THE PUBLIC SCHOOLS OF PETOSKEY
LIMITED PURPOSE HEALTH CARE
FLEXIBLE SPENDING ACCOUNT PLAN

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1.0 PURPOSE OF PLAN

1.1 Establishment of Plan. The Public Schools of Petoskey (the "Employer"), with this instrument establishes this Limited Purpose Health Care Flexible Spending Account Plan as a separate plan document, ancillary to The Restated Public Schools of Petoskey Cafeteria Plan, which will be known as "The Public Schools of Petoskey Limited Purpose Health Care Flexible Spending Account Plan" and for convenience shall be referred to in this document as the "Plan."

1.2. Intent of the Plan. The Plan is intended to meet the requirements of a health care flexible spending account plan under Sections 125, 105 and 223 of the Internal Revenue Code of 1986, as amended (the "Code") and ERISA (to the extent ERISA applies to this Plan) and is to be interpreted in a manner consistent with applicable laws.

1.3 Purpose of the Plan. The primary purpose of the Plan is to attract and retain qualified personnel by allowing them to contribute toward the cost of the benefits described in this Plan on a pre-tax basis, under a salary reduction agreement in accordance with the requirements of Sections 125, 105 and 223 of the Code.

1.4 Plan not an Employment Agreement. This Plan is not an employment agreement between any Participant and the Employer, nor does this Plan give any Participant any right to be retained as an employee of the Employer.

1.5 Rights of Employees. The rights of Employees under the Plan are hereby acknowledged to be legally enforceable. Except as may be permitted under applicable law, the Plan is maintained for the exclusive benefit of Employees of the Employer who are eligible to be participants in the Plan. The Plan has been established with the intention of being maintained for an indefinite period of time.

2.0 DEFINITIONS

The following definitions apply to this Plan and all documents and instruments related to this Plan:

2.1 Administrator -- The Employer, a committee created by the Board of the Employer, or such other person or entity as may be engaged from time to time by the Employer to supervise the administration of the Plan.

2.2 Benefits -- The amounts paid to Participants from the Health Care Reimbursement Account maintained under the Plan as reimbursements for Eligible Medical Expenses paid or incurred by a Participant.

2.3 **Board of Education or Board** -- The duly constituted Board of Education of the Employer, according to the laws of the State of Michigan and the Employer's governing instruments.

2.4 **Cafeteria Plan** -- The Restated Public Schools of Petoskey Cafeteria Plan, being the cafeteria plan maintained by the Employer under Section 125 of the Code. The provisions of the Cafeteria Plan are incorporated by reference into this Plan. Defined terms shall have the same meanings in this Plan and the Cafeteria Plan, except this Plan will control the meaning of defined terms that are defined differently in this Plan where those terms are used in this Plan.

2.5 **Claimant** -- A person submitting a claim for Benefits under this Plan. A Claimant can be a Participant, a Beneficiary of a Participant where appropriate, or a legal representative of a Participant or a Beneficiary who would otherwise be the Claimant, but for a condition making the Participant or Beneficiary incapable of submitting the claim.

2.6 **Code** -- The Internal Revenue Code of 1986, as amended.

2.7 **Collective Bargaining Agreement** -- A collective bargaining agreement between the Employer and Employees who are members of a relevant bargaining unit.

2.8 **Dependent** -- Any individual who is: (1) a dependent as defined as in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; (2) any child (as defined in Code Section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27; and, (3) any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). Notwithstanding the foregoing, this Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order, even if the child does not meet the definition of "Dependent."

2.9 **Effective Date** -- The Effective Date of this Plan is September 1, 2013.

2.10 **Eligible Employee** -- An Employee who has met the eligibility requirements for participation in the Cafeteria Plan. This Plan is intended to provide "permitted coverage" for Employees who participate in Health Savings Accounts in accordance with Code Section 223. An Employee who participates in a general purpose health care flexible spending account plan sponsored by the Employer is not eligible to participate in this Plan.

2.11 Eligible Medical Expenses -- Amounts paid by a Participant while the Participant is participating in this Plan, and which are paid for health care expenses authorized under Code Section 213(d), provided that such expenses shall be within the coverage permitted under Code Section 223, and written guidance promulgated pursuant thereto, including Rev. Rul. 2004-45. As such, a Participant in the Plan may elect to reduce salary for the purpose of paying Eligible Medical Expenses, including dental and vision expenses, and any other permitted expenses; provide that after the minimum deductible under the high deductible health plan (as required by Code Section 223(c)(2)(A)) in which the Participant participates is satisfied, all Eligible Medical Expenses subsequently incurred may be reimbursed to the extent of the Benefit elected by the Participant. Medical expenses paid or reimbursed by (1) any insurance policy or policies, whether owned by the Employer or the Participant, or (2) any federal or state health or accident plan, shall not be eligible for reimbursement under this Plan. Notwithstanding the foregoing or prior practices under the Plan, the term "Eligible Medical Expenses" does not include expenses incurred for medicines or drugs unless the medicine or drug is a prescribed drug (except insulin). In order for an Over-the-Counter medicine or drug (that is, a medicine or drug that is sold lawfully without a prescription) to be an Eligible Medical Expense, it must be compatible with the limited purposes of this Plan and it must be obtained pursuant to a physician's prescription.

2.12 Employee -- Any person who is classified as an "Employee" under the terms of the Cafeteria Plan.

2.13 Employer -- The Public Schools of Petoskey, a governmental entity and public school district organized and existing under the laws of the State of Michigan.

2.14 Health Care Reimbursement Account -- The account maintained by the Administrator for each Participant into which amounts from the reduction of the Participant's Salary are set aside to pay for Eligible Medical Expenses.

2.15 Participant -- An Eligible Employee who has satisfied the requirements for participation in this Plan contained in Section 3.0 and who has elected to participate in this Plan.

2.16 Plan -- This Health Care Flexible Spending Account Plan, under Section 125 and 105 of the Code.

2.17 Plan Year -- The twelve (12) month period commencing of September 1 and ending August 31.

2.18 Salary -- The same as "earned income" as that term is defined in Section 32(c)(2) of the Code.

2.19 Spouse -- The spouse of a Participant, but shall not include an individual legally separated from the Participant under a decree of legal separation.

3.0 ELIGIBILITY

3.1 Electing Coverage. An Eligible Employee may become a Participant in this Plan for a Plan Year by electing Benefits through a written election filed during the Election Period for the Plan Year, in accordance with the terms of the Cafeteria Plan. An election to receive benefits under this Plan may not be changed or revoked by the Participant during the Plan Year, except as permitted under Section 4.3 of the Cafeteria Plan, or as otherwise permitted by applicable sections of the Code, and regulations under the Code.

3.2 Termination of Coverage. A Participant who ceases to be an Eligible Employee shall no longer be eligible to receive Benefits under the Plan as of the date the Employee ceases to satisfy the requirements for eligibility. Participation in the Plan may thereafter be renewed upon satisfaction of the requirements contained in Section 3.1.

3.3 Funding. The cost of Benefits under this Plan will be paid by Participants through Salary Reduction Agreements with the Employer, as described in the Cafeteria Plan.

4.0 BENEFITS

4.1 Entitlement to Reimbursement. Subject to the limitations of Section 5.0, a Participant will be entitled to Benefits under this Plan with regard to a Plan Year for any Eligible Medical Expenses that arise during that Plan Year. Eligible Medical Expenses will be considered incurred when the services or goods giving rise to Eligible Medical Expenses are rendered or delivered, regardless of when the Participant is formally billed, charged or pays for the Eligible Medical Expense. The amount of annual reimbursement to which a Participant is entitled may not exceed the lesser of the amount of the Benefit specified by the Participant in the Participant's Salary Reduction Agreement or the maximum amount stated in Section 5.0.

4.2 Claims for Benefits. If a Participant wants to receive a Benefit under the Plan for Eligible Medical Expenses, the Participant must submit to the Administrator a completed claim form on a form prescribed by the Administrator, along with proof of payment by the Participant of the Eligible Medical Expense, including but not limited to all hospitalization, doctor, dental, pharmacy or other medical bills. The Participant must provide all of the information requested by the claim form, to the full satisfaction of the Administrator. The Administrator may require verification from the Participant that no part of the claim will or may be paid or reimbursed from another source. The Administrator may establish procedures, as the Administrator sees fit, to facilitate the determination of eligibility for Benefits and to expedite the payment of Benefits. Participants are responsible for assuring that all information on record with the Administrator about the Participant, the Participant's Dependents and the Eligible Medical Expenses claimed by the Participant are accurate, complete and up-to-date.

If a claim is denied, the Participant may appeal the denial under the procedures that are set forth in the Cafeteria Plan.

4.3 Payment of Claims. Within a reasonable time after receiving the claim form described in Section 4.2, the Administrator will notify the Participant whether the claim has been accepted or denied. If a claim is accepted, payments from the Participant's Health Care Reimbursement Account will be made directly to the Participant, up to the amount of annual Benefit elected by the Participant in the Participant's Salary Reduction Agreement, less amounts previously reimbursed for that Plan Year. No payments will be made from the Participant's Health Care Reimbursement Account to the provider of the services or goods giving rise to the claim.

4.4 Excess Claims. The reimbursement of a Participant's Eligible Medical Expenses is limited to the amount of annual Benefits elected by the Participant in the Participant's Salary Reduction Agreement, less amounts previously reimbursed for that Plan Year. If a claim by a Participant exceeds the amount of the Participant's remaining annual Benefit, the excess claim will be denied.

4.5 Cessation of Benefits. No Benefits will be paid to a Participant for expenses incurred after the date that the Participant ceases to be an Eligible Employee. Requests for Benefits for Eligible Medical Expenses incurred before a Participant ceases to be an Eligible Employee may be submitted through the sixtieth (60th) day following the date upon which the Participant ceased to be an Eligible Employee.

4.6 Grace Period; End of Year Claims. Notwithstanding anything contained in this Plan to the contrary, amounts remaining in a Participant's Health Care Reimbursement Account shall not be forfeited until the expiration of a grace period immediately following the end of each Plan Year. The grace period shall apply to all Participants in the Plan. Eligible Medical Expenses under this Medical Expense Reimbursement Plan incurred during the grace period may be paid or reimbursed from benefits or contributions remaining unused at the end of the immediately preceding Plan Year. The grace period shall commence on the September 1 of the year immediately following the expiration of the Plan Year, and shall expire on the following November 15. Any Participant who has unused benefits or contributions to a Health Care Reimbursement Account from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses during the grace period, may be paid or reimbursed for those expenses from the unused benefits or contributions as if the Eligible Medical Expenses had been incurred in the immediately preceding Plan Year. However, during the grace period, the Plan shall not cash-out or convert unused benefits or contributions to any other taxable or nontaxable benefit. A Participant may submit claims for reimbursement of Eligible Medical Expenses incurred through the expiration of the grace period until the December 31 next following the last day of the Plan Year (the "run-out period"). Any balance remaining in a Participant's Health Care Reimbursement Account after the payment of all claims properly submitted with respect to a Plan Year (plus the grace period), on or before the December 31 next following the end of the Plan Year will be deemed forfeited.

4.7 Claims in Respect of a Deceased Participant. If a Participant dies during a Plan Year, a legal representative of the Participant may submit claims for Eligible Medical Expenses incurred by the Participant before the Participant's death. All such claims must be submitted

within the 60-day period that begins as of the Participant's date of death. Any amounts remaining credited to the Participant's Health Care Reimbursement Account after the disposition of all such claims submitted by the Participant's legal representative within the 60-day period will be deemed forfeited.

5.0 LIMITATIONS ON BENEFITS

5.1 Dollar Limit on Benefits. A Participant may elect a Benefit under this Plan each Plan Year; provided, however, that the maximum Benefit that may be elected shall not be more than $2,500. The maximum dollar limit on this Benefit shall be adjusted for inflation as provided under Code Section 125(i)(2). Amounts contributed by a Participant to the Participant's Health Care Reimbursement Account to fund Benefits under this Plan not paid out in the form of Benefits by the latest time allowed under Section 4.6 will be deemed forfeited.

5.2 Modification of Elections. The Administrator is authorized to modify elections of Participants under this Plan to comply with any legal requirements relating to the Plan. All such modifications will be implemented on a uniform basis as to similarly situated Participants.

6.0 PLAN ADMINISTRATION

6.1 Administrator. Except for responsibilities reserved to the Employer, the administration of this Plan will be under the supervision of the Administrator. To the extent ERISA applies to this Plan, the Administrator will be the named fiduciary of the Plan for purposes of ERISA with the discretionary authority to control and manage the operation and administration of this Plan, in all of its details, subject to applicable law, including without limitation:

A. Interpretation of the terms and provisions of the Plan; provided that the Administrator may not amend or modify the terms of the Plan.

B. Making and enforcing those written rules and regulations, and promulgating those forms, which it deems necessary for the efficient administration of the Plan.

C. Determining the rights under the Plan of any Participant.

D. Paying expenses incident to the administration of the Plan.

E. Conducting the appeal procedure set forth in Section 6.3 of the Cafeteria Plan.

F. Maintaining records and accounts pertaining to the Plan.

G. Appointing individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal and actuarial counsel.

6.2 **Account Balances; Statements**. The Administrator will periodically during each Plan Year submit to each Participant statements of their Health Care Reimbursement Account balances. In addition, the Administrator will provide each Participant a year-end statement of the amount of Benefits they received during the previous Plan Year. This year-end statement will be furnished to the Participant by the end of the first month following the end of such Plan Year.

7.0 AMENDMENT AND TERMINATION OF PLAN

7.1 **Amendment**. This Plan is intended to be maintained indefinitely. Notwithstanding, the Employer may amend the Plan to comply with applicable law and regulations, provided that such an amendment does not cause the Plan to cease being maintained for the exclusive benefit of Participants, alter the requirements for eligibility to participate or benefit levels, reduce or eliminate a Participant's right to receive a benefit which the Participant already has a present right to receive, or increase the duties of the Administrator, unless the Administrator otherwise agrees. An amendment adopted by the Employer for the purpose of complying with applicable law and regulations shall be submitted by written notice to the appropriate representatives of all bargaining units whose members are eligible to participate in this Plan, at least 30 days before such amendment is to become effective. Any proposed amendment that will affect eligibility to participate in this Plan or benefit levels will not become effective without the consent of the bargaining units whose members are eligible to participate in the Plan. The Administrator will not be bound to the terms of any amendment until a true and accurate copy of the duly signed amendment has been delivered to the Administrator by the Employer.

7.2 **Termination; Discontinuance of Benefits**. Unless prohibited by applicable law, and with the consent of bargaining units whose members are eligible to participate in this Plan, the Employer may terminate or partially terminate the Plan at any time. If the Plan is terminated or partially terminated for any reason, amounts credited to accounts maintained under the Plan for Participants will continue to be applied for the exclusive benefit of the Participants. The termination of the Plan will not reduce or eliminate Participants' rights to reduce Salary earned before the date of the termination, nor affect the right of Participants to have Benefits paid under the provision of the Plan, but only to the extent that there are amounts credited to their accounts available for that purpose. Participants will not have the right to reduce, under this Plan, Salary earned after the date of the termination. Notice of a discontinuance or termination is not required except by the terms of any Policy, Benefit Plan or by law.

8.0 MISCELLANEOUS

8.1 Uniform Rules. The terms and conditions of this Plan and all rules promulgated by the Administrator under authority granted by this Plan will be interpreted and enforced in a uniform manner as to all similarly situated persons, and no action on the part of the Administrator or the Employer will discriminate in favor of highly compensated employees.

8.2 Construction. The Employer's intent and purpose in adopting this Plan is to establish a plan of welfare benefits consistent with relevant sections of the Internal Revenue Code. The Employer intends to comply fully with statutes and regulations governing wages, compensation, and fringe employment benefits. All questions arising in the construction and administration of this Plan must be resolved accordingly. This Plan is to be construed under the laws of the State of Michigan, except to the extent that the laws of the United States of America have superseded those state laws. The headings and subheadings in this Plan have been inserted for convenience only and are not to be construed as a part of this Plan. If a provision of this Plan is invalid, that invalidity does not affect other Plan provisions.

8.3 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of a Participant, before actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under this Plan will be void and of no effect as against the Plan, the Administrator or the Employer. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

8.4 Counterparts. This instrument may be executed in any number of counterparts, each of which shall be deemed an original.

9.0 PATIENT PRIVACY RIGHTS

9.1 Uses and Disclosures of PHI. The Plan and the Plan Sponsor may disclose a Plan Participant's Protected Health Information ("PHI") to the Employer (or to the Employer's agent) for the following Plan administration functions under and to the extent not inconsistent with the Health Insurance Portability and Accountability Act ("HIPAA") regulations, including 45 CFR 164.504(a):

a. Benefits Department: The Benefits Department (or the Employer's office performing equivalent functions) may use PHI for purposes of performing the Plan functions of customer service, the determination of claims and eligibility for benefits, and appeals.

b. Benefits Accounting: The Benefits Accounting Department (or the Employer's office performing equivalent functions) may use PHI for purposes of performing the Plan functions of the payment or funding of

claims (such as through salary reduction), and reconciliation of enrollment and contributions.

c. Business Systems Support and Information Technology: The Business Systems Support and Information Technology Department (or the Employer's office performing equivalent functions) may use PHI for purposes of performing the Plan functions of system support for eligibility, contributions, claims and administrative fees and providing reconciliation and reports to Benefits Department and Benefits Accounting.

9.2 Restriction on Plan Disclosure to the Employer. Neither the Plan nor any of its Business Associates will disclose PHI to the Employer except upon the Plan's receipt of the Employer's certification that the Plan has been amended to incorporate the agreements of the Employer under Section 9.3, except as otherwise permitted or required by law.

9.3 Privacy Agreements of Employer. As a condition for obtaining PHI from the Plan, its Business Associates, and Insurers, the Employer agrees it will:

a. Not use or further disclose such PHI other than as permitted by Section 9.2 of this Article, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;
b. Ensure that any of its agents, including a subcontractor, to whom it provides PHI agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
c. 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 Employer;
d. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware;
e. Make the PHI of a particular Participant available for purposes of the Participant's requests for inspection, copying, and Amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;
f. Make the PHI of a particular Participant available for purposes of required accounting of disclosures by the Employer pursuant to the Participant's request for such an accounting in accordance with HIPAA regulation 45 CFR 164.528;
g. Make the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
h. If feasible, return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer

agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

i. Ensure that there is adequate separation between the Plan and the Employer by implementing the following terms:

(1) Employees With Access to PHI: Identifying employees or other individuals under the control of the Employer that may access PHI received from the Plan.

(2) Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Employer for the Plan.

(3) Mechanism for Resolving Noncompliance: If the Employer's HIPAA Privacy Officer determines that any person described in (1), above, has violated any of the restrictions of this Article, then such individual shall be disciplined in accordance with the policies of the Employer established for purposes of privacy compliance, up to and including dismissal from employment. The Employer shall maintain records of such violations, which shall include the identities of the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

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

9.4 PHI not Subject to this Article. Notwithstanding the foregoing, the provisions of this Article shall not apply to uses or disclosures: of Summary Health Information under 45 CFR 164.504 (f)(l)(ii) for purposes of obtaining premium bids or for modifying, amending, or terminating the Plan; or of information under 45 CFR 164.504(iii) pertaining to whether an individual is participating in the Plan; or of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

9.5 Definitions. All capitalized terms within this Article not otherwise defined herein or in the Plan shall have the meaning given them under HIPAA.

10.0 CONTINUATION COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

10.1 Generally. To the extent required by Federal law, a Participant, and the Participant's Spouse and Dependents, whose coverage terminates under the Plan because of a COBRA qualifying event, shall be given the opportunity to continue coverage under this Plan on an after-tax basis. Individuals will be eligible for COBRA continuation coverage only if they have a positive Health Care Reimbursement Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event.). If COBRA is elected, it will be available only for the year in which the qualifying event occurs; such COBRA coverage for the Health Care Reimbursement Account will cease at the end of the year and cannot be continued for the next plan year. Individuals will not be eligible for COBRA continuation coverage if they have a negative Health Care Reimbursement Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event.)

10.2 Notice by Employer. The Employer shall notify the Administrator of one of the following qualifying events; which results in the termination of participation in the program.

(a) the death of the covered Employee;
(b) the termination of a covered Employee's employment (or ineligibility for coverage due to a reduction in hours);

The Employer shall give the notice not later than thirty-one (31) days after the later of:

(a) an individual's loss of coverage, or
(b) one of the qualifying events shown above.

10.3 Notice by Administrator. Within fourteen (14) days after receiving notice by either an Employee or by the Employer of one of the qualifying events as shown above, the Administrator shall notify the Employee or the Dependent of:

(a) the right to elect to continue coverage, and
(b) the time period in which the election must be made. Notice to an Employee's Spouse is considered to be notice to all children living with that Spouse.

10.4 Election Period. An individual will have sixty (60) days to notify the Plan Administrator if he will continue coverage. The sixty (60) days is from the later of:

(a) the day the coverage is lost; or
(b) the day on which the Plan Administrator sends notice of the right to elect continuation of coverage.

An individual who elects continuation of coverage will be allowed to elect continuation of coverage on behalf of all dependent children whose coverage would terminate due to the Employee's termination of group Health coverage. Evidence of insurability cannot be a condition of continuation of coverage.

10.5 <u>Continuation Coverage</u>. Individuals whose coverage is continued shall receive identical coverage provided under the group plan for similarly situated active Employees and/or Dependents.

THE PUBLIC SCHOOLS OF PETOSKEY

Date:____________________ By:__________________________________

Its:__________________________________

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