the claimant to submit the information required to decide the claim, the notice of extension shall describe the information still needed, and the claimant shall be granted 45 days from the receipt of the notice to provide the additional information. The Plan's period for making the benefit determination shall be the 15-day period beginning on the date the claimant furnishes the additional information. If the claimant does not provide the additional information within 45 days from the receipt of the extension notice, the Plan Administrator may issue a denial of the claim within 15 days after the end of the 45-day period.

(b) Approval of Claim. Except as may be provided in the Plan, if a claim is approved, payment shall be made as soon as administratively feasible.

(c) Denial of Claim. If a claim is denied in whole or in part, the Plan Administrator shall provide the claimant with a written or electronic notification of the denial. The notice shall set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, and describe any additional material or information necessary for the claimant to perfect the claim. The notice shall also describe the Plan's review procedures and related time limits. If the denial was based upon an internal rule, guideline, protocol, or other similar criterion, a copy shall be provided free of charge to the claimant upon request.

7.4 Special Rules for Non-Grandfathered Plans

This Plan is not a grandfathered plan under Health Care Reform. Accordingly, Participants must be provided with the following additional rights with respect to claims and appeals:

(a) A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan.

(b) In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

(c) The Plan cannot base decisions regarding the hiring, compensation, termination, or promotion of a claims adjudicator, medical expert, or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

(d) Certain benefit determination notices and appeal notices may be required to be provided in a non-English language where a minimum number of participants are literate only in the same non-English language. Further, the notices must include additional information such as information sufficient to identify the claim involved; the denial code, its corresponding meaning, and any standard used in denying the claim; and a description of the available internal appeals and external review processes.

(e) No court action may be brought by a claimant until exhausting the claim procedure provisions of the Plan. If the Plan fails to strictly adhere to the internal claim and appeal procedures prescribed by Health Care Reform, the claimant is deemed to have exhausted the internal claim and appeal procedures. As a result, the claimant may initiate an external review or file a legal proceeding.

(f) A Plan must offer an external review process. If the Plan is not subject to ERISA, the Plan may be subject to the applicable state external review processes for fully insured health plans and non-ERISA self-funded health plans. If the Plan is subject to ERISA, the applicable state external review processes may also be used if the state offers access to the processes for ERISA self-funded health plans.

Otherwise, the Plan will offer an external review procedure that satisfies U.S. Department of Labor regulations.

7.5 Review of Claim Denial

If a claim for reimbursement is denied, in whole or in part, the claimant shall have the right to request that the Plan Administrator review the denial.

(a) Claimant's Request for Review (or Appeal). To request review (or appeal), the claimant must file a written request for review with the Plan Administrator within 180 days following the denial of the claim. The claimant (or the claimant's duly authorized representative) may submit written comments, documents, records, and other information relating to the claim to the Plan Administrator. The information shall be considered without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.

(b) Administrative Review. The review shall not defer to the initial denial. The review shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial denial nor a subordinate of that individual.

(c) Administrative Decision. The Plan Administrator shall notify the claimant of the Plan's determination on review within 60 days after the Plan's receipt of the claimant's request for a review of a denial. The Plan Administrator shall provide a claimant with a written or electronic notification of the Plan's determination on review. The notice shall include the same information that must be included in the notification of the initial decision. The decision of the Plan Administrator on appeal shall be final and binding.

ARTICLE VIII: AMENDMENT AND TERMINATION

8.1 Amendment of the Plan

The Plan Sponsor may amend the Plan at any time. No amendment shall reduce or eliminate a Participant's right to receive reimbursement in accordance with the provisions of the Plan for Medical Expenses incurred before the date of amendment. Further, any amendment may be made retroactively to the extent permitted by the Code.

8.2 Termination of the Plan

Although the Plan Sponsor intends to continue the Plan indefinitely, the Plan Sponsor reserves the right to terminate or partially terminate the Plan at any time by action of its Board of Directors. If the Plan is terminated or partially terminated for any reason, this act shall not reduce or eliminate a Participant's right to receive reimbursement in accordance with the provisions of the Plan for Medical Expenses incurred before the date of termination.

ARTICLE IX: MISCELLANEOUS PROVISIONS

9.1 Standard of Care

The Plan Administrator shall administer the Plan in accordance with the terms of the Plan solely in the interest of the Participants and for the exclusive purpose of providing benefits to Participants and defraying the reasonable expenses of administration of the Plan. The Plan Administrator shall administer the Plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims.

The Plan Administrator shall not be liable for any act or omission relating to its duties under the Plan, unless the act or omission violates the standard of care described in this section. The Plan Administrator shall not be liable for any act or omission by another relating to the Plan.

9.2 Uniformity of Treatment

Any discretionary action taken under the Plan by the Plan Administrator shall be uniform in its application to similarly situated persons and shall be based upon the objective criteria set forth in the Plan.

9.3 Nondiscrimination Rules

If the Plan Administrator determines at any time that the Plan may not satisfy a nondiscrimination rule in the Code, the Plan Administrator may take whatever action it deems appropriate to assure compliance with the rule. Any action shall be taken uniformly with respect to similarly situated enrollees.

9.4 Funding of Benefits

Benefits under the Plan shall be paid from the Employer's general assets. Nothing in the Plan shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

9.5 Governing Law

This Plan shall be construed in accordance with the Code and the laws of the state of Michigan.

ARTICLE X: DEFINITIONS

Certain words and phrases used in this Plan are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Where these terms are used elsewhere in the Plan with the meanings assigned to them below, the terms usually will be capitalized, and where these terms are used with their common, non-technical meanings, the terms usually will not be capitalized (except when necessary for proper grammar).

10.1 Benefit Year

The term "Benefit Year" means each 12-consecutive-month period beginning **July 1** and ending **June 30**.

10.2 Board of Directors

The term "Board of Directors" means the governing body of the Employer.

10.3 Business Associate

The term "Business Associate" means a person or entity that does the following:

(a) Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.).

(b) Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

10.4 Claim Administrator

The term "Claim Administrator" means **ADMINISTRATION SYSTEMS RESEARCH CORPORATION INTERNATIONAL (ASR)**, the firm retained by the Plan Administrator to handle the processing, payment, and settlement of benefit claims and other duties specified in a written administration agreement. ASR is not a fiduciary and does not insure that any medical expenses of Participants will be paid. If there is no Claim Administrator (including circumstances owing to the termination or expiration of the administration agreement with ASR, or if the term is used in connection with a duty not expressly assumed by ASR in a signed writing) the term shall mean the Plan Administrator.

10.5 Code

The term "Code" means the Internal Revenue Code of 1986, as amended.

10.6 Dependent

The term "Dependent" means an individual who is a spouse of an Employee or a dependent, as defined in Section 152 of the Code, determined without regard to Section 152(b)(1), (b)(2), and (d)(1)(B) of the Code, of an Employee. Further, the term "Dependent" also includes an Employee's child as defined under Code Section 152(f)(1) who has not attained age 27 as of the end of the calendar year, as provided by Code Section 105(b), as amended by the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010.

10.7 Employee

The term "Employee" means any person who, for tax purposes, is considered by the Employer to be a common-law employee of the Employer. If an independent contractor or a leased employee is subsequently characterized as a common-law employee of the Employer, that person shall not

be eligible to participate in the Plan for any time period before the date on which the determination is made that that person is a common law employee of the Employer.

10.8 Employer

The term "Employer" means **BEAL CITY PUBLIC SCHOOLS**. It also means any related employers to the Plan Sponsor (within the meaning of Section 414 of the Code, or where there is at least a 25% common-ownership interest) who participate in the Employer's group health plan.

10.9 Health Insurance Portability and Accountability Act of 1996

The term "Health Insurance Portability and Accountability Act of 1996" means a federal law that limits the use of pre-existing condition exclusions, waiting periods, and health status exclusions; eliminates certain discriminatory exclusions, such as for self-inflicted injuries; and promulgates administrative simplification provisions. See HIPAA.

10.10 HIPAA

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

10.11 Medical Expenses

The term "Medical Expenses" means any expenses incurred by a Participant or the Participant's Dependent for medical care that would be deductible under Section 213 of the Code (without regard for the 7.5% of adjusted gross income limitation).

10.12 Participant

The term "Participant" means an Employee who has satisfied the participation requirements under Article V and is enrolled in the Plan.

10.13 PHI

The term "PHI" means Protected Health Information. See Protected Health Information.

10.14 PHSA

The term "PHSA" means the Public Health Service Act, as amended. See Public Health Service Act.

10.15 Plan

The term "Plan" means Beal City Public Schools Employer-Funded Medical Reimbursement Plan, as periodically amended.

10.16 Plan Administrative Functions

The term "Plan Administrative Functions" means activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan. Plan Administrative Functions include quality assurance, employee assistance, claims

processing, auditing, monitoring, and management of carve-out-plans such as vision and dental. PHI for these purposes may not be used by or between the Plan or Business Associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan Administrative Functions specifically do not include any employment-related functions.

10.17 Plan Administrator

The term "Plan Administrator" means **BEAL CITY PUBLIC SCHOOLS**, the named fiduciary responsible for the day-to-day operation and administration of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

10.18 Plan Sponsor

The term "Plan Sponsor" means **BEAL CITY PUBLIC SCHOOLS**.

10.19 Protected Health Information

The term "Protected Health Information" means information that is created or received by the Plan or a Business Associate of the Plan, and relates to the past, present, or future physical or mental health or condition of a Participant or the Participant's Dependent; the provision of health care to a Participant or the Participant's Dependent; or the past, present, or future payment for the provision of health care to a Participant or the Participant's Dependent; and that identifies the Participant or the Participant's Dependent or for which there is a reasonable basis to believe the information can be used to identify the Participant or the Participant's Dependent (whether living or deceased). The following components of a Participant's or the Participant's Dependent's information are considered to enable identification:

- Names
- Street address, city, county, precinct, or zip code
- Dates directly related to a Participant's or the Participant's Dependent's receipt of health care treatment, including birth date, health facility admission and discharge dates, and date of death
- Telephone numbers, fax numbers, and electronic mail addresses
- Social Security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code

See PHI.

10.20 Public Health Service Act

The term "Public Health Service Act" means a federal law that gives workers of state and local governmental employers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances. See PHSA.

10.21 Summary Health Information

The term "Summary Health Information" means information that may be individually identifiable health information. It summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a health plan. The information described in 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information may be aggregated to the level of five-digit ZIP codes.

ARTICLE XI: NO RIGHTS UNDER ERISA

ERISA does not apply to this Plan. The fact that the Plan may, in some respects, conform to the requirements of ERISA, or include provisions often found in plans that are subject to ERISA, shall not be interpreted or construed to mean that the Plan is intended to comply with ERISA, or that Employees, Participants, or beneficiaries have any rights under ERISA.

RULES OF CONSTRUCTION

The use of the singular includes the plural where applicable and vice versa. The headings do not limit or extend the provisions of the Plan. Capitalized terms, except where capitalized solely for grammar, have the meaning provided in the Plan. Errors cannot cause the Plan to provide a benefit that a Participant or the Participant's Dependent is not otherwise entitled to under the Plan. If a provision is unenforceable in a legal proceeding, the provision shall be severed solely for purposes of that proceeding and the remaining provisions of the Plan shall remain in full force.

Beal City Public Schools has caused this Plan to be effective as of 12:01 a.m. local time, July 1, 2012.

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