Williamsport Area School District Employee Benefit Plan And

Summary Plan Description

Effective Date:

July 1, 2016

Updated July 1, 2021

The following information is provided to you in accordance with the Section 125 of the Internal Revenue Code, as amended, and summarizes all benefits offered under the Williamsport Area School District Employee Benefit Plan.

Contents

INTRODUCTION

The Williamsport Area School District values their employees, retirees and their families and we are pleased to provide you with a comprehensive and cost effective benefit package.

Purpose of the Plan Document

Williamsport Area School District is providing this document to address certain information that may not be addressed in the attached group insurance contracts. This document, together with the group insurance contract issued by the Insurance Company, is the Plan document required by Section 125 of the Internal Revenue Code. This Plan document is not intended to give any substantive rights to benefits that are not already provided by the attached group insurance contracts.

This document includes a description of the Williamsport Area School District Employee Benefit Plan. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants by providing the following benefit programs:

Plan Benefits and Premium Contribution Requirements:

Attachment# 1	Highmark Blue Cross Blue Shield Medical (including prescription drugs) PPO Blue Plan DI Group Numbers: 10213048 - 10213052 www.highmark.com	Self-Insured
Attachment# 2	Highmark Blue Cross Blue Shield Medical (including prescription drugs) PPO Blue Bronze *(This program is available exclusively to Eligible Variable Hourly Employees)* Group Numbers: 10213068 - 01784915 www.highmark.com	Self-Insured
Attachment # 3	Highmark Blue Cross Blue Shield Medical (including prescription drugs) with Health Savings Accounts PPO Blue Qualified High Deductible Health Plan (QHDHP) Group Numbers: 10213053 - 10213067 www.highmark.com	Self-Insured
Attachment # 4	Delta Dental www.deltadental.com	Self-Insured
Exhibit A	Flexible Spending Account Plan ("FSA") Dependent Care Spending Accounts (DCAP) Further www.hellofurther.com	Self-Funded
Exhibit B	Health Reimbursement Arrangement ("HRA'") ***You must be a participant in the Qualified High Deductible Health Plan (QHDHP) medical (including prescription drugs) program and ineligible to open a Health Savings Account (HSA) in order to receive benefits from the HRA.*** Further www.hellofurther.com	Self-Funded
Exhibit C	Health Savings Account Program ***You must be a participant in the PPO Blue Qualified High Deductible Health Plan (QHDHP) in order to participate in the Health Savings Account Program*** Further www.hellofurther.com	Self-Funded
Exhibit D	**Outline of Coverage:** PPO Blue Plan DI PPO Blue Bronze PPO Blue Qualified High Deductible Plan ("QHDHP'')	*NIA*
Attachment# 5	Schedule of Employee Premium Contribution Requirements – Open Enrollment Materials and Collective Bargaining Agreements	*NIA*

Your coverage under the Plan will take effect for an eligible Employee or Retiree and designated Dependents when the Employee or Retiree and such Dependents satisfy all of the eligibility requirements of the Plan.

Williamsport Area School District fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason with appropriate notification requirements to eligible employees.

The purpose of the Plan is to provide Employees with the opportunity to choose among those benefits available to them under the Plan. All eligible employees contribute towards the premium cost of medical benefits (including prescription drugs) on a pre-tax basis through salary reduction.

A schedule of employee premium contribution requirements can be found in Attachment # 5 and has been previously distributed to you. Information regarding your employee benefits may also be found on the District's Intranet under Departments, Human Resources. You may request a copy by submitting a written request to the Human Resource's Office.

The Plan is intended to qualify as a "cafeteria plan" under Internal Revenue Code Section 125, and regulations issued shall be interpreted to accomplish that objective. Not all benefits offered in the Plan are Internal Revenue Code Section 125 benefits. The Health Reimbursement Arrangement is a self-insured group health plan operating under Section 105 of the Internal Revenue Code.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another governing document prepared by the Insurance Company.

A copy of each booklet, summary or other governing document is addressed in this document as Attachments #1 through # 4 noted above. Information regarding your employee benefits may also be found on the District's Intranet under Departments, Human Resources. Copies of all attachments for the Plan have been previously delivered to you and are on file at the Williamsport Area School District Human Resource's Office and are available to you with your written request.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminates, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force.

The Plan also covers the employees in accordance with their collective bargaining agreements currently in place:

Collective Bargaining Unit	**Group**
Williamsport Area Education Support Professionals	(''WAESP'') /PSEA
Williamsport Area Education Association	("'WEA'') / PSEA

Information regarding eligibility and participation can be found in the current collective bargaining agreements.

Williamsport Area School District fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason with the appropriate required notification requirements pursuant to eligible employees' collective bargaining agreements.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

When this Summary Plan Description uses the term ''Plan Sponsor", it is referring to the Williamsport Area School District which sponsors the Plan.

If anything in the Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator in the Human Resources Office.

Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator, the Plan Sponsor, and the Insurance Company with his or her current address. If required by the Insurance Company, each employee who is a Participant shall be responsible for providing the Insurance Company with the address of a covered spouse and each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Insurance Company, the Plan Administrator, and the Plan Sponsor shall have no obligation or duty to locate a Participant.

DEFINITIONS

Active Employee is an employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time or part-time basis.

Benefit Period -

Coverage	Plan/Policy Year
Medical (including prescription drugs), Health Savings Account Program, and Dental	7/1 to 6/30
Health Reimbursement Arrangement WAESP/Confidential Secretaries: WEA/WASA:	 1/1 to 12/31 2/1 to 1/31
Flexible Spending Account Plan (including Medical and Dependent Care reimbursement accounts)	2/1 to 1/31

Claims Fiduciary means Highmark Blue Cross Blue Shield. Delta Dental, or Further shall act as a fiduciary under the laws of the Commonwealth of Pennsylvania in connection with the exercise of its responsibilities regarding benefit determinations and reviews of denied claims for benefits under the health benefits program. Claim Fiduciary means having the authority and responsibility to adjudicate claims in accordance with the provisions of the Plan. In the event a member appeal for review of a denied claim, the Claim Fiduciary makes the final determination as to whether the claim is covered. Williamsport Area School District cannot overrule this determination.

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

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

Covered Person is an Employee or Dependent who is covered under this Plan.

Dependent - Medical means any child (including adopted child(ren), child(ren) under court-appointed guardianship, or step-child(ren)) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. Benefit eligibility will terminate the end of the month following when any child reaches the age of 26.

Dependent - Dental - means any child (including step-children and adopted children) provided such children are dependent upon the employee for support and maintenance. Children from birth to age 19 and children who maintain full- time student status until age 25 in an accredited school, college, or university. The name of the school the child is attending must appear on all claims for the student.

Dependent - Medical and Dental - A child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability and considered to be totally disabled, and who was covered under the Plan prior to reaching the limiting age or due to other loss of dependent's eligibility and who lives with the employee, will remain eligible for coverage under the Plan beyond the date coverage would otherwise end.

To cover a child under this provision, the Plan Administrator must receive proof of incapacity within 31 days after coverage would otherwise terminate. The Plan Administrator may require at reasonable intervals during the two (2) years following the dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency.

Your eligible Dependents can be enrolled in medical (including prescription drugs) or dental coverage under the Plan only if the Eligible Employee is enrolled.

The following individuals are not eligible for medical (including prescription drugs) or dental coverage, regardless of whether they are tax dependents of the employee:

- A spouse or a child living outside the United States; or
- A parent of you or your Spouse.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; or any person, who is covered under the Plan as an Employee.

At any time, the Plan may require proof that a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Dependent – ***Michelle's Law*** - allows for continuation of coverage for college students during a medical leave. Under this law, a group health plan must continue to provide coverage to a dependent that otherwise would lose coverage under the plan for failing to maintain full-time enrollment in a post-secondary institution in the event the dependent requires a medically necessary leave of absence. To qualify for coverage under the law, the dependent must suffer from a serious illness or injury and lose eligibility due to the medically-necessary leave. The dependent's treating physician is required to certify that the dependent is suffering from a medical illness or injury and that the leave of absence is medically necessary. Coverage under Michelle's Law must be

extended for at least one year; however, coverage may end earlier for certain reasons such as aging out of the plan (i.e. exceeding the Plan's normal dependent-eligibility age). Please see the Plan Administrator for necessary forms in the event your dependent child is entitled to extended coverage under this law.

Dependent Care Spending Account ("DCAP") means an account in the Flexible Spending Account Plan that is authorized by Section 129 of the Internal Revenue Code and reimburses eligible dependent care expenses. The Dependent Care Spending Account operates under Section 125 Cafeteria Plan rules of the Internal Revenue Code and allows payments for certain benefits on a pre-tax basis.

Domestic partner(s) means an individual who is a member of a domestic partnership consisting of 2 partners each of whom: (i) is at least 18 years of age or older; (ii) resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time; (iii) is not related to the other partner by adoption or blood; (iv) is not married to anybody else; (v) is the sole domestic partner of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this domestic partnership for the last 6 months; (vi) agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and (vii) is able to demonstrate financial interdependence by submission of proof of 3 or more of the following documents:

- A joint mortgage or lease;
- A designation of one of the partners as beneficiary in the other partner's will;
- A durable property and health care powers of attorney;
- A joint title to an automobile, or joint bank account or credit account; or
- Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

See the Human Resources Department for information regarding enrolling your Domestic Partner in the medical benefit option in the Plan.

Eligible Employee means any full or part-time individual employed by the Employer or Affiliated Employer as a common law employee. An individual shall be considered to be employed by the Employer or Affiliated Employer as a common- law employee only if the Employer or Affiliated Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer or Affiliated Employer, and such individual is determined by the Employer or Affiliated Employer to be a common-law employee for purposes of the Employer's or Affiliated Employer's payroll records. It is expressly provided that any individual who is treated as an independent contractor by the Employer or Affiliated Employer and any other common-law employee not described above is not an Employee and is not eligible to participate in this Plan. Any individual who is retroactively or in any other way held or found to be a "statutory" or "common-law employee" of the Employer or Affiliated Employer will not be eligible to participate in the Plan for any period he or she was not contemporaneously treated as a common-law employee by the Employer or Affiliated Employer.

Employer means the School District, any of its Affiliates, and any other persons, firms, or organizations that have expressly adopted this Plan with the consent of Williamsport Area School District.

Enrollment Period means such period of time, when you are initially eligible for benefits. Once you have made an election for benefits under this plan, your election, will remain in place until you wish to make a change due to a Special Enrollment Period or Change in Election Event

occurs. You may also make changes to your elections at Open Enrollment each year.

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

Family Coverage means coverage for the Participant and one or more of the Participant's Dependents.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

HIPAA means the federal Health Insurance Portability and Accountability Act of 1996.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

National Medical Child Support Order means the District will also provide benefits as required by any medical child support order, as provided by law under the National Medical Support Notice ("NMSN''). The Plan will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries.

Participant means an Eligible Employee, who has met the requirements of component benefits in the Plan and participates in the Plan or an eligible Dependent.

Plan means Williamsport Area School District Employee Benefit Plan, which is a benefits plan for eligible employees of Williamsport Area School District and is described in this document.

Plan Administrator means the Lycoming County Insurance Consortium for the medical benefit program on behalf of the Williamsport Area School District and the Director of Human Resources of the Williamsport Area School District for all other benefit coverage. Each is named in the General Information about the Plan Section of this document. The Plan Administrator is not Highmark Blue Cross Blue Shield.

Plan Year means a twelve (12) consecutive month period that commences and ends on a date selected by the Sponsor and shown in the General Information Section of this Summary Plan Description.

Pre-Tax Salary Reduction means a separate written authorization of the Employee to have his or her after-tax salary reduced in exchange for the Employer making equivalent pre-tax contributions on the Employee's behalf directly to the Insurer to pay for the level of health insurance coverage elected by the Employee for himself and his Dependents under the Health Insurance Program. The maximum Employer pre-tax contributions which can be made hereunder in consideration of a Salary Reduction cannot exceed the cost of the level of coverage elected by the Participant under the medical benefit or dental program reduced by any School District premium contributions.

Qualified Beneficiary under COBRA means an individual, on the day before a COBRA Qualifying Event, is a Spouse or dependent child of an Employee and who is covered under the medical, dental or flexible spending plan components. In the case of a Qualifying Event, Qualified Beneficiary means an individual who on the day before the Qualifying Event is an Employee covered by the Plan.

Qualifying Event under COBRA means any of the following events: (a) death of an Employee; (b) the voluntary or involuntary termination (other than by reason of gross misconduct) of an Employee; (c) a change in an Employee's status to a part-time Employee; (d) divorce or legal separation of an Employee from his or her Spouse; (e) an Employee's commencement of entitlement to coverage under Medicare or a similar governmental benefit plan; (f) a dependent child ceasing to be a dependent child under the terms of the medical, dental or flexible spending account programs.

PSERS means the Pennsylvania Public School Employees' Retirement System.

Retiree means Eligible Employees who retire are eligible for coverage in the group medical (including prescription drugs) coverage with superannuation as defined by PSERS. Please contact the Districts Human Resource Department for more information regarding retiree group medical (including prescription drugs) insurance coverage.

Sponsor means the employer identified in the General Information Section of this Summary Plan Description. Sponsor also means any successor entity assuming the obligations created in this Plan. Solely for the purposes of nondiscrimination testing under Code Section 125, the Sponsor shall include all entities which are treated as an Affiliate.

Spouse means the Spouse is an Employee's husband or wife married under a legally valid marriage including common law marriage in States where it is recognized The term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

At any time, the Plan may require proof that a Spouse or child qualifies or continues to qualify as a Spouse or Dependent as defined by this Plan.

Variable Hour Employee means, based on facts and circumstances, it cannot be determined the Employee is reasonably expected to work on average at least 30 hours per week.

WHCRA means the Women's Health and Cancer Rights Act of 1998, as amended.

GENERAL INFORMATION ABOUT THE PLAN

Employer Name:	Williamsport Area School District
Plan Name:	Williamsport Area School District Employee Benefit Plan
Employer Address:	2780 West Fourth Street Williamsport, PA 17701
Employer's Telephone Number:	570-327-5500
Plan/Policy Years: Medical (including prescription drugs), Health Savings Account Program, and Dental:	July 1st to June 30th
Plan Year: Flexible Spending Account Plan (including medical and dependent care spending accounts):	February 1st to January 31st
Plan Year: Health Reimbursement Arrangement: **WAESP/Confidential Secretaries:** **WEA/WASA:**	 January 1st to December 31st February 1st to January 31st
Employer's Federal Tax Identification Number:	24-0859746
Plan Sponsor:	Williamsport Area School District 2780 West Fourth Street Williamsport, PA 17701
Plan Administrator/Named Fiduciary : **(Dental and Flexible Spending Account Plan):**	Williamsport Area School District 2780 West Fourth Street Williamsport, PA 17701 Directort of Human Resources and the Business Administrator
Plan Administrator/Named Fiduciary **(Medical (including prescription drugs):**	Lycoming County Insurance Consortium

Highmark Blue Cross and Blue Shield are fiduciaries with regard to eligibility for benefits and benefit claims in the medical programs offered under the Plan.

Agent for Service of Legal Process:

Fred Holland, Esq.,
Solicitor Murphy,
Butterfield & Holland, P.C.
442 William Street
Williamsport, PA 17701

Funding Medium and Type of Plan Administration:

The insurance companies or third party administrators, not Williamsport Area School District, are responsible for paying claims with respect to these programs. Williamsport Area School District shares responsibility with the insurance companies or third party administrator for administering these program benefits.

The following benefits under the Plan are self-funded and paid with employee pre-tax salary reductions for the medical (including prescription drugs), flexible spending account plan and the health savings account program. Premium payments are then paid to the administrative service providers out of the general assets of the employer. Employee contributions to the health savings account program are forwarded to the program's trustee for deposit into individual employee accounts. Benefit claim payments for the health reimbursement arrangement are paid from the employer's general assets:

Coverage	***Self-Insured with Administrative Services Provided by:***
Medical (including prescription drugs):	Highmark Blue Cross Blue Shield
Health Savings Account Program:	Further
Health Reimbursement Arrangement:	Further
Dental:	Delta Dental
Flexible Spending Account Plan:	Further

Insurance premiums for employees and their eligible family members are paid in part by Williamsport Area School District out of its general assets and in part by employees· pre-tax salary reductions. A schedule of required employee pre-tax contributions for coverage for the current Plan Year can be found in Attachment# 5 and on the District's Intranet under Human Resources.

The administrative service provider, not Williamsport Area School District, is responsible for paying claims with respect to the self-funded programs. Williamsport Area School District shares responsibility with the administrative services provider for administering these benefits.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

ELIGIBILITY, ENROLLMENT AND PARTICIPATION

Eligible Classifications

Eligibility for benefits includes coverage for Employees, Spouses, Domestic Partners, and eligible Dependents and Retirees and their Spouses.

Eligible full and part-time employees pay for a portion of the premiums for medical (including prescription drugs). To find out your required premium contribution, please see Attachment# 5.

Component Benefit	Eligibility
Medical (including prescription drugs), Health Reimbursement Arrangement, Health Savings Account Program. Dental and Flexible Spending Account Plan (including medical and dependent care spending accounts)	**Full-Time Support Staff:** Regularly scheduled to work more than five (5) hours per day, five days per week; **Full-Time Administrators:** Regularly scheduled to work five (5) hours or more per day; **Professional Staff/Confidential Staff:** Regularly scheduled to work 7 ½ hours per day; and **Part-Time Professional Staff.**

Dependent - Medical means any child (including adopted child(ren), child(ren) under court-appointed guardianship, or step-child(ren)) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. Benefit eligibility will terminate the end of the month following when any child reaches the age of 26.

Dependent - Dental - means any child (including step-children and adopted children) provided such children are dependent upon the employee for support and maintenance. Children from birth to age 19 and children who maintain full- time student status until age 25 in an accredited school, college, or university. The name of the school the child is attending must appear on all claims for the student.

Dependent - Medical and Dental - A child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability and considered to be totally disabled, and who was covered under the Plan prior to reaching the limiting age or due to other loss of dependent's eligibility and who lives with the employee, will remain eligible for coverage under the Plan beyond the date coverage would otherwise end.

To cover a child under this provision, the Plan Administrator must receive proof of incapacity within 31 days after coverage would otherwise terminate. The Plan Administrator may require at reasonable intervals during the two (2) years following the dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency.

Your eligible Dependents can be enrolled in medical (including prescription drugs) or dental coverage under the Plan only if the Eligible Employee is enrolled.

The following individuals are not eligible for medical (including prescription drugs) or dental coverage, regardless of whether they are tax dependents of the employee:

- A spouse or a child living outside the United States; or

- A parent of you or your Spouse.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; or any person who is covered under the Plan as an Employee.

At any time, the Plan may require proof that a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Spouse means the Spouse is an Employee's husband or wife married under a legally valid marriage including common law marriage in States where it is recognized. The term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

At any time, the Plan may require proof that a spouse or child qualifies or continues to qualify as a Spouse or Dependent as defined by the Plan.

Domestic partner(s) means an individual who is a member of a domestic partnership consisting of 2 partners each of whom: (i) is at least 18 years of age or older; (ii) resides with the other pa1iner and intends to continue to reside with the other partner for an indefinite period of time; (iii) is not related to the other partner by adoption or blood; (iv) is not married to anybody else; (v) is the sole domestic partner of the other partner. with whom he/she has a close committed and personal relationship, and has been a member of this domestic partnership for the last 6 months; (vi) agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and (vii) is able to demonstrate financial interdependence by submission of proof of 3 or more of the following documents:

- A joint mortgage or lease;
- A designation of one of the partners as beneficiary in the other partner's will;
- A durable property and health care powers of attorney;
- A joint title to an automobile, or joint bank account or credit account; or
- Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

See the Human Resources Department for information regarding enrolling your Domestic Partner in the medical benefit option in the Plan.

Retiree means Eligible Employees who retire are eligible for coverage in accordance with his/her applicable collective bargaining agreement or compensation plan currently in place. Retirees are responsible for a portion of the premium cost of coverage. Benefits will continue until the Retiree reaches the age of 65 and becomes eligible for Medicare. Spouses and Dependents may participate provided the Retiree is participating in the Plan. The retiree shall pay the full amount for any dependent coverage. Employees covered under the dental program may continue their dental benefits under COBRA. Please see the Director of Human Resources for more information regarding retiree group medical (including prescription drugs) insurance coverage.

Component Benefit	When Participation Begins
Medical (including prescription drugs), Health Reimbursement Arrangement, Health Savings Account Program, Dental, and the Flexible Spending Account Plan	Date Full-Time or Part-Time Service Begins

The Patient Protection and Affordable Care Act (Health Care Reform) requires employers who sponsor group health plans (including prescription drugs) to determine the eligibility of what is called a Variable Hour and/or Seasonal Employee. Eligibility determinations are made on the basis of hours worked within a certain timeframe.* See *the Human Resources Department for additional information regarding eligibility in the medical (including prescription drug) benefits program. If it is determined you are eligible for benefits in the medical (including prescription drug) program you may enroll in the PPO Bronze Plan offered in the Plan.

You may become a participant on your participation date, provided you properly submit an election form to the Plan Administrator prior to that date and during the period designated by the Plan Administrator as your initial "enrollment period'' and provided Williamsport Area School District determines you have the status of an active employee of Williamsport Area School District on your participation date.

After you complete an initial election form, your initial benefit election will remain in effect indefinitely unless you need to change your elections for certain other reasons or until you make a new benefit election by requesting, completing and submitting a new election form to the Plan Administrator during an election period or for Special Enrollment Periods.

Participant/Spouse Employment

If both you and your Spouse are eligible employees of Williamsport Area School District you may be covered under the medical (including prescription drugs) Plan with husband and wife coverage or individual single coverage. For medical (including prescription drugs) coverage, your Dependent children may be covered under the Plan either by you or your Spouse, but not both. For dental coverage, your dependent children may be covered under both you and your Spouse's plans.

Leased or Temporary Employment

Leased employees, persons classified by Williamsport Area School District as temporary employees of Williamsport Area School District (as determined by Williamsport Area School District) are not eligible for benefits in the Plan. A person who is characterized by Williamsport Area School District as a leased employee of Williamsport Area School District, but who is later characterized by a regulatory agency or court as being an Employee, will not be eligible for the period during which they are characterized as a leased employee by Williamsport Area School District.

Special Enrollment Periods

Special Enrollment Rights - **Health Insurance Portability and Accountability Act ("HIPAA").** If you, your Spouse or a Dependent is entitled to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) under a group health plan, you may change your election to correspond, with the special enrollment right. For example, if you declined enrollment in Williamsport Area School District Employee Benefits Plan medical plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of

employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment, within 30 days after the applicable event. Furthermore, whether you are participating or not, if you have a new Dependent as a result of marriage, birth. adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and newly acquired Dependent, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights - **Children's Health Insurance Program Reauthorization Act** - **2009.** If you and your dependents are eligible but not enrolled for coverage under your employer's group health plan you may enroll in two circumstances: 1) you or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; and 2) you or your dependent becomes eligible for a Subsidy under Medicaid or CHIP (if offered by your state). You or your dependent(s) must request coverage within **60 days** after you or your dependent is terminated from, or determined to be eligible for such assistance.

Change in Election Events

If a Change in Election Event (including a Change in Status) occurs, you must inform the Administrator and complete a Change in Status Form within **30 days** of the occurrence.

Generally, you cannot change your election to participate in the medical (including prescription drugs), dental and flexible spending account components of the Plan or vary the salary reduction amounts you have selected during the Plan Year (known as the irrevocability rule). Your election will terminate if you are no longer working for the School District. Of course, you can change your elections for benefits and salary reductions prior to July 1st during open enrollment for medical (including prescription drugs) and dental; prior to February 1st for flexible spending account plan benefits but that will apply only for the upcoming Plan Year.

Before the beginning of each Plan Year, the District will make election forms available, along with a schedule showing the cost of coverage. <u>If you do not return the election form before the due date, your elections for the prior Plan Year will remain in effect, including an election of no coverage.</u> Any election to be covered by the flexible spending account plan (including medical and dependent care spending accounts) in the prior plan year will be cancelled and you will not have coverage in the subsequent Plan Year.

Employees who are covered by the High Deductible Health Plan and have opened a health savings account may change their election each month.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events*. "Change in Election Events" include the following events, as more fully described below: FMLA leave, Change in Status, certain judgments, decrees and orders; Medicare and Medicaid: Change in Cost, and Change in Coverage. *(Change in Status, Cost and Coverage* are defined below). However, the Change in Election Events do not apply to all benefits in the Plan, exclusions apply. Examples are described below for each such Event.

- **FMLA Leave**

  You may change an election under the Plan upon commencement of or return from FMLA leave.

- **Change in Status**

  If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:

- A change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). "Spouse" means the person who is legally married to you and is treated as a Spouse under the Internal Revenue Code (Code);
- A change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). "*Dependent*" means your tax dependent under the Code:
- Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility including (this Plan or other employee benefit plan of you, your Spouse, or your Dependents). Such events include any of the following changes in employment status, termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave absence, a change in work site, switching from salaried to hourly paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of Employment; or any other similar change which makes the individual become (or cease to be) eligible for benefit;
- An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a benefit (such as attaining a specified age, student status, or similar circumstance); and
- A change in your, your Spouse's or your Dependent's place of residence.

- **Change in Status-Other Requirements.**

  If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in his/her sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

  - Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For accident and health benefits (here, the medical insurance under the Health Insurance Plan), a special rule governs which type of election changes are consistent with the Change of Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

    Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the Plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no health coverage. The health coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

However, if you, your Spouse, or Dependent elect COBRA continuation coverage under the Employer's plan for any reason other than divorce, annulment or legal separation, or your child's ceasing to be a Dependent, and you remain a Participant under the terms of this Plan, you may be able to increase your contribution to pay for such coverage.

- Gain of Coverage Eligibility under another Employer's Plan. For a Change in Status in which you, your Spouse or your Dependent gains eligibility for coverage under another employer's cafeteria plan (qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan. See the Plan Administrator or Benefits Coordinator to obtain cost information for Williamsport Area School District's Plan.

- **Certain Judgments, Decrees and Orders**

  If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.

- **Medicare or Medicaid**

  If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage under the Health Insurance Plan. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

- **Change in Cost**

  If the Administrator notifies you that the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if there is no option available under the Plan that provides similar coverage; (d) coverage under another employer plan, such as a Spouse's or Dependent's employer, is treated as similar coverage. For insignificant increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.

- **Change in Coverage**
  You may also change your election for the Plan if one of the following events occurs:

  - *Significant Curtailment of Coverage*. If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under another Plan option that provides similar coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of benefit coverage. then you may either revoke your election and elect coverage under another Plan option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage.
  - *Addition or Significant Improvement of Plan Option*. If the Plan adds a new option or

significantly improves an existing option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the component Plan.

- *Loss of Other Group Health Coverage*. You may change your election to add group health coverage for you, your Spouse or Dependent, if any of you lose coverage under any group health coverage sponsored by a government or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election under another Employer Plan*. You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during his/her employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.

- **Dependent Care**
  You may make an election change to the contribution to your Dependent Care FSA that is due to a change in the provider of dependent care. You may also make an election change to the contribution to your Dependent Care FSA that is due to a change in cost of dependent care; so long as the provider of dependent care is not your relative.

If the employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year or coverage period (as determined by the Plan Sponsor), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

Note that changes such as Automatic Small Cost Changes, Significant Cost Increases (with or without loss of coverage), Significant Coverage Curtailment, Addition or Elimination of Benefit Package Option or Change in Coverage under Other Employer's Plan does not permit changes to your Flexible Spending Account Plan accounts.

Benefits for Adopted Children / Guardianship Agreements

With respect to component benefit plans that are group health plans, the Plan will extend benefits to dependent children placed with you for adoption or a child under guardianship under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

Employee Participants who currently cover eligible dependents under a Guardianship Agreement will be required, upon enrollment and subsequent requests, to show proof of continued guardianship in order to continue coverage in the Plan for dependent child(ren).

Termination of Participation

Medical (including prescription drugs), Health Reimbursement Arrangement, Health Savings Account Program [1], and Dental	Last day of the month in which termination occurred
Flexible Spending Account Plan (dependent care spending account)	Last day of employment

[1] Health Savings Accounts are portable. You may continue to contribute to your account after you are no longer employed but you must be enrolled in a high deductible health plan. If you are no longer enrolled in a high deductible health plan, you are no longer eligible to contribute to your account but may continue to spend clown your account balance for qualified or non-qualified expenses.

Coverage may also terminate if:

- Your hours drop below any required hourly threshold
- You submit false claims;
- Williamsport Area School District discontinues the plan for any reason;
- If you are covered under a collectively bargained agreement that has changed eligibility for benefits under contract;
- The day on which an eligible dependent ceases to be an eligible dependent; or
- Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer.

For all retroactive terminations, the school district will be responsible for claims incurred after the termination if the termination was processed retroactively. Administrative fees for retroactively terminated participants are fully refundable.

Uniformed Services Employment and Re-employment Rights Act

Regardless of any provision described above, if you take a leave of absence from employment with the Williamsport Area School District because of military service, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for you and your covered Spouse or Dependents or you may extend benefits through COBRA.

You have the following rights under USERRA:

1. If your military leave period is for 30 days or less, you have the right to continue health coverage for yourself and dependents that were covered under the group health plan for up to 30 days, at a cost of not more than the cost for a similarly situated active employee.
2. If the military leave period is for 31 days or more, you have the right to elect USERRA continuation coverage for yourself and your dependents that were covered under the health plan. The maximum period is 24 months.

You will be required to pay up to the 102% of the applicable premium whether you elect continuation coverage under USERRA or COBRA.

If you extend your coverage through USERRA, such coverage will end on the earlier of: (1) the last day of the 24-month period beginning on the date your absence begins: or (2) the day after the date on which you fail to apply for or return to a position of employment with the Williamsport Area School District. See the COBRA section of this document for more information on continuation of coverage through COBRA.

If you elect USERRA continuation coverage, the Plan is under no further obligation to offer COBRA election rights when the USERRA continuation coverage expires. However, if your Spouse or Dependent child would lose USERRA continuation coverage because of another qualifying event, such as your death or divorce, or because the Dependent ceases to be an eligible Dependent, then the Plan must offer your Spouse or Dependent child the right to continue coverage for 36 months measured from the date you entered active military service.

If you take military leave, but your coverage under the Plan is terminated - for instance, because you do not elect the extended coverage, when you return to work, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies. Please contact the Plan Administrator if you have questions about coverage during periods of military service.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

The Employer reserves the right to terminate coverage for you, your Spouse, your Domestic Partner, or your Dependent(s) prospectively without notice for cause or if you, your Spouse, your Domestic Partner, or your Dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you, your Spouse, or your Dependent(s) commits fraud or intentional misrepresentation in an application for coverage under the Plan, in a claim or appeal for benefits, or in response to any request for information by the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, the Plan Administrator may terminate your, your Spouse's, your Domestic Partner, or your Dependent's coverage retroactively to the date of the fraud or misrepresentation upon 30 day notice.

When you enroll a family member in the Plan, you represent the following:

- The individual is eligible under the terms of the plan; and
- You will provide evidence of eligibility on request.

Further, you understand that:

- The Plan is relying on your representation of eligibility in accepting the enrollment of your family members;
- Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
- Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual becomes ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on rescission of coverage.

If the medical (including prescription drugs) or dental program undertakes an eligibility audit and finds an ineligible Spouse or Dependent(s) enrolled in the Plan, the Plan may cancel coverage for the ineligible Spouse or Dependent(s) prospectively without violating the prohibition on rescission rules of the Patient Protection and Affordable Care Act (Health Care Reform). A termination of coverage with prospective effect is not considered a rescission and may be permitted without proof of fraud or misrepresentation.

In order to cancel coverage retroactively, however, the Plan must make a showing of fraud or intentional misrepresentation of a material fact and provide advance written notice of the rescission.

National Medical Child Support Orders

With respect to benefits, Williamsport Area School District Employee Benefit Plan will also provide benefits as required by any medical child support order, as provided by law under the National Medical Support Notice **("NMSN'').** The Plan will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries. The Plan Administrator will ask the Employee to submit an enrollment form to obtain coverage and will administer the provision of benefits under the Plan according to the NMSN, to the extent required by law.

In order for this Plan to recognize a National Medical Support Order it must satisfy the following criteria:

1. It must be a judgment, decree or other court order relating to health benefits coverage for a Dependent Child of a covered Employee; and

2. The order must specify:

    a. the name and address of the Employee or their designee;
    b. the name and mailing address of each dependent child covered by the order;
    c. a reasonable description of the type of coverage afforded by the Plan;
    d. a beginning period for which the order applies; and
    e. the name and address of each Alternate Payee, which means the Spouse, former Spouse, legal guardian of the dependent child or the child of an Employee.

Upon receipt of a medical child support order, the Plan Administrator shall promptly notify the Employee and Alternate Payee. The Plan Administrator shall determine whether an order received meets the criteria and promptly notify the Employee an each Alternate Payee. In the event of a dispute regarding any medical child support order furnished to the Plan Administrator, the Employee or Alternate Payee shall promptly notify the Plan Administrator in writing.

Coverage shall commence upon either the date specified in the order or the date the Employee becomes eligible for coverage, if later.

Any order that requires the Williamsport Area School District Employee Benefit Plan to provide any type of benefit or increased benefits not otherwise provided by this Plan, other than under COBRA, will not be recognized as a National Medical Support Order.

Please see the Director of Human Resources for questions regarding National Medical Support Orders.

COBRA RIGHTS

"Continuation Coverage" means your right your Spouse's and Dependents' right, to continue the same coverage under any medical benefit plan coverage that was in place the day before a *Qualifying Event* if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of such Qualifying Event. Continuation coverage under federal law is provided under *COBRA* (Consolidated Omnibus Budget Reconciliation Act of 1985). Williamsport Area School District is subject to COBRA.

There may be other coverage options for you and your family. You will be able to buy coverage through the Health Insurance Marketplace during the open enrollment period or if you have a

special enrollment opportunity. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Initial COBRA Notification

The Employee (if he or she is covered under the Plan) and the Employee's covered Dependent Spouse must receive a written General Notice explaining COBRA continuation coverage rights under the Plan. The General Notice will be furnished not later than the earlier of:

- Ninety days from the date on which the Employee first becomes or his or her Dependent Spouse first becomes covered under the Plan, or

- The first date after coverage starts that the Employee or his or her Dependent Spouse or Dependent Child is required to be furnished with a qualifying event notice.

The General Notice requirement will be satisfied by furnishing a single, written General Notice addressed to both the covered Employee and his or her covered Dependent Spouse, if:

- Based on the most recent information available to the Plan, the Employee and his or her Dependent Spouse reside at the same location, and

- The Dependent Spouse's coverage under the Plan first begins on or after the date that the Employee's coverage under the Plan first begins but not later than the date that the Employee must be provided with materials explaining his or her right to the continuation coverage provided under the Plan.

Otherwise, separate mailings will be made to the covered Employee and his or her covered Dependent and/or Spouse.

The General Notice will be delivered by first class mail. The General Notice will be considered "furnished" as of the mailing date.

Basic COBRA Continuation Coverage Rights

If Williamsport Area School District amends the medical (including prescription drugs), dental, or flexible spending account plan benefits for active employees and their family members during your COBRA Coverage period, your COBRA Coverage under the plan will be amended in the same manner.

If you are an Employee covered by the Williamsport Area School District Employee Benefit Plan, you have the right to choose this continuation coverage if you, your Spouse or a Dependent child loses group health coverage because of any of the following Qualifying Events:

- termination of your employment (other than by reason of gross misconduct);
- reduction of your work hours;
- your death;
- divorce or legal separation from or death of your Spouse;

- you or your Spouse becoming enrolled to receive Medicare (under Part A, Part B, or both) benefits; or
- Dependent child ceases to be a "Dependent child'' under the Williamsport Area School District Employee Benefit Plan.

For a Qualifying Event other than a change in your employment status or death, it will be your obligation to inform the Williamsport Area School District Employee Benefit Plan, Plan Administrator of the qualifying event within *60 days* of its occurrence. The Administrator, in turn. will furnish you (and your Spouse, as the case may be) with separate, written options to continue the coverage(s) provided at stated premium costs with respect to each health plan in which you are participating. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage. Similar rights may apply to Spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

The law requires that former employees and beneficiaries be afforded the opportunity to maintain continuation coverage for 18 months if coverage is lost due to termination of employment or reduction in hours. This I8-month period may be extended to 36 months if a beneficiary experiences a second qualifying event (such as death, divorce, legal separation, Medicare entitlement, or no longer meeting the description of a dependent). Qualified beneficiaries may also be eligible for 36-month continuation coverage if group coverage has been lost for any reason other than termination of employment, reduction in hours or bankruptcy.

The 18 months may be extended to 29 months if an individual is determined to be disabled (for Social Security disability purposes) and the Plan Administrator is notified of that determination within 60 days. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled. In no event will continuation coverage last beyond 3 years from the date the event that originally made a qualified beneficiary eligible to elect coverage.

A summary of the length of your coverage periods follows:

Qualifying Event Resulting in a Loss of Coverage	**Maximum Coverage Period**
Employee's reduced work hours, except for a reduction in hours in connection with Family and Medical Leave	18 months
Employee's termination (except for gross misconduct) or retirement	18 months
Employee's death, divorce or legal separation of the employee and Spouse	36 months
Dependent child's loss of eligibility (for example, by reaching the age limit)	36 months
Dependent's loss of coverage because employee enrolls in Medicare	36 months

In no event will COBRA continuation coverage last beyond 36 months from the date of the original qualifying event that made a qualified beneficiary eligible to elect COBRA continuation coverage.

The law also provides that your continuation coverage may be terminated for any of the following reasons:

1. Williamsport Area School District no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become entitled to Medicare;
4. You extend coverage for up to 29 months due to your disability and there has been a final

determination that you are no longer disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate the coverage of a Plan Participant or beneficiary not receiving continuation coverage (such a fraud).

The Trade Preferences Extension Act of 2015 and COBRA

The Trade Act of *2002* created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals typically include those who have been displaced due to foreign competition). The Trade Preferences Extension Act restored the provisions of the Trade Act of 2002 which expired on January 1, 2014. Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of a portion of premiums paid for qualified health insurance including continuation coverage. The new legislation also added rules for coordinating the health care tax credit with the premium tax credit that is available under health care reform to eligible individuals receiving individual health insurance through an Exchange. A new rule excludes coverage through an Exchange from the list of qualified health insurance for which the health care tax credit may be claimed beginning in 2016. There is also a new requirement to make an election in order for the health care tax credit to apply, and the premium tax credit is not available for the months to which the election applies.

Flexible Spending Account Plan

Most coverage under COBRA is paid for with the value of your premiums (plus a 2% administration fee) associated with each insured benefit (i.e. medical and dental). If you have not incurred claims sufficient to spend-down your account balance as of your date of termination, you may continue your participation in the Flexible Spending Account Plan medical account for the remainder of the current Plan Year. Payment for continuation of your Flexible Spending Account Plan benefit is based on the contribution you made to your account while employed. Your premium is the same amount of those contributions withheld from your paycheck during employment.

There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says, that at the end of the 18 month or 3 year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided by the insurance carrier under Williamsport Area School District Employee Benefit Plan.

The covered Employee, another member of his or her family who is a qualified beneficiary with respect to the event, or any representative acting on behalf of the qualified beneficiary must provide notice of the occurrence of either of these qualifying events to Williamsport Area School District within 60 days after the latest of:

- The qualifying event date;
- The qualified beneficiary's loss of coverage date under the Plan due to the qualifying event; or
- The date on which the qualified beneficiary is informed through the furnishing of this document or the initial General Notice, of both the qualified beneficiary's responsibility to provide notice and the Plan's procedures for providing notice.

Send all premium payments for COBRA coverage to the COBRA Administrator. As of the date of the SPD, the COBRA Plan Administrator is P&A group, Inc. unless you are notified by Williamsport Area School District of a different COBRA Administrator.

Oral notice, including notice by telephone is not acceptable. The notice must be in writing and be mailed to this address:

P&A Group, Inc.
Department 652
P.O. Box 8000
Buffalo, NY 14267-8000

1-800-688-2611
www.padmin.com

Satisfactory written notice must be postmarked no later than the last day of the required 60-day notice period. Otherwise, COBRA continuation coverage does not have to be offered.

If there are any changes to your marital status, you or your Spouse's address(es), or the Dependent status of any of your children under the Plan, please notify the Plan Administrator immediately.

If you have any questions about your COBRA rights, please contact your Director of Human Resources at Williamsport Area School District, 2780 West Fourth Street, Williamsport, PA 17701.

COBRA Notice Procedures

The notice must include the name of the Plan, the name, address, and member number of the covered Employee, the name(s), address(es), and member number(s) of the qualified beneficiary(ies), a description of the qualifying event, and the date on which the qualifying event occurred. If the qualifying event is a divorce, the notice must include a copy of the divorce decree. The notice must also include any other information that Williamsport Area School District, in its sole discretion, may require.

Within 30 days of receiving the timely, written notice, Williamsport Area School District will forward the notice to the COBRA Administrator. Within 14 days of being notified of the qualifying event, the COBRA Administrator will send COBRA information to the covered Employee, the qualified beneficiary, or other individual with respect to the event.

If it is determined that an individual is not entitled to COBRA continuation coverage, he or she will be provided with a Notice of Unavailability of Continuation Coverage explaining why the individual is not entitled to continuation coverage. If it is determined that an individual is a qualified beneficiary entitled to COBRA continuation coverage, he or she will be provided with an Election Notice.

Notice is required when an SSA determination of disability occurred before or occurs during an 18-month period of continuation coverage.

To obtain the 11-month extension of coverage, there are special deadlines and special procedures for providing notice of the SSA disability determination. The covered Employee, another member of his or her family who is a qualified beneficiary with respect to the event, or any representative acting on behalf of a qualified beneficiary must provide notice about the occurrence of the determination. The notice must be provided before the end of the first 18 months of COBRA continuation coverage and within 60 days after the latest of:

- The date of the disability determination by the Social Security Administration;
- The date that the covered Employee's employment ends or reduction in hours of employment occurs;

- The date on which coverage is lost due to termination of the covered Employee's employment or reduction in hours of employment; or
- The date on which the qualified beneficiary is informed through the furnishing of this document or the initial General Notice, of both the qualified beneficiary's responsibility to provide notice and the Plan's procedures for providing notice.

Notice is required when certain second qualifying events occur during an I8-month period of continuation coverage. Those second qualifying events are: the covered Employee's death, the covered Employee's divorce or legal separation, the covered Employee becoming entitled to Medicare benefits (Part A, Part B, or both), or a Dependent Child ceasing to be a Dependent Child under the terms of the Plan.

A deadline and special procedures apply to providing this notice. The covered Employee, another member of his or her family who is a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the qualified beneficiary must provide notice about the occurrence of a second qualifying event within 60 days after the latest of:

- The date on which the second qualifying event occurs;

- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the second qualifying event; or

- The date on which the qualified beneficiary is informed through the furnishing of this document or the initial General Notice, of both the qualified beneficiary's responsibility to provide notice and the Plan's procedures for providing notice.

Oral notice, including notice by telephone is not acceptable. The notice must be in writing and mailed to the following address:

P&A Group, Inc.
Department 652
P.O. Box 8000
Buffalo, NY 14267-8000

1-800-688-2611
www.padmin.com

Satisfactory written notice must be postmarked no later than the last day of the required 60-day notice period. Otherwise, COBRA continuation coverage does not have to be offered.

The notice must include the name of the Plan, the name, address, and member number of the covered Employee, the name(s), address(es), and member number(s) of the qualified beneficiary(ies), a description of the second qualifying event, and date on which the second qualifying event occurred. The notice must also include any other information that Williamsport Area School District, in its sole discretion, may require.

Within 14 days after satisfactory written notice is received, if it is determined that an individual is not entitled to an extension of COBRA continuation coverage, the individual will be provided with a Notice of Unavailability of Continuation Coverage explaining why the individual is not entitled to the extension.

Consequences of Providing Incomplete Notices

The Plan will not reject an incomplete notice as untimely if the notice is provided within the time limits specified above and contains enough information to enable the identification of the Plan, the covered Employee and qualified beneficiary(ies), the qualifying event or SSA disability determination, and the date on which such event or determination occurred. However, the covered Employee, a qualified beneficiary with respect to the event, or a representative acting on behalf of the covered Employee or qualified beneficiary will be required to supply the missing information. A deficient notice will be rejected and all rights to continuation coverage under the Plan will be lost if, following a request for more complete information, the covered Employee, qualified beneficiary, or representative fails to provide the requested information, in writing, postmarked no later than the 30th day after the date of the request.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

FAMILY MEDICAL LEAVE ACT OF 1993 (FMLA)

Benefit and Service Continuation during Family Leave

- During the period of your leave under this Plan, the Williamsport Area School District Employee Benefit Plan will continue your medical benefits, as required by law. This means the Williamsport Area School District will continue your benefits on the same basis as if you were continuing your employment.

- Employees on unpaid leave are required to pay required premiums for medical (including prescription drugs) and flexible spending account plan coverage during their leave. Premiums can be paid on a pre-tax basis prior to the leave, during the leave with post-tax dollars, or upon return from leave with pre-tax dollars. The method of payment will be chosen at the discretion of the Plan Administrator.

If you elect to cease participation in the flexible spending account plan, medical (including prescription drugs) or dental plan, expenses incurred while participation has lapsed will not be eligible for reimbursement. If you elect to continue participation in the dependent care spending account, expenses incurred during the leave would not be eligible for reimbursement because you are not working, but contributions could be made during the leave and applied to expenses incurred after you return from leave.

If you elect to cease participation during the leave period, coverage will resume upon your return to work under your prior elections, unless changed by you in accordance with the Change in Election Event rules described above. However, you have two choices regarding the flexible spending medical account:

- You can elect to have your contributions resume at the level in effect prior to the leave, in which case the annual medical account contribution you elected would be reduced to reflect the period of no contributions.

- You can elect to increase your contributions for the remainder of the year following

the leave so that your annual contribution to the flexible spending medical account will equal the annual contribution in effect prior to the leave.

For example, suppose you had elected a $1,200 flexible spending medical account (monthly contributions of$100) and were absent on leave for the months of April, May and June. When you return to work in July, you could continue to make contributions of $100 per month, in which case the maximum annual reimbursement from the flexible spending medical account would be $900 ($1,200 minus $300 in missed contributions). Alternatively, you could increase your monthly contribution to $150 for the remainder of the year and have a maximum annual reimbursement from the flexible spending medical account of $1,200 (three months of $100 contributions, three months of $0 contributions and six months of $150 contributions).

- Leaves of absence under this policy shall not constitute a break in the employee's length of continuous service; you will not lose any employment benefits you have accrued prior to taking leave.

- If you terminate your employment during your leave, the date of your qualifying event will be the day your employment ends with the Williamsport Area School District.

Please contact the Human Resources Department regarding procedures and guidelines for the Family Medical Leave Act.

CONTRIBUTIONS FOR COVERAGE, SPECIAL RIGHTS FOR WOMEN, GENETIC NON- DISCRIMINATION ACT ("GINA"), NON ASSIGNMENT OF BENEFITS, CONTINUATION AND CONVERSION RIGHTS

Contributions for Coverage

Williamsport Area School District will pay the total premium cost for the following coverage:

- Dental
- Health Savings Accounts (employer contributions)
- Health Reimbursement Arrangement (HRA)

You will pay a portion of the total premium cost of your coverage under the following plans:

- Medical (including prescription drugs) (pre-tax dollars) [2]
- Dental (pre-tax dollars) [3]

You will pay all of the cost of coverage under the following plans:

- Flexible Spending Account Plan (including medical and dependent care spending accounts) (pre-tax dollars)

A summary of the current structure of Participant pre-tax contribution requirements for the current Plan Year can be found in Attachment# 5.

With respect to benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as CHIPRA, COBRA, FMLA, HIPAA, HITECH, GINA, NMHPA, MHPAEA, WHRCRA, and PPACA.

Special Rights on Childbirth

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Special Rights for Women

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

[2] Part-time Professional Staff premium contributions for medical (including prescription drugs) coverage are based on hours worked.

[3] Part-time Professional Staff premium contributions for dental coverage are 50% of current premium costs

Genetic Information Nondiscrimination Act ("GINA")

GINA prohibits employer-sponsored group health plans and health insurers providing group insurance from:

- Increasing premium or contribution amounts based on genetic information;
- Requesting or requiring an individual or family member to undergo a genetic test; and
- Requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Genetic information means:

- The individual's genetic tests;
- The genetic tests of family members;
- The manifestation of a disease or disorder in family members; or
- Any request for, or receipt of, genetic services or participation in clinical research that includes genetic services, by the individual or family member.

Genetic information does not include information about the sex or age of any individual, it does include, with respect to a pregnant woman, an individual who is utilizing an assisted reproductive technology,

or a family member, genetic information of any fetus carried by the pregnant woman or of any embryo legally held by the individual or family member.

Mental Health Parity and Addiction Equity Act ("MHPAEA")

MHPAEA prohibits financial requirements and treatment limits for mental health and substance use disorder benefits that are more restrictive than the predominant financial requirement or treatment limit that applies to all or substantially all medical and surgical benefits.

Treatment limits include limits on the scope and duration of treatment.

The MHPAEA regulations set out a framework for assessing compliance with respect to financial requirements such as deductibles and coinsurance and quantitative treatment limits (e.g. day and visit limitations).

When the plan provides a mental health or substance use disorder benefit in any of the following six classifications, mental health and substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

The Plan is prohibited from providing a more restrictive financial requirement or treatment limit than the predominant level that applies to all or substantially all medical/surgical benefits on any mental health or substance use disorder benefit within each of the above classifications.

Non-Assignment of Benefits

Except as may be required pursuant to a "National Medical Child Support Order" which provides for Plan coverage for an alternate recipient, no participant or beneficiary may transfer, assign or pledge any Plan benefit.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends and if you have exhausted your rights under COBRA. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your benefit continuation or conversion rights, please contact the insurance company.

HOW THE PLAN IS ADMINISTERED

Plan Administration

The Lycoming County Insurance Consortium on behalf of the Williamsport Area School District is the Plan Administrator for medical (including prescription drugs) plan. The Director of Human Resources and the Business Administrator of the Williamsport Area School District have been designated to act as the Plan Administrator for all other benefits offered under the Plan.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

Duties of the Plan Administrator

I) To administer the Plan in accordance with its terms for the exclusive benefit of persons entitled to participate in the Plan;
2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
3) Prescribe applicable procedure, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan;
4) To decide disputes that may arise relative to a Plan participant's rights;
5) To prescribe procedures for filing a claim for benefits and to review claim denials;
6) To keep and maintain the Plan documents and all other records pe1taining to and necessary for the administration of the Plan;
7) To reject elections or to limit contributions or benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Internal Revenue Code;
8) To provide Employees with reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;
9) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Plan Administrator determines shall be paid if the Plan Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Plan Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;
10) To appoint a Claims Supervisor to pay self-insured claims, or to appoint agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan; and
11) The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

Plan Administrator Compensation

The Plan Administrator serves without compensation however, all expenses for plan administration, including compensation for hired services, will be paid by the School District.

Power and Authority of the Plan Administrator

The Plan has benefits that are self-insured with administrative services provided by third party administrators. The Plan Administrator along with the Third Party Administrator are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Williamsport Area School District has contracted with the following third party administrators to provide the following benefits:

Highmark Blue Cross Blue Shield	Medical (including prescription drugs)

Delta Dental	Dental
Further	Flexible Spending Account Plan (including medical and dependent care spending accounts)
Further	Health Savings Account Program
Further	Health Reimbursement Arrangement

Questions

If you have questions regarding eligibility for, or the amount of, any benefit payable under the self- insured component benefit plan, please contact the third party administrator or the Plan Administrator.

CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

Denial or Loss of Benefits

An Eligible Employee's benefits (and the benefits of his or her eligible spouses, domestic partners, and dependents) will cease when the Employee's participation in the Plan terminates (that is, when coverage ends). Benefits also cease upon termination of the Plan. In both instances, expenses incurred before coverage ended generally remain payable.

Other Circumstances

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied based on lack of medical necessity. The group insurance contracts provide additional information.

AMENDMENT OR TERMINATION OF THE PLAN

Williamsport Area School District as the Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by Williamsport Area School District or any of its delegates. Williamsport Area School District reserves the right to modify the Plan, including but not limited to, an increase in employee contributions or reduction in benefits, or the suspension or termination of the entire Plan or any benefit offered under the Plan, at any time. Union employees covered by a collective bargaining agreement will be notified in advance of any changes. Should the Plan or any benefit offered under the Plan terminate, all eligible claims incurred prior to the termination date will be paid, subject to the procedures described in the section entitled "Claims Procedures". Any claims incurred after the date of termination of the Plan or any benefit offered under the Plan will not be considered for payment, except to the extent required by law.

The President of the Board of School Directors and/or the Director of Human Resources signs administrative contracts for this Plan on behalf of Williamsport Area School District, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

NO CONTRACT OF EMPLOYMENT

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Williamsport Area School District to the effect that you will be employed for any specific period of time.

CLAIM ADMINISTRATIVE SERVICES

CLAIMS AND APPEALS TIMETABLE

	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision{s)
Medical Dental Medical Flexible Spending Accounts	Urgent Care Claims	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your claim by the Claims Administrator. Note that this notice may be given to you orally within the applicable time period, and a written or electronic notice will follow within three days of such oral notice.	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your request for review by the Claims Administrator.
	Pre-Service Claims	Within a reasonable period of time appropriate to the medical circumstances but not later than **15 days** after receipt of your claim by the Claims Administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of your request for review by the Claims Administrator.
	Post-Service Claims	Within a reasonable period of time, but not later than **30 days** after receipt of your claim by the Claims Administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator.
	Concurrent Care Claims	An extension of a course of treatment will follow the pre-service, post- service or urgent care procedures above, but a claim for urgent care continuation submitted **24 hours** before the end of the of the approved course of treatment must be processed within **24 hours** instead of **72 hours.**	An appeal for an extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above

All Eligibility Determinations and Other Benefits	Dependent Care Flexible Spending Account	Within a reasonable period of time, but not later than **90 days** after receipt of your claim by the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator. May be extended for an additional **60 days.***

*Upon written notice explaining the special circumstances that create a need for an extension.

CLAIMS EXPENSE AND OTHER CHARGES TO THE SCHOOL DISTRICT

The School District shall pay and fund in full all Cost of Services on behalf of the School District plus any additional amounts set forth therein.

NOTICE OF DECISION OF A CLAIM

Claims under the Health Plan

If your claim for benefits under the Plan is denied, you will receive a written notice of the decision to deny the claim within 30 days after Highmark Blue Cross Blue Shield, Delta Dental, or Further (the designated claims processors) receipt of the claim, unless special circumstances require an extension of up to 15 additional days to process the claim. If such an extension of time for processing the claim is required, as determined in the designated claims processor's sole discretion, you will receive written notice of the extension before the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the designated claims processor expects to render a benefit determination.

- The specific reason or reasons for the denial;
- Reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit the claim for review.

Review Procedures for Denied Claims Review of Claims under the Health Plan

The following claims review procedures apply without regard to any conflicting procedures described in the attached booklet.

Appeal. If your claim for benefits is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim or no notification as to an extension of the determination period within 90 days after submission of the claim to the designated claims processor, the claim for benefits will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing a written request for review with the insurance company Claims Administrator.

You must file a written request for review of a denied claim within 60 days after you receive written notice of the denial of the claim, or within 60 days after the date such claim is deemed to be denied. In connection with an appeal, you shall be permitted to review pertinent documents with respect to your claim, as determined by the insurance company Claims Administrator. Additionally, you may submit to the insurance company Claims Administrator written issues and comments relating

to your claim in connection with the insurance company Claims Administrator's review of your claim.

Review. The insurance company Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The insurance company Claims Administrator will render a decision regarding the claim within 60 days after the date the insurance company Claims Administrator receives your request for review, unless the insurance company Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case the insurance company Claims Administrator will render a decision as soon as possible, but not later than 120 days after the insurance company Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the insurance company Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 60-day period. The extension notice shall indicate the special circumstances requiring an extension of time.

The insurance company Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim.

Disposition on Review. You will receive written notification of the insurance company Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:

- The specific reason or reasons for the denial of the claim; and
- Specific references to pertinent plan provisions on which the benefit determination is based.

If the decision on review is not furnished within the period specified above, the claim shall be deemed denied on review at the expiration of that period.

You may, upon request and free of charge, obtain the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination regarding your claim, without regard to whether such expert's advice was relied upon in making a benefit determination on review.

For purposes of determination of the amount of, and entitlement to benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance.

If your claim is denied, you may appeal to the insurance company.

SUBROGATION

Employer Responsibilities

Employer warrants that the SPD confers on the Employer rights of subrogation and third party recovery. Employer delegates or assigns these subrogation rights and third party recovery rights to Highmark Blue Cross Blue Shield as the Employer's agent for purposes of subrogation only.

Highmark Blue Cross Blue Shield's Subrogation Duties

Highmark Blue Cross Blue Shield shall undertake reasonable steps to identify claims in which the Employer has a subrogation interest and shall manage subrogation cases on behalf of the Employer. Highmark Blue Cross Blue Shield shall be subrogated, and succeed to the rights of a Participant for any and all recovery of Covered Services paid and reasonably expected to be paid against any person or organization except insurers or policies of health insurance issued to and in the name of Participant. Highmark Blue Cross Blue Shield shall provide the Participant's attorney with updated lien amounts, as requested, and shall work with the Participant's attorney to recover 100% of the Covered Services paid (unless such amount is compromised as set forth in Section C and D). Highmark Blue Cross Blue Shield shall credit the Employer with the amount received, minus, as applicable, Highmark Blue Cross Blue Shield's attorney's fees and its pro-rata share of the costs expended in the recovery of the subrogation interest.

In consideration for the advancement of benefits, Highmark Blue Cross Blue Shield is subrogated to all of the rights of the Participant against any party liable for the Participant's injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Participant under Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield may assert this right independently of the Participant. This right includes, but is not limited to, the Participant's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Participant's rights under Highmark Blue Cross Blue Shield to bring an action to clarify his or her rights under Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield is not obligated in any way to pursue this right independently or on behalf of the Participant, but may choose to pursue its rights to reimbursement under Highmark Blue Cross Blue Shield, at its sole discretion.

Authority to Compromise Liens

In those instances where an Employer's subrogation lien should, in the opinion of Highmark Blue Cross Blue Shield, be compromised or abandoned, the Employer delegates to Highmark Blue Cross Blue Shield full authority to act on behalf of the Employer to compromise or abandon the lien. Any determination by Highmark Blue Cross Blue Shield with respect to subrogation liens shall be final and conclusive, unless overturned under a limited arbitrary and capricious standard of review.

Participant's Duties

The Participant is obligated to cooperate with Highmark Blue Cross Blue Shield and its agents in order to protect Highmark Blue Cross Blue Shield's subrogation rights. Cooperation means providing Highmark Blue Cross Blue Shield or its agents with any relevant information requested by them, signing and delivering such documents as Highmark Blue Cross Blue Shield or its agents reasonably request to secure Highmark Blue Cross Blue Shield's subrogation claim, and obtaining the consent of Highmark Blue Cross Blue Shield or its agents before releasing any party from liability for payment of medical expenses.

Highmark Blue Cross Blue Shield shall have the right to recover, against any source, which makes payments, or to be reimbursed by the covered Participant who receives such benefits, 100% of the amount of covered benefits paid. If the 100% reimbursement provided above exceeds the amount recovered by the covered Participant, less legal and attorney's fees incurred by the covered Participant in obtaining such recovery, the covered Participant shall reimburse Highmark Blue Cross Blue Shield the entire amount of such net recovery. The Participant shall take such action, furnish such information and assistance, and execute such papers as Highmark Blue Cross Blue Shield may require to facilitate enforcement of its rights and shall take no action prejudicing the rights and interests of Highmark Blue Cross Blue Shield. In those instances where the subrogation recovery efforts of the Participant's attorney should, in the opinion of Highmark Blue Cross Blue Shield, be compensated, the Employer delegates to Highmark Blue Cross Blue Shield full authority to act on behalf of the Employer to negotiate reasonable attorney fees, to be deducted from Participant's payment to Highmark Blue Cross Blue Shield, not to exceed forty percent (40%).

If the Participant enters into litigation or settlement negotiations regarding the obligations of other parties, the Participant must not prejudice, in any way, the subrogation rights of Highmark Blue Cross Blue Shield under this section. In the event that the Participant fails to cooperate with this provision, including executing any documents required herein. Highmark Blue Cross Blue Shield may, in addition to remedies provided elsewhere in Highmark Blue Cross Blue Shield and/or under the law, set off from any future benefits otherwise payable under Highmark Blue Cross Blue Shield the value of benefits advanced under this section to the extent not recovered by Highmark Blue Cross Blue Shield.

Highmark Blue Cross Blue Shield's subrogation right takes first precedence and must be satisfied in full prior to any other claim of the Participant or his/her representative(s), regardless of whether the Participant is fully compensated for his/her damages. The costs of legal representation of Highmark Blue Cross Blue Shield in matters related to subrogation shall be borne solely by Highmark Blue Cross Blue Shield. The costs of legal representation of the Participant shall be borne solely by the Participant.

Prohibited by Law

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.

Claim Procedures for the Self-Funded Flexible Spending Account Plan, Health Reimbursement Arrangement, and Dental Plan

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through Williamsport Area School District's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute and submit to the Plan Administrator a written claim on the form available from the Plan Administrator.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim.

To receive any benefit under this Plan, a covered Employee, his or her covered Dependents, and any representative designated by the covered Employee or a covered Dependent must follow the Plan's procedures for requesting benefits and filing claims. Covered Employees should read the procedures explained in this section of the document and ask questions about any procedures that he or she does not understand.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Insured Benefits and State Insurance Laws

With respect to any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 24 months after the final review/appeal decision by the insurance company Claims Administrator has been rendered (or deemed rendered).

HIPAA PROVISIONS FOR HEALTH COMPONENT BENEFITS

This provision shall only apply to benefits that are subject to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its implementing regulations, issued under the Privacy Regulations at 45 CF.R. Parts 160 and 164.

This section shall be interpreted in a manner that permits the Plan to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state laws regarding protection of Protected Health Information (PHI).

The health component benefits of the Plan will use and disclose protected health information (PHI), as defined in 45 CFR 164.501, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the health component benefits will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as defined in the health component benefit HIPAA Privacy Notice (as defined in 45 CFR 164.520) distributed to Participants.

Health *information* means any information, whether oral or recorded in any form or medium, that:

a) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

b) Relates to the past, present, future physical or mental health or condition of any individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual; and:

I. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

2. Relates to the past, present, or future payment for the provision of health care to an individual; and
   a. Identifies the individual; or
   b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information means individually identifiable health information (defined above):

1. Except as provided in paragraph *(2)* of this definition; that is:
   a. Transmitted by electronic media;
   b. Maintained in electronic media; or
   c. Transmitted or maintained in any other form or medium.
2. Protected Health Information excludes individually identifiable health information in:
   a. Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g:
   b. Records described at *20* U.S.C. l 232g(a)(4)(B)(iv); and
   c. Employment records held by a covered entity in its role as employer.

The HIPAA Privacy Rules covers protected health information in any medium while the HIPAA Security Rule covers electronic protected health information.

The health component benefits of the Plan will disclose PHI to Williamsport Area School District only upon receipt of a certification from Williamsport Area School District that this Summary Plan Description has been amended to incorporate the provisions below and that the Employer agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the health component benefits and Williamsport Area School District.

WILLIAMSPORT AREA SCHOOL DISTRICT'S OBLIGATIONS WITH RESPECT TO PHI

With respect to PHI Williamsport Area School District agrees to certain conditions. Williamsport Area School District agrees to:

- not use or disclose PHI other than as permitted or required by this Summary Plan Description or as required by law;
- ensure that any agents (including a subcontractor) to whom Williamsport Area School District provides PHI received from the Plan agree to the same restrictions and conditions that apply to Williamsport Area School District with respect to such PHI;
- not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of Williamsport Area School District unless authorized by an individual;
- report to the Plan any PHI use or disclosures of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures:
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA;
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Williamsport Area School District will follow the privacy and security obligations required under the Health Information Technology for Economic and Clinical Health Act (HITECH), including notification of a breach involving unsecured PHI within the required 60-day timeframe, securing PHI, and development of procedures for breach identification.

Access to PHI within Employer

Adequate separation will be maintained between the Plan and Williamsport Area School District. Only the individuals or classes of employees identified in the health component benefits HIPAA Privacy Notice distributed to Participants in accordance with HIPAA shall have access to PHI. The persons described in the health component benefits HIPAA Privacy Notice may use or disclose PHI only for Plan administration functions that Williamsport Area School District performs for the Plan. If the persons described herein or any other employees do not comply with the Summary Plan Description. Williamsport Area School District shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. Williamsport Area School District shall cooperate with the Plan to correct and mitigate any such noncompliance.

Privacy Official

The Privacy Official shall be responsible for compliance with Williamsport Area School District and the health component benefits obligations under this section and HIPAA. Specific rules regarding the Privacy Official follow:

1. Appointment. Resignation and Removal of Privacy Official. Williamsport Area School District shall appoint one or more individuals to act as Privacy Official on matters regarding the health

component benefits. The individual appointed as Privacy Official may resign by giving 30 day notice in writing to Williamsport Area School District. Williamsport Area School District shall have the power to remove that individual for any or no reason.

2. Policies and Procedures. The Privacy Official shall from time to time formulate and issue to Participants and Williamsport Area School District such policies and procedures as he or she deems necessary for substantive provision of the health component benefits. Additionally, such policies and procedures must be accepted by the Plan Administrator.
3. Privacy Notice. The Privacy Official shall be responsible for arranging with Williamsport Area School District, the Plan Administrator and any third-party administrator for the issuance of, and any changes to the Privacy Notice.
4. Complaint Contact Person. The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this section and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the health component benefits HIPAA Privacy Notice.

If you would like to place a request for alternate communications, or file a complaint regarding your privacy rights, you may contact us by writing to:

Williamsport Area School District
Privacy Officer - Director of Human Resources

It has always been the goal of Williamsport Area School District to ensure the protection and integrity of our members' personal and health information. Therefore, we will notify you of any potential situations where your information would be used for reasons other than payment and health plan operations.

HIPAA Security Standards

This section explains the Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information under the security standards of HIPAA.

Where Electronic Protected Health Information (e-PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor will reasonably safeguard thee-PHI as follows:

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that the Plan Sponsor creates, receives, maintains; or transmits on behalf of the Plan,
- The Plan Sponsor will ensure that the adequate separation that is required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures,
- The Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides e-PHI agrees to implement reasonable and appropriate security measures to protect such e-PHI, and The Plan Sponsor will report to the Plan any Security Incidents of which it becomes aware as described below:
- The Plan Sponsor will report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure. modification, or destruction of the Plan's e-PHI, and
- The Plan Sponsor will report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

PARTICIPANT RIGHTS TO DOCUMENTS:

Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with any government agency.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator at the Human Resource's Office. Williamsport Area School District may make a reasonable charge for the copies.

- The people who operate your Plan, called "fiduciaries" of the plan, have a duty to operate the Plan prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under applicable law. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under the Plan document, and under applicable law, there are steps you can take to enforce the above rights. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a court of competent jurisdiction. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file suit in a court of competent jurisdiction. If you have any questions about your Plan, you should contact the Plan Administrator.

SIGNATURE

IN WITNESS WHEREOF, we have executed this Plan Agreement the date and year first written above.

Employer/Plan Sponsor: Anne Logue

Williamsport Area School District

Date: 12/7/2021

Attest: Alesia Rudinski

Exhibit A

Section 125 / Cafeteria Plan Benefits Flexible Spending Account Plan:
Medical and Dependent Care Spending Accounts

Before Tax Savings

When you elect to make contributions to the Medical or Dependent Care Flexible Spending Account or elect to pay premiums under the Medical (including prescription drugs) program with before-tax payroll reductions, you save the federal income tax and the Social Security tax that would ordinarily be deducted from your paycheck as a result of that compensation.

Your actual tax savings will depend on how much you earn, your federal income rate, and how much you spend on before- tax benefits. Suppose that you earn $25,000 and are married; that your rate on your joint tax return is 24%; and that you decide to pay $1,000 for dependent care coverage. You would calculate your savings (based on 2020 federal income tax and Social Security tax rates) as follows:

7.65%	Social Security tax rate
+ 24.00%	Federal income tax rate
31.65%	Total tax savings rate

31.65% x $1,000 = $316.50 total savings.

If your compensation is greater than the Social Security taxable wage base in any year ($137,700 in 2020 and $142,800 in 2021), you will have lower Social Security tax savings. This is because the old age portion of the Social Security tax (6.2% out of 7.65%) is not applied to compensation in excess of the taxable wage base for a year. The Medicare portion of Social Security tax (1.45% out of 7.65%) continues to apply to compensation in excess of the taxable wage base for the year. Therefore, your tax "savings'' are reduced with respect to compensation in excess of the taxable wage base. However, you will still save federal income tax and possibly state and local income tax (see below). Most states do not impose an income tax on employee before-tax contributions to plans such as the Cafeteria Plan. Please consult your tax advisor on whether these amounts are taxable by municipal taxing authorities.

Examples of Tax Advantages When Participating in the Plan

Participating in the Plan can actually increase your take home pay. Consider the following example:

You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the Employee-only premium, plus $2,000 for family coverage under the Employer's medical insurance plan). You earn $50,000 and your Spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan	If you do not participate in the Cafeteria Plan
1. Gross Income	$50,000	$50,000
2. Salary Reductions for Premiums	$2,400 (pretax)	$0
3. Adjusted Gross Income	$47,600	$50,000
4. Standard Deduction	($9,700)	($9,700)
5. Exemptions	($9,300)	($9,300)
6. Taxable Income	$28,600	$31,000
7. Federal Income Tax (Line 6 x applicable tax schedule)	($3,590)	($3,904)
8. FICA Tax (7.65% x Line 3 Amount)	($3,641)	($3,825)
9. After-tax Contributions	($0)	($2,400)
10. Pay After Taxes and Contributions	$40,369	$39,871
11. Take Home Pay Difference	$498	

Wages which are reported to the Social Security Administration (SSA) will not include your payroll reductions under the Section 125 Cafeteria Plan. Wages reported to the SSA are eventually used to determine the average compensation on which your Social Security benefit is based. Consequently, you may have a slightly reduced Social Security retirement or disability benefit. This will happen if your taxable wages after before-tax contributions are less than the Social Security taxable wage base ($137,700 indexed for 2020 and $142,800 for 2021). However, the current tax advantages should more than offset any reduction in your Social Security benefit.

Flexible Spending Accounts

If you contribute to the Flexible Spending Account Plan (including medical or dependent care accounts) the school district will establish an account in your name under the applicable plan(s). Your contributions for medical expense reimbursement will be allocated to your medical flexible spending account, and your contributions for dependent care assistance will be allocated to your dependent care flexible spending account. You may contribute before-tax dollars to either or both accounts.

See your Flexible Spending Account Plan information regarding eligible expenses in the program. Any eligible dependent care expenses may be reimbursed out of your dependent care flexible spending account. Amounts cannot be transferred from one flexible spending account to the other.

When you elect to contribute an amount to medical or dependent care accounts, the school district will deduct the amount you have elected to contribute and allocate that amount in the account you have chosen. When you incur an eligible medical or dependent care expenses, you are reimbursed from the appropriate account.

Contributions

Generally, you may contribute up to a maximum of $2,750 for 2021, indexed each year. You may contribute up to a maximum of $5,000 (or up to $2,500 if you are married and file separate tax returns) to the Dependent Care Spending Account each year. However, see the tax related sections below regarding the amount of tax-free reimbursement you can receive from the dependent care account each year.

The amounts you contribute to the Flexible Spending Account Plan are contributed on a before-tax basis and will not be subject to federal or, in most cases, state income tax. This means that your taxable compensation will be reduced, but your gross income will not be.

Special Rule for Dependent Care Spending Account Contributions

The amount of contribution into the Dependent Care Spending Account cannot be greater than the Participant's income or the Participants Spouse's income, whichever is lower. For example, if the Participant earns $25,000 a year and a Spouse earns $4,500, the maximum contribution for dependent care expenses cannot exceed $4,500.

Eligible medical expenses that exceed my account balance

You may be reimbursed from your medical account up to the total amount you have elected to contribute for the Plan Year, even if the balance in your Account is less than the elected amount at the time you request the reimbursement.

Eligible dependent care expenses that exceed my account balance

Unlike your medical account, you will only be reimbursed up to the balance in your dependent care account at the time of your request for reimbursement. Any eligible expenses exceeding your balance will automatically be reimbursed as new contributions are added to your account.

Special Rules for Flexible Spending Account Grace Period Extensions

Plan permits you to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year (January 31st) for Medical Care Expenses incurred during a Grace Period following the end of the Plan Year. Grace Periods will begin on February 1st and will end on April 15th

In order to take advantage of the Grace Period, you must be:

- A Participant in the Plan with Health FSA coverage that is in effect on the last day of the Plan Year to which the Grace Period relates (January 31st), or
- A qualified beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the Grace Period relates (January 31st).

The following additional rules will apply to Medical Care Expenses that are incurred during a Grace Period or are submitted after the close of the Plan Year in which they were incurred:

- Medical Care Expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $200 remains in your Health FSA Account at the end of the 2020 Plan Year and that you have also elected $2,400 of Health FSA coverage for 2021. If you submit a $500 Medical Care Expense that was incurred on February 15, 2021, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA Account from the 2020 Plan Year and the remaining $300 will be paid out of the amounts that are available to reimburse you for Medical Care Expenses incurred in the 2021 Plan Year. Claims will be paid in the order in which they are approved.
- Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the $500 Grace Period expense, you discover $200 of 2020 Medical Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2020 expenses. The Plan will not

reprocess the $500 Grace Period expense so as to pay it entirely from your 2021 Health FSA amounts. For this reason, if you have Health FSA coverage for both the prior and current years, you may want to wait to submit Medical Care Expenses you incur during the Grace Period until you are sure you have no remaining un-reimbursed expenses from the prior Plan Year.

- Expense incurred during a Plan Year or its Grace period must be submitted by the June 15 following the close of the Plan Year in order to be considered for reimbursement from amounts remaining at the end of that Plan Year. Unused amounts remaining in a Participant's Health FSA Account at the end of a Plan Year that are not applied to pay expense submitted on or before the April 15 deadline will be forfeited.

Reimbursable medical account expenses

Generally, only expenses which are considered by the Internal Revenue Service to be tax-deductible medical expenses are considered eligible for reimbursement under the medical account, with the exception of premiums paid for other health plan coverage (including Medicare or plans maintained by the School District or the employer of your Spouse applies for income tax purposes). A prescription is required for reimbursement of over-the-counter (OTC) medical care items.

Refer to IRS Publication 502, "Medical and Dental Expenses," (available on the IRS' website at www.irs.gov) for more information regarding eligible and ineligible medical expenses, subject to the caveats in the preceding paragraph.

If you receive a reimbursement from your Medical Spending Account and reimbursement for the same expense through your medical (including prescription drugs), dental or another health plan, you must refund the reimbursement you received from your Medical Spending Account to the Plan.

Eligible expenses reimbursable from dependent care spending accounts

Generally, reimbursable expenses include day-care costs for children and dependent adults: provided such expenses are necessary in order for you and your Spouse to work or attend school full-time. (A special rule applies if your Spouse is physically incapacitated.).

If the dependent is a child, the following rules also apply:

The child must be younger than 13, lives with you for more than one-half of the calendar year and does not provide more than one-half of his or her own support for the year;

Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent for income tax purposes or one of your children under age 19;

If the care is provided by a facility that cares for more than six children, the facility must be licensed.

If the dependent is an adult or an older dependent child, the following rules also apply:

- The dependent must be physically or mentally incapable of caring for him or herself;
- He or she must either be your spouse or be dependent upon you for at least 50% of his financial support; He or she must live with you for more than one-half of the calendar year;
- He or she must not have gross income in excess of a specified amount; this

does not apply to a spouse. He or she must not be someone else's "qualifying child'' for federal income tax purposes;

- Care may be provided either inside or outside your home; however, expenses outside of your home (e.g., at a nursing home) are eligible only if the dependent regularly spends at least eight hours each day in your household.

To make sure your situation and the type of care being provided meets IRS requirements refer to IRS Form 2441 and IRS Publication 503, "Child and Dependent Care Expenses."

Dependent care provider in your home

If you use a dependent care provider inside your home you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees.'' These forms and publications are available on the IRS' website (wwvv.irs.gov), and also should be available at your local post office or public library.

Reimbursements under the medical and dependent care account and taxation

Amounts paid to you under the Flexible Spending Account Program are intended to be tax-free to you and no taxes will be withheld from any reimbursement. However, special rules applicable to the dependent care account may cause some reimbursement to be taxable to you. Federal law provides that the amount of dependent care reimbursement excluded from your gross income cannot exceed the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or
- Your spouse's annual income.

If your Spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your Spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents). The amount you use to determine your Spouse's annual income is the greater of the actual earned income or these assumed monthly income amounts of either $250 or $500. By making an election under the Plan to contribute to a dependent care account, you are representing to the Employer that your contributions to the Flexible Spending Account Plan dependent care account are not expected to exceed these limits.

If you are married and filing separate federal income tax returns, the $2,500 limit described above will not apply if you are (1) legally separated or (2) your Spouse did not reside with you for the last six (6) months of the calendar year, you maintained a household that was your dependent's primary residence for more than six (6) months during the year and you paid more than half of the expenses of that household.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The

identification number of a care provider who is an individual and not a care center is that individual's social security number. Your care provider should be made aware of this reporting requirement.

Other income tax considerations affecting participation in the dependent care account

You should be aware that there is a dependent care tax credit and an earned income credit.

The Federal Dependent Care Tax Credit

Dependent care expenses for which you are reimbursed from your dependent care account will not qualify for the federal tax credit available with respect to dependent care expenses. Under the Internal Revenue Code, you are entitled to a dollar for dollar credit against your income tax liability in an amount equal to a specified percentage of your qualifying dependent care expenses. For purposes of the credit, there are limitations on the dollar amount of qualifying dependent care expenses that can be taken into account. These limitations are reduced dollar for dollar by dependent care expenses reimbursed under the Dependent Care FSA. In addition, these expenses cannot be taken into account to the extent they exceed the lesser of your or your spouse's earned income.

Therefore, you must determine whether it is more advantageous for you not to establish a dependent care account in order to avail yourself of the federal tax credit. In making this determination, it is important to consider that the amount of compensation you elect to reduce under the Plan is not subject to federal income tax, but also is not subject to Social Security withholding tax (FICA) (7.65% up to $137,700 in 2020 and $142,800 in 2021).

As a general rule, depending upon your particular situation, paying for qualifying dependent care expenses through compensation reduction under the dependent care account will produce greater tax savings the higher your income level. ***If you are not certain as to what extent, if any, it is to your advantage to participate in the Plan, you should consult your personal tax advisor.***

The Federal Earned Income Credit

Another tax credit available under current tax law is the earned income credit. This credit also reduces dollar-for dollar the federal tax you have to pay, but is calculated somewhat differently from the child care credit described above. The credit is available to individuals with a child who is under age 19 (under age 24 if a student) or who is totally and permanently disabled. An additional credit is available to individuals with a child who is under one year old. The credit does not depend on the amount you pay in child care expenses. The earned income credit has no effect on the amount you can contribute under the dependent care account for dependent care expenses, and the earned income credit cannot be claimed for any individual for whom you claim the child care credit described above. Moreover, the use of the dependent care account may result in a reduction in your taxable income thus qualifying you for the earned income credit where you would not otherwise have qualified.

Losing coverage under the Flexible Spending Account Plan

If you elect to participating in the medical account, you have a right to choose continuation coverage if you lose your coverage due to a qualifying COBRA event. In general, you may only continue coverage in the amount in effect on the day before you lost coverage: you may not alter the coverage. If you lose coverage under the Plan, see the COBRA Section **in** this document for your rights to continue coverage in the Flexible Spending Account Plan. Special continuation rules do not apply to any dependent care account election in the Flexible Spending Account Plan.

Special rules for highly compensated and key employees

Under the Internal Revenue Code, certain employees are considered "Highly Compensated Employees" and "Key Employees". To prevent discrimination in favor of these employees, the Plan Administrator may limit or reduce their contributions in a uniform and nondiscriminatory manner. If you are a Highly Compensated and/or a Key Employee, the Plan Administrator will notify you if it becomes necessary to modify the amount of your contributions.

Incorrect amounts in connection with the Plan

It will be assumed that all payments to you are excludable for federal and state income tax purposes and no taxes will be withheld. It is your obligation to determine whether each payment is actually excludable from your gross income for such purposes.

If you receive any payment or reimbursements under the Flexible Spending Account Plan that are not warranted, justified or correct, you will indemnify and reimburse the Employer for any liability which it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements.

Benefit Claims for the Flexible Spending Account Plan

You can submit a claim for an eligible medical expense at any time during the Plan Year.

Claims Administrator:

Further
Customer Service: 1-800-859-2144
www.hellofurther.com

For paper claims, you may also obtain a Reimbursement Request Form for Medical Reimbursement from the Plan Administrator. When submitting your claim form, you must also submit a copy of the original itemized bill or receipt for an expense not covered under your medical (including prescription drugs), vision or dental coverage, or the explanation of benefits from the insurance company.

In accordance with the Uniform Reimbursement Requirement for Flexible Spending Accounts under the provisions of the Internal Revenue Code, you may obtain reimbursement up to the amount you have elected (plus any available Employer contributions) to deposit into your Medical Spending Account.

You can submit a claim for an eligible dependent care expense at any time during the Plan Year.

The money deposited in your account for the Plan Year will be used to reimburse you for eligible

expenses incurred during that year only. An expense is incurred when the care is provided, and not when the bill is sent or payment is made. There is no extension of the claims incurrence period for the Dependent Care Spending Account.

Reimbursements for dependent day care expenses are allowed up to the amount actually in your Dependent Care Spending Account at the time you submit your request. If your claim for benefits exceeds the amount currently available in your Dependent Care Spending Account, you will receive additional reimbursements as more money is deposited into your account through salary reductions.

Change in Employment Status or Death of a Participant

In the event of a death of a participant, deposits stop. Your surviving dependents may submit for reimbursement, eligible expenses incurred prior to the participant's death. Claims for eligible expenses incurred prior to the participant's death must be submitted within 90 days following the close of the Plan Year.

If your employment status changes from an eligible to ineligible status, deposits stop at the date of the change in status. Requests for reimbursement of expenses incurred prior to the change in employment status must be submitted within 90 days following the close of the Plan Year.

Denial of benefit in the Flexible Spending Account Plan

If your claim for medical account benefits is denied by the Plan Administrator or Third Party Administrator, you will be notified of this, in writing, within thirty-one (31) days after receipt of your claim. If the Plan Administrator or Third Party Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Plan Administrator or Third Party Administrator will notify you within the initial thirty-one (31) day period that the Plan Administrator or Third Party Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because you failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that you will need to provide to the Plan Administrator or Third Party Administrator. You will have no less than forty-five (45) days from the date you receive the notice to provide the requested information.

If your claim for dependent care account benefits is denied by the Plan Administrator or Third Party Administrator, you will be notified of this, in writing, within ninety (90) days (or one hundred eighty (180) days under special circumstances) after receipt of your claim.

The written notice of denial will include the following information:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect his or her claim and an explanation as to why such information is necessary;
- in the case of a medical account claim, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at the claimant's request; and

- a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that the claimant is eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal).

If an initial claim for benefits is denied by the Plan Administrator or Third Party Administrator, you or your duly authorized representative may appeal the denial by filing a written request with the Plan Administrator or Third Party Administrator within sixty (60) days (in the case of a dependent care account claim) or one hundred eighty (180) days (in the case of a medical account claim) after receipt of the notice denying the initial claim for benefits. Upon your decision to appeal a denied claim for benefits, you or your duly authorized representative will be able to submit written comments, documents, records, and other information relating to his or her claim for benefits (regardless of whether such information was considered in the initial claim for benefits) to the Plan Administrator or Third Party Administrator for review and consideration. You or your duly authorized representative will be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the appeal.

Upon receipt of your appeal of a denied claim for benefits, the Plan Administrator or Third Party Administrator will respond to the claim within sixty (60) days (or one hundred twenty (120) days in the case of a dependent care account claim), after receipt of the appeal.

If the Plan Administrator or Third Party Administrator denies the claim (in whole or in part), the Plan Administrator or Third Party Administrator will provide you or your duly authorized representative with written notice of the denial. This notice will include the following:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the claim and/or appeal for benefits;
- in the case of a medical account claim, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you or your duly authorized representative free of charge at his or her request; and

You must follow all the steps described above before you may consider legal action against the Plan or the Plan Administrator. Naturally, both you and the Plan Administrator will want to avoid legal action. However, if you feel that legal action is necessary, any summons or other legal documents should be served to the agent for service of legal process found in this Plan document.

Termination of Employment

If you terminate your employment with the school district, all claims for benefits from the Flexible Spending Account Plan incurred during your employment are reimbursable to you within 90 days of your date of termination. You must submit the appropriate claim form to the Claims Administrator for the Flexible Spending Account Plan. You may also have a right to COBRA continuation coverage for your limited purpose medical spending account.

Exhibit B

Williamsport Area School District Health Reimbursement Arrangement (HRA)

Purpose of the Plan

The Williamsport Area School District Health Reimbursement Arrangement (HRA) is adopted by Williamsport Area School District is the Plan Sponsor. The purpose of the program is to allow Eligible Employees of Williamsport Area School District to obtain reimbursement of medical care expenses on a non-taxable basis from the program. Williamsport Area School District intends the program qualify as an employer-provided medical reimbursement program under Code Sections 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The medical care expenses reimbursed under the program are intended to be eligible for exclusion from the Participants income for Federal Income Tax purposes under Section 105(h) of the Internal Revenue Code.

Under the terms of IRS Notice 2013-54, your HRA is considered an "Integrated HRA" with the following specification:

> The HRA will be integrated with the Williamsport Area School District's group health plan (medical (including prescription drugs plan)). This means you must be enrolled in your employer's group health plan in order to receive benefits from this program. If you are a participant you may opt out of the HRA at any time during the year.

Plan Year

WAESP/Confidential Secretaries: 1/1 to 12/31
WEA/WASA: 2/1 to 1/31

Participation

An individual is eligible to participate in the program if the individual is an Employee; regularly works 30 or more hours per week; and is eligible to participate in and is enrolled in the Williamsport Area School District's group health insurance program.

Cessation of Participation

A Participant will cease to be a Participant as of the earliest of:

1. the date on which the program terminates;
2. the date on which the Employee ceases to be an Eligible Employee; provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Plan Administrator on a uniform and consistent basis.

Reimbursements from the HRA after termination of participation will be made pursuant to a 90 day run-out period for submitting claims incurred prior to termination and relating to COBRA.

Provision of Benefits

When an Eligible Employee becomes a Participant in the program, a HRA Account will be established for the Participant to receive benefits in the form of reimbursements for medical care expenses. Under no circumstances shall benefits be provided in the form of cash or any other

taxable or no-taxable benefit other than reimbursement for eligible medical care expenses.

Employee Contributions

There are no employee contributions for benefits under the program.

Employer Contributions

The Employer funds claims for each Participant as they occur. The Participant is required to complete a HRA Reimbursement Form for Williamsport Area School District in order to receive benefits in the program.

Nondiscrimination

The program shall not discriminate in favor of Highly Compensated Individuals as to eligibility and benefits as defined under Code Section 105(h).

Benefits

The program will reimburse Participants for medical care expenses up to the unused amount available to the Participant in the **HRA** Program.

Eligible Medical Care Expenses

Under the HRA, a Participant may receive reimbursement for eligible medical care expenses incurred during a period of coverage.

An eligible medical care expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical care expenses incurred before a Participant first becomes covered by the program are not eligible for reimbursement. A medical care expense incurred during one period of coverage may be paid during a later period of coverage provided that the Participant was a Participant in the program during both periods of coverage.

Maximum Benefits

Employer contributions will be made on the basis of your participation in the group health insurance program for Employee only coverage and all other remaining coverage levels per plan year. See the Human Resources Department for more information regarding benefit levels available for you and your family.

Substantiation of Expenses

Medical expenses that qualify and expenses that do not qualify for reimbursement are defined in the benefit booklet of the group medical (including prescription drugs) benefit plan insured by Highmark Blue Cross Blue Shield.

The group medical (including prescription drugs) plan will provide each Participant with an explanation of benefits (EOB) explaining whether the expense qualified for payment or credit against the deductible. Each Participant must submit a written HRA Reimbursement Form to the Plan Administrator accompanied by a copy of the EOB stating the expense has been incurred, the

amount, and whether the claim qualifies for payment or credit against the deductible.

Carryover of Accounts

You may carryover any unused balances in your account for expenses incurred in the upcoming Plan Year.

Ineligible Expenses

The HRA pays for qualifying expenses applicable to the plan year in-network deductible only. If an expense is not covered by the medical (including prescription drugs) plan and not applied to the deductible it not a covered expense. Medical expenses that do qualify for reimbursement are defined in the limitations and exclusions section of the medical (including prescription drugs) plan benefit booklet.

Termination of Employment

Participants may submit claims for reimbursement for expenses incurred before the date of termination, up until three months after you leave. If you elect to continuation coverage through COBRA, you may continue to use your HRA benefits while you are actively participating in COBRA.

Balances at the End of the Plan Year

Participants have three months after the Plan Year ends to submit claims on expenses incurred in that Plan Year, unless you terminate your employment. A terminated employee has three months from their date of termination to submit claims incurred in that Plan Year.

Exhibit C

Health Savings Account Program

A Health Savings Account (HSA) is a tax-favored savings account created for the purpose of paying eligible medical expenses. Contributions to your Health Savings Account are 100% deductible up to the legal limit. Withdrawals to pay qualified medical expenses are never taxed. Interest earnings accumulate tax-deferred, and if used for qualified medical expenses, are tax-free.

Unused money in your HSA is not forfeited at the end of the year and it continues to grow tax-deferred. Your Employer provides you with the opportunity to enroll and contribute to your HSA with pre-tax dollars through salary reduction.

Once you are enrolled in a High Deductible Health Plan and have opened a Health Savings Account, you may submit expenses to your HSA administrator for yourself, your eligible Spouse and your eligible Dependents.

Further is the administrator for the program.

<u>High Deductible Health Plan (HDHP) and Health Savings Accounts (HSA)</u>

HSAs are available when you are participating in a High Deductible Health Plan, as defined by the Internal Revenue Code. As long as you are enrolled in a HDHP, you are permitted to make contributions into and withdrawals from your HSA without taxation if your withdrawals are for qualified medical expenses.

*You **cannot** open an HSA if you are:*

- Covered by any health plan[4] other than a qualified high deductible health plan (HDHP) (dental and vision plans are not included in this restriction);
- Enrolled in Medicare;
- Claimed as a Dependent on another individual's tax return.

<u>Contributions</u>

You decide how much to contribute up to the allowable amount each year. You can contribute through pre-tax salary reduction, or by depositing money from your personal bank account.

The Internal Revenue Service (IRS) sets a limit each year on how much you and/or your Employer can contribute to your HSA during a calendar year. If you are 55 or older, you can add an extra amount each year. This is called a "catch-up" contribution deposit.

Contribution maximums for 2021 include:

- Individual HDHP coverage: $3,600;
- Family HDHP coverage: $7,200; and
- Catch-Up contribution for Employees 55 and older: $1,000.

Additionally, please note the following:

- These amounts are adjusted each year by the IRS for inflation;
- Maximum allowable contributions include any Employer contribution made to your account;
- Your contribution elections may be changed on a monthly basis.
- If you enroll outside of the open enrollment period for the program, you may still be able to

contribute the full annual allowable contribution as long as you continue to be enrolled on December 1st of the Plan Year in which you are first enrolled in the program. If you discontinue your enrollment in a short-plan year (less than 12 consecutive months) prior to December 1st, all contributions made into the program will become taxable to you.

[4] Other health insurance does not include coverage for the following: accidents, dental care, disability, long-term care and vision care. Workers Compensation, specified disease, and fixed indemnity coverage is permitted.

Medical Expenses

A qualified medical expense is one for medical care as defined by Internal Revenue Code Section 213(d). Qualified medical expenses can also be found in IRS Publication 502 (Medical and Dental Expenses) and 969 (Health Savings Accounts and other Tax-Favored Health Plans) available on the IRS' website at www.irs.gov). A listing of eligible expenses can also be found at www.hellofurther.com.

Non-medical or non-qualified withdrawals are considered taxable income. A 20% penalty will apply if you use your contributions for non-qualified withdrawals and have not reached the age of 65. Non-qualified expenses may be withdrawn after you reach the age of 65 without penalty, ordinary income taxes will apply. Exceptions to the 20% penalty for non-qualified medical expenses include:

- Attain age 65;
- Become totally and permanently disabled; or
- Die.

Examples of some expenses that do not qualify are[5]:

- Surgery purely for cosmetic reasons;
- Insurance premiums;
- Health club dues;
- Illegal operations or treatment;
- Maternity clothes;
- Toothpaste, toiletries, and cosmetics; or
- Non-prescription over-the-counter medicines.

Generally, insurance premiums are not considered qualified expenses. No penalty or taxes will apply if your money is withdrawn to pay premiums for:

- Insurance premiums paid through COBRA;
- Qualified Long Term Care insurance;
- Health insurance while you are receiving federal or state unemployment compensation; or
- Medicare premiums.

Claims for Expenses

You may submit claims for qualified or non-qualified expenses to the administrative service provider or use your debit card.

Manual claims for expenses should be submitted to:

Further
Customer Service: 1-800-859-2144
www.hellofurther.com

Health Savings Accounts in the Event of Your Death

Your HSA will be treated as your surviving Spouse's HSA, but only if your Spouse is the named beneficiary. If there is no surviving Spouse or your Spouse is not the beneficiary, then the savings account will cease to be an HSA and will be included in the federal gross income of your estate or the named beneficiary.

[5] This list is not all inclusive of non-qualified medical expenses. See Publications 502 and 969 for a comprehensive listing of non-qualified medical expenses.

Exhibit D

Outline of Coverage

The following pages include Outlines of Coverage offered under the following Highmark Blue Cross Blue Shield medical (including prescription drugs) benefits.

Outline of Coverage:

PPO Blue Plan Dl
PPO Blue Bronze (Available to: Variable Hour Employees Only)
PPO Blue Qualified High Deductible Plan ("QHDHP")

LCIC Williamsport Area SD PPO Blue Plan D1 10213048, 10213049, 10213050, 10213051, 10213052 Effective: 7-1-2021

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 none none	 $200 $600
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 none none	 $2,000 $6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $8,550 $17,100	 not applicable not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $40 copay	80% after deductible
Virtual Visit Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after $40 copay	80% after deductible
Telemedicine Services (3)	100% after $15 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100%	 80% after deductible
Adult Immunizations	100%	80% after deductible
Routine Gynecological Exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, Annual Routine	100%	80% after deductible
Mammograms, Medically Necessary	100%	80% after deducitble
Diagnostic Services and Procedures	100%	80% after deductible
Routine Pediatric Physical Exams	 100%	 80% after deductible
Pediatric Immunizations	100%	80% (deductible does not apply)
Diagnostic Services and Procedures	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copay (waived if admitted)	
Ambulance (includes coverage for wheelchair van transports)	100%	100% (deductible does not apply) for emergencies; 80% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $40 copay limit: 20 visits/benefit period	80% after deductible

Benefit	In Network	Out of Network
Respiratory Therapy	100%	80% after deductible
Speech Therapy	100% after $40 copay	80% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	100% after $40 copay	80% after deductible
	limit: 12 visits/benefit period	
Spinal Manipulations	100% after $40 copay	80% after deductible
	limit: 12 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100%	80% after deductible
Inpatient Detoxification / Rehabilitation	100%	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100%	80% after deductible
Outpatient Substance Abuse Services	100%	80% after deductible
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100%	80% after deductible
	Limit: $40,000 annual maximum	
Assisted Fertilization	not covered	not covered
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $75 copay	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment Orthotics and Prosthetics	100%	80% after deductible
Home Health Care	100% after $40 copay	80% after deductible
Hospice	100%	80% after deductible
	limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care	
Infertility Counseling, Testing and Treatment (6)	100%	80% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	100%	80% after deductible
	limit: 60 days/benefit period	
Transplant Services	100%	80% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) Hard Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30-day Supply)** $3 low cost generic copay $3 formulary low cost generic copay $3 non-formulary low cost generic copay $10 formulary generic copay $10 non-formulary generic copay $20 formulary brand copay $35 non-formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $6 low cost generic copay $6 formulary low cost generic copay $6 non-formulary low cost generic copay $20 formulary generic copay $20 non-formulary generic copay $40 formulary brand copay $70 non-formulary brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(7) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and, in the cost, -sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.
With the Active Choice program, you must choose how you want to fill your maintenance prescription drugs. You may choose a retail pharmacy or your mail order program. If after two fills at a retail pharmacy you have not made your selection, you will need to pay full cost of the drug allowed by your plan for any future refills. You can change your selection at any time. Your plan requires that you use Alliance Rx Walgreens Prime specialty pharmacy for select specialty medications. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुहुन्छ। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

LCIC Williamsport Area SD PPO Blue Bronze Plan 10213068, 01784915
Effective: 7-1-2021

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $2,500 $5,000	 $5,000 $10,000
Plan Pays – payment based on the plan allowance	50% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 none none	 none none
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $8,550 $17,100	 not applicable not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	50% after deductible	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	50% after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	50% after deductible	50% after deductible
Virtual Visit Originating Site Fee	50% after deductible	50% after deductible
Urgent Care Center Visits	50% after deductible	50% after deductible
Telemedicine Services (3)	50% (deductible does not apply)	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 50% after deductible
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 50% after deductible
Pediatric Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services	50% (deductible does not apply)	
Ambulance (includes coverage for wheelchair van transports)	50% (deductible does not apply) for emergencies; 50% after deductible for non-emergencies	50% (deductible does not apply) for emergencies; 50% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	50% after deductible	50% after deductible
Hospital Outpatient	50% after deductible	50% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% (deductible does not apply)	50% after deductible
Maternity (non-preventive facility services) including dependent daughter	50% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	50% after deductible	50% after deductible
Therapy and Rehabilitation Services		

Benefit	In Network	Out of Network
Physical Medicine	50% after deductible	50% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	50% after deductible	50% after deductible
Speech Therapy	50% after deductible	50% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	50% after deductible	50% after deductible
	limit: 12 visits/benefit period	
Spinal Manipulations	50% after deductible	50% after deductible
	limit: 12 visits/benefit period	
Cardiac Rehabilitation Therapy	50% after deductible	50% after deductible
Infusion Therapy	50% after deductible	50% after deductible
Chemotherapy	50% after deductible	50% after deductible
Radiation Therapy	50% after deductible	50% after deductible
Dialysis	50% after deductible	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	50% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	50% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	50% after deductible	50% after deductible
Outpatient Substance Abuse Services	50% after deductible	50% after deductible
Other Services		
Allergy Extracts and Injections	50% after deductible	50% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	50% after deductible	50% after deductible
	Limit: $40,000 annual maximum	
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	50% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	50% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	50% after deductible	50% after deductible
Durable Medical Equipment Orthotics and Prosthetics	50% after deductible	50% after deductible
Home Health Care	50% after deductible	50% after deductible
Hospice	50% after deductible	50% after deductible
	limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care	
Infertility Counseling, Testing and Treatment (6)	50% after deductible	50% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	50% after deductible	50% after deductible
	limit: 60 days/benefit period	
Transplant Services	50% after deductible	50% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	

Benefit	In Network	Out of Network
Prescription Drug Program (8) Hard Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30-day Supply)** $3 low cost generic copay $3 formulary low cost generic copay $3 non-formulary low cost generic copay $30 formulary generic copay $30 non-formulary generic copay $90 formulary brand copay $150 non-formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $6 low cost generic copay $6 formulary low cost generic copay $6 non-formulary low cost generic copay $60 formulary generic copay $60 non-formulary generic copay $180 formulary brand copay $300 non-formulary brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(7) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and, in the cost, -sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.
With the Active Choice program, you must choose how you want to fill your maintenance prescription drugs. You may choose a retail pharmacy or your mail order program. If after two fills at a retail pharmacy you have not made your selection, you will need to pay full cost of the drug allowed by your plan for any future refills. You can change your selection at any time. Your plan requires that you use Alliance Rx Walgreens Prime specialty pharmacy for select specialty medications. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.

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  - Qualified sign language interpreters
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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
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알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुहुन्छ। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

HIGHMARK. | PPO Blue

LCIC Williamsport Area SD QHDHP 10213053-10213067, 10212988
Effective: 7-1-2021

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Employee Only Plan Family Plan	 $1,400 $2,800	 $2,500 $5,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copays. Once met, plan pays 100% coinsurance for the rest of the benefit period) Employee Only Plan Family Plan	 $600 $1,200	 $4,000 $8,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Employee Only Plan Family Plan	 $2,000 $4,000	 not applicable not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	90% after deductible	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	90% after deductible	70% after deductible
Specialist Office Visits & Virtual Visits	90% after deductible	70% after deductible
Virtual Visit Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	90% after deductible	70% after deductible
Telemedicine Services (3)	90% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	70% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services	90% after deductible	
Ambulance (includes coverage for wheelchair van transports)	90% after deductible	70% after deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% (deductible does not apply)	70% after deductible
Maternity (non-preventive facility services) including dependent daughter	90% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	70% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Medicine	90% after deductible	70% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	90% after deductible	70% after deductible
Speech Therapy	90% after deductible	70% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	90% after deductible	70% after deductible
	limit: 12 visits/benefit period	
Spinal Manipulations	90% after deductible	70% after deductible
	limit: 12 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	90% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	90% after deductible	70% after deductible
Outpatient Substance Abuse Services	90% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	90% after deductible	70% after deductible
	Limit: $40,000 annual maximum	
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
	limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care	
Infertility Counseling, Testing and Treatment (6)	90% after deductible	70% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	limit: 60 days/benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible	
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(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. In addition, with your non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. Finally, with your non-embedded TMOOP, once the entire family TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the family, for the rest of the plan year.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
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(7) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(8) At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and, in the cost, -sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.
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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुहुन्छ। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

Exhibit E

Notice for Employer-Sponsored Wellness Programs

New rules published on May 17, 2016, under the Americans with Disabilities Act (ADA) require employers that offer wellness programs that collect employee health information to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential.

BeHIP Wellness Program Lycoming County Insurance Consortium

NOTICE REGARDING WELLNESS PROGRAM

The BeHIP Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a **voluntary health risk assessment or "HRA"** that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test through a finger stick for:

- Lipid Profile - (Cholesterol, Triglycerides, HDL, LDL, Glucose)

The blood test through venipuncture will include:

- Metabolic Profile & Complete Blood Count with Differential
- Lipid Profile - (Cholesterol, Triglycerides, HDL, LDL)

You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive points for meeting specific criteria. Earn points and you will receive a wellness bonus dependent upon the level of incentive program you wish to participate in (i.e. Bronze, Silver, Gold or Platinum). Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the reward. The Program begins each year on August 1st and you will need to earn all of your points by the following July 31st to receive a reward.

Incentive points may be available for employees who participate in certain health-related activities, including online tobacco affidavit or tobacco cessation program, online wellness workshops, workplace events, wellness and enhanced wellness commitments, log weight, log time exercised, log steps, log fruits/vegetables, log water, log sleep and/or resistance training or achieve certain health outcomes. If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Health and Wellness Coordinator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as engage with a health advocate or to receive a flu shot. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the Lycoming County Insurance Consortium may use aggregate information it collects to design a program based on identified health risks in the workplace. The BeHIP Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are those individuals providing you with services under the wellness program and Terry Carmen, Health and Wellness Coordinator.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach should occur, involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact **Carmen Terry, Health and Wellness Coordinator at 570-323-8561 x1067 or at cterry@iu17.org**