

THORNAPPLE KELLOGG SCHOOLS

MEDICAL REIMBURSEMENT PLAN

(As of July 1, 2010)

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THORNAPPLE KELLOGG SCHOOLS
MEDICAL REIMBURSEMENT PLAN

Article 1

Establishment of the Plan

Thornapple Kellogg Schools established the Thornapple Kellogg Schools Medical Reimbursement Plan 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 Section 105(h). This document sets forth the terms of the Plan as of July 1, 2010.

Article 2

Definitions

The following terms used in the Plan shall have the meanings described in this Article unless the context clearly indicates another meaning.

2.1 Benefit Administrator

“Benefit Administrator” means the entity, if any, designated under Section 6.2 to be responsible for the administration of some or all of the benefits under the Plan.

2.2 Board of Education

“Board of Education” means the governing body of Employer.

2.3 COBRA

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

2.4 Code

“Code” means the Internal Revenue Code of 1986, as amended.

2.5 Dependent

“Dependent” means an individual who is a spouse of an Employee and/or a dependent (as defined in Section 152 of the Code, determined without regard to Sections 152(b)(1), (b)(2) and (d)(1)(B) of the Code) of an Employee and who is enrolled in Employer’s Health Plan.

2.6 Employee

“Employee” means any person who, for tax purposes, is considered by Employer to be a common-law employee of Employer. A person who is treated by Employer as a leased employee or an independent contractor is not an Employee.

2.7 Employer

“Employer” means Plan Sponsor. It also means any related employers to Plan Sponsor (within the meaning of Section 414 of the Code) who participate in the Health Plan.

2.8 Health Plan

“Health Plan” means the group health benefits plan sponsored by Plan Sponsor.

2.9 HIPAA

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

2.10 Medical Expenses

“Medical Expenses” means medical expenses described in Section 4.1 which are 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).

2.11 Participant

“Participant” means an Employee who has satisfied the participation requirements under Article 3 and is enrolled in the Plan.

2.12 Plan

“Plan” means the Thornapple Kellogg Schools Medical Reimbursement Plan.

2.13 Plan Administrator

“Plan Administrator” means the named fiduciary responsible for the operation and administration of the Plan. Plan Sponsor shall be the Plan Administrator.

2.14 Plan Sponsor

“Plan Sponsor” means Thornapple Kellogg Schools.

2.15 Plan Year

For all administrators and non-union Employees, “Plan Year” means the 12-consecutive-month period beginning on July 1 and ending on the following June 30. For all

union Employees, “Plan Year” means the 12-consecutive-month period beginning on September 1 and ending on the following August 31.

Article 3

Participation

3.1 Eligibility and Participation

Each Employee of Employer who is eligible for and has elected coverage under the Health Plan shall be eligible to participate in the Plan. An eligible Employee shall become a Participant on the later of:

- (a) The effective date of the Plan;
 - (b) The date the Employee begins to participate in the Health Plan;
- and/or
- (c) For purposes of Section 4.1(b), July 1, 2010.

The Health Plan complies with the special enrollment rights requirements of HIPAA. As a result, because the participation provisions of this Plan are tied to the participation requirements of the Health Plan, this Plan shall comply with the special enrollment rights requirements of HIPAA.

3.2 Termination of Participation

An individual who stops participating in the Health Plan shall also terminate participation in the Plan as of that date. The individual shall be ineligible to receive reimbursement under the Plan for Medical Expenses incurred after the participation termination date, except to the extent the individual continues to participate in the Plan as described in Section 3.3.

3.3 Continuation Coverage

During any time period in which the Plan is subject to COBRA, an individual whose participation in the Plan terminates under Section 3.2 has the option of continuing to participate in the Plan to the extent required by the continuation coverage provisions of COBRA. This Plan shall be considered a part of the Health Plan for purposes of COBRA.

If an individual is eligible to elect COBRA, 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 Participants. 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 COBRA. However, the continuation coverage provided under this Section shall terminate immediately upon the occurrence of any of the following events:

(a) Plan Sponsor and its related employers within the meaning of Section 414 of the Code no longer offers 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 continuation COBRA 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 which does not apply to the individual or is satisfied by the individual due to HIPAA;

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

(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 due to 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 COBRA.

3.4 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 Health Plan.

Article 4

Benefits

4.1 Eligible Medical Expenses

For each Plan Year, Employer shall reimburse a Participant for a portion of the Medical Expenses incurred by the Participant or the Participant's Dependents during the Plan Year. For purposes of the Plan, the term "Medical Expenses" means the following:

(a) For all Employees who participate in the Health Plan, Medical Expenses means expenses incurred to satisfy the prescription drug co-pays under the Health Plan. For each Plan Year, the reimbursement of prescription drug co-pays shall apply to amounts in excess of a threshold amount determined by Employer, subject to any applicable collective bargaining agreement. The threshold amount currently is \$200 in prescription drug co-pays incurred by a Participant and, if applicable, the Participant's Dependents during that Plan Year.

(b) For administrators and non-union Employees who participate in the Health Plan, in addition to (a) above, effective as of July 1, 2010, Medical Expenses also means 50% of the expenses incurred by a Participant and, if applicable, the Participant's Dependents toward satisfying the deductible under the Health Plan.

For purposes of the Plan, a Medical Expense shall be incurred on the date the service or supply is provided. Eligible Medical Expenses are subject to the limitations in Section 4.2.

4.2 Limitations on Benefits

A Medical Expense is eligible for reimbursement only if:

- (a) The Medical Expense satisfies the requirements of Section 4.1.
- (b) The Medical Expense is ineligible to be paid or reimbursed by health insurance or any other source.
- (c) The Medical Expense was incurred while the Employee or former Employee was a Participant.
- (d) The Medical Expense is not a premium paid to obtain health insurance.

4.3 Reimbursement

A Participant shall request reimbursement using a form provided by the Plan Administrator (or the Benefit Administrator, if one is appointed). Any bills or invoices documenting the Medical Expense shall accompany the form. The Plan Administrator may establish additional procedures for the submission of claims for reimbursement.

The Plan Administrator (or the Benefit Administrator, if one is appointed) shall verify each claim for reimbursement and determine whether the claim is for expenses covered by the Plan. All reimbursement checks shall be made payable to the Participant. The Plan shall not recognize an assignment of benefits. Claims shall be paid at least monthly.

All claims for reimbursement of Medical Expenses incurred during a Plan Year must be filed with the Plan Administrator (or the Benefit Administrator, if one is appointed) no later than 90 days after the end of the Plan Year. If a claim is not timely filed, it shall be denied (see the "Claim for Reimbursement" and "Review of Claim Denial" sections in Article 6). At the end of the Plan Year, upon termination of participation, or upon termination of the Plan, all eligible claims incurred as of the applicable date shall be paid, up to the limitations described in Section 4.2.

4.4 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 Participants.

4.5 Funding of Benefits

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

Article 5

HIPAA Privacy and Security Rules

5.1 This Article Generally

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

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

Subject to obtaining written certification pursuant to Section 5.4, the Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

- (a) Performing Plan Administrative Functions which Plan Sponsor performs for the Plan.
- (b) Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan.
- (c) Modifying, amending or terminating the Plan.

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

5.3 Conditions of Disclosure

Plan Sponsor agrees that with respect to any PHI, it shall:

- (a) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
- (b) 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 Plan Sponsor with respect to PHI.
- (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 Plan Sponsor.

(d) 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) Make available to an individual Participant who requests access, the Participant's PHI in accordance with 45 CFR §164.524.

(f) Make available to an individual Participant the right to request an amendment to the Participant's PHI and incorporate any amendments to the Participant's PHI in accordance with 45 CFR §164.526.

(g) Make available to an individual Participant who requests an accounting of disclosures of the Participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

(h) 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 for purposes of determining compliance by the Plan with the HIPAA privacy rules.

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

(j) Ensure that the adequate separation between Plan and Plan Sponsor, as required in 45 CFR §164.504(f)(2)(iii), is satisfied and that the terms set forth in Section 5.6 are followed.

(k) Plan Sponsor 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, Plan Sponsor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and 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. Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

5.4 Certification of Plan Sponsor

The Plan shall disclose PHI to Plan Sponsor only upon the receipt of a certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth in Section 5.3.

5.5 Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to Plan Sponsor, provided such Summary Health Information is only used by Plan Sponsor for the purpose of obtaining premium bids from health plan providers for providing health coverage under the Plan, or modifying, amending or terminating the Plan.

5.6 Adequate Separation Between Plan and Plan Sponsor

(a) The Employees, or classes of Employees, who shall be given access to PHI shall be set forth in Plan Sponsor's HIPAA privacy policies and procedures for its group health plans.

(b) The access to and use of PHI by the individuals described in subsection (a) shall be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

(d) To comply with the HIPAA security rules, 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.

5.7 Disclosure of Certain Enrollment Information to Plan Sponsor

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

5.8 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.

5.9 Definitions

For purposes of this Article, the following terms shall have the meanings described in this Section:

(a) "Business Associate" means a person or entity who:

(1) 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.); or

(2) 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.

(b) “Plan Administrative Functions” mean 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.

(c) “Protected Health Information” or “PHI” 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; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant (whether living or deceased). The following components of a Participant’s information are considered to enable identification:

- (1) Names;
- (2) Street address, city, county, precinct or zip code;
- (3) Dates directly related to a Participant’s receipt of health care treatment, including birth date, health facility admission and discharge dates, and date of death;
- (4) Telephone numbers, fax numbers and electronic mail addresses;
- (5) Social Security numbers;
- (6) Medical record numbers;
- (7) Health plan beneficiary numbers;
- (8) Account numbers;
- (9) Certificate/license numbers;

- (10) Vehicle identifiers and serial numbers, including license plate numbers;
 - (11) Device identifiers and serial numbers;
 - (12) Web Universal Resource Locators (URLs);
 - (13) Biometric identifiers, including finger and voice prints;
 - (14) Full face photographic images and any comparable images;
- and
- (15) Any other unique identifying number, characteristic or code.

(d) “Summary Health Information” means information that may be individually identifiable health information:

(1) That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Plan Sponsor has provided health benefits under a health plan; and

(2) From which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

5.10 Participant Notification

Participants shall be notified of the provisions of this Article in the notice of privacy practices.

Article 6

Administration

6.1 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.

6.2 Administrative Services

The Plan Administrator may enter into an administration agreement with a Benefit Administrator, under which the Benefit 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. If a Benefit Administrator is appointed, the Benefit Administrator shall review, interpret, and evaluate all claims for reimbursement under the Plan. However, the Benefit 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 Benefit Administrator under an administration agreement, 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 Benefit Administrator as the Plan Administrator shall in its discretion select.

6.3 Claim for Reimbursement

A claim for reimbursement shall be submitted to the Plan Administrator (or the Benefit Administrator, if one is appointed), evaluated, and the Participant shall be notified of the approval or disapproval, in accordance with the provisions of the Plan.

(a) **Claims Evaluation** Any Participant whose claim under the Plan is not paid or is denied, in whole or in part, shall be given notice in writing of the nonpayment or denial by the Plan Administrator (or the Benefit Administrator, if one is appointed). The Plan Administrator shall provide the notice of the nonpayment within 90 days after the payment is due and shall provide the notice of the denial within 90 days after the claim is received by the Plan, unless special circumstances require an extension of time for processing the claim. If an extension of time is required, the Plan

Administrator shall provide the Participant written notice of the extension before the expiration of the initial 90-day period. However, in no event shall the extension exceed a period of 90 days from the end of the initial 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 notice of the nonpayment or denial shall be in easily understood language and shall indicate the reasons for the nonpayment or denial and the specific provisions of the Plan on which the nonpayment or denial is based. The notice shall explain that the Participant may request a review of the nonpayment or denial and the procedure for requesting review. The notice shall describe any additional information necessary to perfect the Participant's claim and explain why the information is necessary.

6.4 Review of Claim Denial

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

(a) **Participant's Request for Review** A Participant may make a written request to the Plan Administrator for a review of any nonpayment or denial under the Plan. The request must be in writing and must be made within 90 days after the mailing date of the notice of nonpayment or denial. The request shall refer to the provisions of the Plan on which it is based and shall set forth the facts relied upon as justifying a reversal or modification of the determination being appealed.

A Participant who requests a review of a nonpayment or denial in accordance with this appeal procedure may examine pertinent documents and submit pertinent issues and comments in writing. A Participant may have a representative act on his behalf in exercising his right to request a review and the rights granted by this appeal procedure.

(b) **Administrative Decision** The Plan Administrator shall provide a review of the decision within 60 days after receiving the written request for review.

6.5 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.

6.6 No Interest

The Plan shall not pay interest on any claim for Plan benefits, regardless of when paid.

6.7 Uncashed Checks

If a check for the payment of Plan benefits is not cashed within one year after the date it is issued, the check will not be paid.

Article 7

Amendment and Termination

7.1 Amendment of the Plan

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

7.2 Termination of the Plan

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

Article 8

Miscellaneous Provisions

8.1 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.

8.2 Governing Law

To the extent that Michigan law is not preempted by ERISA, the provisions of the Plan shall be governed by the laws of the state of Michigan.

Signature

Plan Sponsor has signed the Thornapple Kellogg Schools Medical Reimbursement Plan this _____ day of _____, 2010.

THORNAPPLE KELLOGG SCHOOLS

By _____

Its _____