



# **Montoursville Area School District**

## **Employee Benefit Plan**

**and**

## **SUMMARY PLAN DESCRIPTION**

**Amended and Restated  
Effective Date:**

**July 1, 2016**

*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 Montoursville Area School District Employee Benefit Plan.*

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# 1. INTRODUCTION

The Montoursville 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**

Montoursville 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.

Attachment # 1	Highmark Blue Cross Blue Shield Medical (including prescription drugs) PPO Blue Plan G Group Numbers: 10213018 - 10213019 <a href="http://www.highmark.com">www.highmark.com</a>	Self-Insured
Attachment # 2	Highmark Blue Cross Blue Shield Medical (including prescription drugs) PPO Blue Plan C Group Numbers: 10213015 - 10213017 <a href="http://www.highmark.com">www.highmark.com</a>	Self-Insured
Attachment # 3	Highmark Blue Cross Blue Shield Medical (including prescription drugs) PPO Blue Bronze ( <i>This program is available exclusively to Eligible Variable Hourly Employees</i> ) Group Numbers: 10213023 <a href="http://www.highmark.com">www.highmark.com</a>	Self-Insured
Attachment # 4	Highmark Blue Cross Blue Shield Medical (including prescription drugs) with Health Savings Accounts PPO Blue Qualified High Deductible Health Plan (QHDHP) Group Numbers: 10213020 - 10213022 <a href="http://www.highmark.com">www.highmark.com</a>	Self-Insured
Attachment # 5	Highmark Blue Cross Blue Shield Medical (including prescription drugs) PPO Blue Plan E Group Number: 10213012 - 10213014 <a href="http://www.highmark.com">www.highmark.com</a>	Self-Insured
Attachment # 6	Delta Dental Group Number: 01167 <a href="http://www.deltadental.com">www.deltadental.com</a>	Self-Insured
Exhibit A	Health Savings Account Program <i>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</i> Discovery Benefits, Inc. <a href="http://www.discoverybenefit.com">www.discoverybenefit.com</a>	Self-Funded
Exhibit B	<b>Outline of Coverage:</b> PPO Blue Plan G PPO Blue Plan C PPO Blue Bronze PPO Blue Qualified High Deductible Plan (“QHDHP”) PPO Blue Plan E	N/A
Attachment # 7	Schedule of Employee Premium Contribution Requirements (See the Human Resources Department for current premium contribution requirements or your collective bargaining agreement.)	N/A

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.

Montoursville 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 and pursuant to collective bargaining agreements.

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 and on a post-tax basis if a properly completed waiver form is completed and submitted to the Business Manager.

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.

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 to # 6 noted above. Copies of all attachments for the Plan have been previously delivered to you and are on file at the Montoursville Area School District Business Manager’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.

<b>Collective Bargaining Unit</b>	<b>Group</b>
Montoursville Area Education Support Professionals	(“MAESP”) /PSEA
Montoursville Area Education Association	(“MAEA”) / PSEA

Information regarding eligibility and participation can be found in the current 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 Montoursville 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 Business 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.

## 2. 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 –**

<u>Coverage</u>	<u>Plan/Policy Year</u>
Medical (including prescription drugs), Health Savings Account Program and Dental	7/1 to 6/30

**Claims Fiduciary** means Highmark Blue Cross Blue Shield 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.

**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 living with the employee or coverage that is provided through an order of the court)) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. Coverage is available until the end of the month following the date the dependent child reaches the age of 26.

**Dependent – Dental** means the Eligible Employee's unmarried children until the day of their 19th birthday. Such children include (a) a blood descendant of the first degree, (b) a legally adopted child (including a child living with the adopting parents during the period of probation), (c) a child for whom the Eligible Employee has legal guardianship, (d) a stepchild of the Eligible Employee, or (e) a child who is the subject of a Court Order of support directed to a Eligible Employee without regard to the amount of support contributed by the Eligible Employee or custodial arrangement for the child. Documentation of the above must be furnished as a required by Delta Dental.

Eligible Dependents include unmarried children of an Eligible Employee who are full-time students in a bona fide educational institution until the day of their 23rd birthday. In the event a full-time student is required, because of military duty, to take a military leave of absence for more than thirty (30) days for other than training, coverage will extend for a period equal to the duration of the eligible Dependent's service on active duty or active State duty or until the eligible Dependent is no longer a full-time student. Proof of continuing eligibility must be furnished as required by Delta Dental.

Unmarried children of a Eligible Employee covered by the Contract prior to attainment of age 19 or 23 if a full-time student and who are incapable of employment by reason of mental retardation or physical handicap and who became incapable prior to age 19 or 23 if a full-time student while covered by this contract or another dental service contract or dental insurance policy of School district and who are chiefly dependent upon the Eligible Employee for support and maintenance. Eligibility of these dependent children shall not terminate while the contract remains in force and the dependent child remains in such condition. The dependent child is not required to reside with a parent or legal guardian who is a Eligible Employee. Proof of physical or mental disability must be furnished as required by Delta Dental.

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

**Eligible Employee** means any full-time (including full-time substitute teachers) or part-time individuals 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 Montoursville 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.

**Medical Care Expense** means any expense which meets the criteria as a deductible health care expense under Internal Revenue Code Section 213, specifically including dental, vision and hearing care expenses.

**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 Montoursville Area School District Employee Benefit Plan, which is a benefits plan for eligible employees of Montoursville 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 Montoursville Area School District and the Business Manager of Montoursville 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 First Priority Life.

**Post-Tax Payroll Deduction** means employees who do not wish to have Pre-Tax Salary Reductions may have their contributions for premium payments deducted on a post-tax payroll deduction basis by completing, signing and submitting a Waiver of Participation Form to the Business Manager.

**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 Employee 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 program reduced by the District's premium contribution.

**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 plan. 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 program.

**PSERS** means the Pennsylvania Public School Employees' Retirement System.

**Retiree** means Eligible Employees who retire are eligible for coverage in the group medical and dental insurance coverage and with superannuation as defined by PSERS, have retired with thirty or more years of credited service, or have taken disability retirement. Spouses and Dependents may participate provided the Retiree is participating in the Plan. Please see the Business Manager for more information regarding the availability and cost of retiree group medical and dental 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.

**Statutory Leave** means an unpaid leave of absence under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act.

**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.

**3. GENERAL INFORMATION ABOUT THE PLAN**

**Employer Name:** Montoursville Area School District

**Plan Name:** Montoursville Area School District  
Employee Benefit Plan

**Employer Address:** 50 North Arch Street  
Montoursville, PA 17754

**Employer's Telephone Number:** 570-368-3500

**Plan/Policy Year:** July 1<sup>st</sup> to June 30<sup>th</sup>

**Employer's Federal Tax Identification Number:** 23-1667972

**Plan Sponsor:** Montoursville Area School District  
50 North Arch Street  
Montoursville, PA 17754

**Plan Administrator/Named Fiduciary - Dental and the Health Savings Account Program:** Montoursville Area School District  
50 North Arch Street  
Montoursville, PA 17754  
Business Manager

**Plan Administrator/Named Fiduciary (Medical (including prescription drugs)):** Lycoming County Insurance Consortium

*Highmark Blue Cross Blue Shield is a fiduciary with regard to eligibility for benefits and benefit claims in the medical programs offered under the Plan.*

**Agent for Service of Legal Process:** Lycoming County Insurance Consortium  
On behalf of:  
Montoursville Area School District  
50 North Arch Street  
Montoursville, PA 17754

**Funding Medium and Type of Plan Administration:**

The insurance companies, not Montoursville Area School District, are responsible for paying claims with respect to these programs. Montoursville Area School District shares responsibility with the insurance companies for administering these program benefits.

The following benefits under the Plan are self-funded and paid through pre-tax salary reductions and/or the general assets of the employer:

<b><i>Coverage:</i></b>	<b><i>Administrative Services Provided by:</i></b>
Medical (including prescription drugs):	Highmark Blue Cross Blue Shield
Dental:	Delta Dental
Health Savings Account Program:	Discovery Benefits, Inc.

Insurance premiums for employees and their eligible family members are paid in part by Montoursville 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 # 7. Eligible Employees covered by a collective bargaining agreement should refer to their respective collective bargaining agreements for the cost of coverage in any medical (including prescriptions drugs) plan.

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

#### **4. ELIGIBILITY, ENROLLMENT AND PARTICIPATION**

##### **Eligible Classifications**

Eligibility for benefits includes coverage for Employees, Spouses and eligible Dependents and Retirees and their Spouses. Eligible full-time employees may be required to pay for a portion of the premiums for medical (including prescription drugs). To find out your required premium contribution, please see Attachment # 7.

*Coverage will not be offered to those individuals who have equivalent coverage with another plan or a plan offered by another employer.*

<b>Component Benefit</b>	<b>Eligibility</b>
Medical (including prescription drugs), Dental, and the Health Savings Account Program	<p><b>Full-time Administrative Staff</b> Employees who regularly work eight (8) hours per day at least 200 days per year.</p> <p><b>Full-time Professional Staff</b> Employees who work seven hours and twenty minutes (7 hours 20 minutes) per day and 188 days per year.</p> <p><b>Full-time Union Classified Staff</b> Employees who work more than thirty (30) hours per week for nine (9) or more months per year.</p> <p><b>Full-time Non-Union Classified Staff</b> Employees who work more than six (6) hours per day five (5) days per week.</p> <p><b>Part-time Professional Staff Employees</b> who work four (4) or more hours per day five (5) days during a regularly scheduled work-week.</p>
Medical (including prescription drugs) and the Health Savings Account Program	<b>Full-time Substitute Teachers</b>

**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.

**Dependent – Dental** means the Eligible Employee’s unmarried children until the day of their 19th birthday. Such children include (a) a blood descendant of the first degree, (b) a legally adopted child (including a child living with the adopting parents during the period of probation), (c) a child for whom the Eligible Employee has legal guardianship, (d) a stepchild of the Eligible Employee, or (e) a child who is the subject of a Court Order of support directed to a Eligible Employee without regard to the amount of support contributed by the Eligible Employee or custodial arrangement for the child. Documentation of the above must be furnished as a required by Delta Dental.

Eligible Dependents include unmarried children of an Eligible Employee who are full-time students in a bona fide educational institution until the day of their 23rd birthday. In the event a full-time student is required, because of military duty, to take a military leave of absence for more than thirty (30) days for other than training, coverage will extend for a period equal to the duration of the eligible Dependent’s service on active duty or active State duty or until the eligible Dependent is no longer a full-time student. Proof of continuing eligibility must be furnished as required by Delta Dental.

Unmarried children of a Eligible Employee covered by the Contract prior to attainment of age 19 or 23 if a full-time student and who are incapable of employment by reason of mental retardation or physical handicap and who became incapable prior to age 19 or 23 if a full-time student while covered by this contract or another dental service contract or dental insurance policy of School district and who are chiefly dependent upon the Eligible Employee for support and maintenance. Eligibility of these dependent children shall not terminate while the contract remains in force and the dependent child remains in such condition. The dependent child is not required to reside with a parent or legal guardian who is an Eligible Employee. Proof of physical or mental disability must be furnished as required by Delta Dental.

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.

**Retiree** means Eligible Employees who retire are eligible for coverage in the group medical and dental insurance coverage and with superannuation as defined by PSERS, have retired with thirty or more years of credited service, or have taken disability retirement. Spouses and Dependents may participate provided the Retiree is participating in the Plan. Please see the Business Manager for more information regarding the availability and cost of retiree group medical and dental insurance coverage.

<b><u>Component Benefit</u></b>	<b><u>When Participation Begins</u></b>
Medical (including prescription drugs), Health Savings Account Program, and Dental	First of the Month Following Date of Hire

***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 Business Manager 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 Montoursville Area School District determines you have the status of an active employee of Montoursville 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.

### **Termination of Employment and Subsequent Rehire**

If you terminate your employment with Montoursville Area School District and are subsequently rehired you will be treated as a new Employee and subject to the same waiting period as mentioned above.

### **Leased or Temporary Employment**

Leased employees, persons classified by Montoursville Area School District as temporary employees of Montoursville Area School District (as determined by Montoursville Area School District) are not eligible for benefits in the Plan. A person who is characterized by Montoursville Area School District as a leased employee of Montoursville 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 Montoursville 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 Montoursville 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) component 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 1<sup>st</sup> during open enrollment period 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. 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.

You may change your elections in the health savings account program monthly.

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.

1. **FMLA Leave.** You may change an election under the Plan upon commencement of or return from FMLA leave.
2. **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.
3. **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 Montoursville Area School District's Plan.
4. **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.
  5. **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.
  6. **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.
  7. **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.

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.

**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 Savings Account Program <sup>1</sup> , and Dental	Last day of the month in which termination occurred
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Coverage may also terminate if:

- ❖ Your hours drop below any required hourly threshold;
- ❖ You submit false claims;
- ❖ Montoursville 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.

<sup>1</sup> 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 down your account balance for qualified or non-qualified expenses.

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.

## **Employees on Military Leave**

### **Uniformed Services Employment and Re-employment Rights Act**

Regardless of any provision described above, if you take a leave of absence from employment with Montoursville 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 Montoursville 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 Business Manager 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, and Dependent(s) prospectively without notice for cause or if you, your Spouse, or Dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you, your Spouse, or Dependent(s) commit 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, or Dependent’s coverage retroactively to the date of the fraud or misrepresentation upon 30 day notice. Failure to inform the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, as applicable, that you, your Spouse, or Dependent(s) is covered under another plan constitutes fraud under the Plan.

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 ineligible dependents enrolled in the Plan, the Plan may cancel coverage for such dependents 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, Montoursville 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 Business Manager 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 order must indicate who will pay for the Alternate Payee’s coverage (required contributions towards premium, deductibles, coinsurance, copayments or other benefit payments);
  - c. statement that acknowledges the Plan’s right to terminate coverage under the Order for which payment is not made on a timely basis as required;
  - d. the name and mailing address of each dependent child covered by the order;
  - e. a reasonable description of the type of coverage offered by the Plan;
  - f. a beginning period for which the order applies;
  - g. an end date for which the Alternate Payee would no longer be eligible for coverage;
  - h. social security number of each dependent child covered by the order; and
  - i. 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 and 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 Montoursville 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.

See the Business Manager for questions regarding National Medical Support Orders.

## **5. 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). Montoursville 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 Montoursville Area School District amends the medical 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 Montoursville 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 Montoursville 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 Montoursville 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 18-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, no longer being a full-time student, getting married or becoming a full-time employee)	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. Montoursville 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.

### **COBRA Premium Payments**

You do not have to show that you are insurable to choose continuation coverage. Qualified beneficiaries must pay for the COBRA continuation coverage they elect. Your employer reserves the right to charge an additional 2% administration fee in addition to the regular premium. However, during an extension of coverage for disability, you and your qualified beneficiaries may be required to pay 150% of the “cost of coverage” under the medical plan.

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 Montoursville 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 Montoursville 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 CM Regent, unless you are notified by Montoursville 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:

CM Regent  
P.O. Box 81  
New Cumberland, PA 17070  
1-866-403-7700

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 Business Manager at Montoursville Area School District, 50 North Arch Street, Montoursville, PA 17754.

### **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 Montoursville Area School District, in its sole discretion, may require.

Within 30 days of receiving the timely, written notice, Montoursville 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 18-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:

CM Regent  
P.O. Box 81  
New Cumberland, PA 17070  
1-866-403-7700

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 Montoursville 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.

## **6. FAMILY MEDICAL LEAVE ACT OF 1993 (FMLA)**

### **Benefit and Service Continuation during Family Leave**

- ❖ During the period of your leave under this Plan, the Montoursville Area School District Employee Benefit Plan will continue your medical benefits, as required by law. This means the Montoursville 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) 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 medical (including prescription drugs) program, expenses incurred while participation has lapsed will not be eligible for reimbursement.

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.

- ❖ 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 Montoursville Area School District.

Please contact the Business Manager regarding procedures and guidelines for the Family Medical Leave Act.

## **7. CONTRIBUTIONS FOR COVERAGE, SPECIAL RIGHTS FOR WOMEN, GENETIC NON-DISCRIMINATION ACT (“GINA”), NON ASSIGNMENT OF BENEFITS, CONTINUATION AND CONVERSION RIGHTS**

### **Contributions for Coverage**

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

- Dental
- Health Savings Account Program (Employer Contributions)<sup>2</sup>

You may be required to pay a portion of the total premium cost of your coverage under the following plans:

- Medical (including prescription drugs) (pre-tax dollars)

You make contributions in the following program:

- Health Savings Account Program (Employee Contributions) (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 # 7 or in your collective bargaining agreement.

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, USERRA, HIPAA, HITECH, GINA, NMHPA, MHPAEA, WHCRA, 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.

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<sup>2</sup> The School District makes employer contributions to the Health Savings Account Program as required by current collective bargaining agreements. The School District reserves the right to discontinue contributions at any time with appropriate notification to Employee/Participants and in accordance with collective bargaining agreements.

## **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.

## **8. HOW THE PLAN IS ADMINISTERED**

### **Plan Administration**

The administration of the Plan is under the supervision of the Plan Administrator. The Lycoming County Insurance Consortium on behalf of the Montoursville Area School District is the Plan Administrator for medical (including prescription drugs) plan. The Business Manager of Montoursville Area School District has been designated to act as the Plan Administrator for all other benefits offered under the Plan.

### **Right to Receive and Release Necessary Information**

Each of (i) Montoursville Area School District or (ii) contract administrator (with respect to participants or beneficiaries receiving benefits under the Plan which it administers or provides services with respect to) may, without the consent of or notice to any person, release or obtain any information which such Plan Sponsor or contract administrator reasonably deems necessary in order to perform its duties under the Plan. Any person claiming benefits under the Plan shall furnish such information as may be reasonably required by Pennsylvania Psychiatric Institute or contract administrator. Montoursville Area School District or any contract administrator will act in accordance with the rules established under the Health Insurance Portability and Accountability Act's Privacy and Security Rules.

### **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**

- 1) 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 pertaining 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 establish and communicate procedures to determine whether a national child support order is qualified;
- 10) 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 they should be paid and 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;
- 11) 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
- 12) 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 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.

Montoursville 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
Discovery Benefits, Inc.	Health Savings Account Program

## **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 appropriate Plan Administrator named above.

## **9. CIRCUMSTANCES WHICH MAY AFFECT BENEFITS**

### **Denial or Loss of Benefits**

An Eligible Employee's benefits (and the benefits of his or her eligible spouses 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.

## **10. AMENDMENT OR TERMINATION OF THE PLAN**

Montoursville 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 Montoursville Area School District or any of its delegates. Montoursville 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 Business Manager signs administrative contracts for this Plan on behalf of Montoursville 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.

## **11. 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 Montoursville Area School District to the effect that you will be employed for any specific period of time.

## 12. CLAIM ADMINISTRATIVE SERVICES – Highmark Blue Cross Blue Shield / Delta Dental

### 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.

#### CLAIMS AND APPEALS TIMETABLE

	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
Medical  Dental	Urgent Care Claims	As soon as possible, taking into account the medical exigencies, but not later than <b>72 hours</b> 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 <b>72 hours</b> 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 <b>15 days</b> after receipt of your claim by the Claims Administrator, unless an extension of up to an additional <b>15 days</b> 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 <b>30 days</b> after receipt of your request for review by the Claims Administrator.
	Post-Service Claims	Within a reasonable period of time, but not later than <b>30 days</b> after receipt of your claim by the Claims Administrator, unless an extension of up to an additional <b>15 days</b> is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time, but not later than <b>60 days</b> 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 <b>24 hours</b> before the end of the of the approved course of treatment must be processed within <b>24 hours</b> instead of <b>72 hours</b> .	An appeal for an extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above

#### 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 the designated claims processor's (Highmark Blue Cross Blue Shield or Delta Dental) 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

### **A. 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 as the Employer's agent for purposes of subrogation only.

### **B. Highmark's Subrogation Duties**

Highmark 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. Highmark shall credit the Employer with the amount received, minus, as applicable, Highmark'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.

### **C. 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.

### **D. 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 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. The costs of legal representation of the Participant shall be borne solely by the Participant.

**E. Prohibited by Law**

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

**MISCELLANEOUS**

**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).

### **13. 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 C.F.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:

1. 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. 1232g(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 Montoursville Area School District only upon receipt of a certification from Montoursville 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 Montoursville Area School District.

#### **Montoursville Area School District’s Obligations with Respect to PHI**

With respect to PHI, Montoursville Area School District agrees to certain conditions. Montoursville 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 Montoursville Area School District provides PHI received from the Plan agree to the same restrictions and conditions that apply to Montoursville 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 Montoursville 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
- Montoursville 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 Montoursville 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 Montoursville Area School District performs for the Plan. If the persons described herein or any other employees do not comply with the Summary Plan Description, Montoursville Area School District shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. Montoursville 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 Montoursville 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. Montoursville 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 Montoursville Area School District. Montoursville 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 Montoursville 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 Montoursville Area School District, the Plan Administrator and any third-party administrator for the issuance of, and any changes to the Privacy Notice under the health component benefits.
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:

Montoursville Area School District  
Privacy Officer – Business Manager

It has always been the goal of Montoursville 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 the e-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.

#### **14. 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 Business Manager's Office. Montoursville 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.

**15. SIGNATURE**

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

**Employer/Plan Sponsor:** \_\_\_\_\_  
**Montoursville Area School District**

**Date:** \_\_\_\_\_

**Attest:** \_\_\_\_\_

## Exhibit A

### **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.

Discovery Benefits is the administrator for the program.

#### High Deductible Health Plan (HDHP) and Health Savings Accounts (HSA)

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<sup>3</sup> 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.

#### Contributions

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<sup>4</sup> 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 2016 include:

- Individual HDHP coverage: \$3,350;
- Family HDHP coverage: \$6,750; 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 1<sup>st</sup> 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 1<sup>st</sup>, all contributions made into the program will become taxable to you.

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<sup>3</sup> 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.

<sup>4</sup> The School District makes employer contributions to the Health Savings Account Program as required by current collective bargaining agreements. The School District reserves the right to discontinue contributions at any time with appropriate notification to Employee/Participants and in accordance with collective bargaining agreements.

## 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](http://www.irs.gov)). A listing of eligible expenses can also be found at [www.discoverybenefits.com](http://www.discoverybenefits.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<sup>5</sup>:

- 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:

***Discovery Benefits, Inc., P.O. Box 2926, Fargo, ND 58108-2926***  
***866-451-3399***  
[www.discoverybenefits.com](http://www.discoverybenefits.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.

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<sup>5</sup> 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 B**

### **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 G  
PPO Blue Plan C  
PPO Blue Bronze  
PPO Blue Qualified High Deductible Plan (“QHDHP”)  
PPO Blue Plan E

# Montoursville ASD PPO Blue Plan G PPO Blue Sharing-80%/60%

Group #'s:10213018,10213019

**\$10/\$20 OV Copay; \$50 ER Copay  
Rx - \$3/\$10/\$20/\$35 Retail; \$6/\$20/\$40/\$70 MS; Comprehensive**

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	Network	Out-of-Network
<b>General Provisions</b>		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$250	\$500
Family	\$750	\$1,500
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$1,500	\$3,000
Family	\$4,500	\$9,000
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	\$6,850	Not Applicable
Family	\$13,700	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
Retail Clinic Visits & Virtual Visits	100% after \$10 copay	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$10 copay	60% after deductible
Specialist Office & Virtual Visits	100% after \$20 copay	60% after deductible
Virtual Visit Originating Site Fee	100% after deductible	60% after deductible
Urgent Care Center Visits	100% after \$20 copay	60% after deductible
Telemedicine Services(3)	100% after \$5 copay	Not Covered
<b>Preventive Care(4)</b>		
Routine Adult Physical exams	100% (deductible does not apply)	60% after deductible
Adult immunizations	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine	100% (deductible does not apply)	60% after deductible
Mammograms, medically necessary	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric Physical exams	100% (deductible does not apply)	60% after deductible
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
<b>Emergency Services</b>		
Emergency Room Services	100% after \$50 copay (waived if admitted)	
Ambulance – Emergency	100% (deductible does not apply)	
Ambulance – Non-Emergency	80% after deductible	60% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	60% after deductible
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	80% after deductible	60% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	80% after deductible	60% after deductible
Speech & Occupational Therapy	80% after deductible	60% after deductible
	Limit: 12 visits per therapy/benefit period	

Benefit	Network	Out-of-Network
<b>Therapy and Rehabilitation Services (cont.)</b>		
Spinal Manipulations	80% after deductible	60% after deductible
	Limit: 12 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
<b>Mental Health/Substance Abuse</b>		
Inpatient	80% after deductible	60% after deductible
Inpatient Detoxification/Rehabilitation	80% after deductible	60% after deductible
Outpatient (includes virtual behavioral health visits)	80% after deductible	60% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(5)	80% after deductible	60% after deductible
Assisted Fertilization Procedures – limited to artificial insemination – 3 attempts/lifetime	Not Covered	Not Covered
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment(6)	80% after deductible	60% after deductible
Private Duty Nursing	Not Covered	Not Covered
Skilled Nursing Facility Care	80% after deductible	60% after deductible
	Limit: 60 days/benefit period	
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements(7)	Yes	
<b>Prescription Drugs</b>		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program(8) Soft 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.	<p style="text-align: center;"><b>Retail Drugs (31/60/90-day Supply)</b></p> <p style="text-align: center;">\$3 low cost generic copay \$10 standard generic copay \$20 formulary brand copay \$35 non-formulary brand copay</p> <p style="text-align: center;"><b>Maintenance Drugs through Mail Order (90-day Supply)</b></p> <p style="text-align: center;">\$6 low cost generic copay \$20 standard generic copay \$40 formulary brand copay \$70 non-formulary brand copay</p>	

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- (1) Your group's benefit period is based on a Calendar Year. The Calendar 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. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed \$6,850 for individual and \$13,700 for two or more persons.
- (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 Outpatient Mental Health/Substance Abuse benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits 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) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (8) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copay or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copay or coinsurance amounts, which may apply.



# Montoursville ASD PPO Blue Plan C

Group #'s:10213015,10213016,10213017

**PPO Blue Sharing-100%/80%;  
\$10/\$20 OV Copay; \$50 ER Copay  
Rx - \$3/\$10/\$20/\$35 Retail; \$6/\$20/\$40/\$70 MS; Comprehensive**

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	Network	Out-of-Network
<b>General Provisions</b>		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	None	\$200
Family	None	\$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	None	\$2,000
Family	None	\$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	\$6,850	Not Applicable
Family	\$13,700	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
Retail Clinic Visits & Virtual Visits	100% after \$10 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$10 copay	80% after deductible
Specialist Office & Virtual Visits	100% after \$20 copay	80% after deductible
Virtual Visit Originating Site Fee	100 %	80% after deductible
Urgent Care Center Visits	100% after \$20 copay	80% after deductible
Telemedicine Services(3)	100% after \$5 copay	Not Covered
<b>Preventive Care(4)</b>		
Routine Adult Physical exams	100%	80% after deductible
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	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 deductible
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
<b>Emergency Services</b>		
Emergency Room Services	100% after \$50 copay (waived if admitted)	
Ambulance – Emergency	100%	
Ambulance – Non-Emergency	100%	80% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
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
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	100% after \$20 copay	80% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	100%	80% after deductible
Speech & Occupational Therapy	100% after \$20 copay	80% after deductible
	Limit: 12 visits per therapy/benefit period	

Benefit	Network	Out-of-Network
<b>Therapy and Rehabilitation Services (cont.)</b>		
Spinal Manipulations	100% after \$20 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
<b>Mental Health/Substance Abuse</b>		
Inpatient	100%	80% after deductible
Inpatient Detoxification/Rehabilitation	100%	80% after deductible
Outpatient (includes virtual behavioral health visits)	100%	80% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	100%	80% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(5)	100%	80% after deductible
Assisted Fertilization Procedures	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%	80% after deductible
Hospice	100%	80% after deductible
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	
<b>Prescription Drugs</b>		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program(8)	<b>Retail Drugs (31/60/90-day Supply)</b>	
Soft Mandatory Generic	\$3 low cost generic copay	
Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.	\$10 standard generic copay	
	\$20 formulary brand copay	
	\$35 non-formulary brand copay	
Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.	<b>Maintenance Drugs through Mail Order (90-day Supply)</b>	
	\$6 low cost generic copay	
	\$20 standard generic copay	
	\$40 formulary brand copay	
	\$70 non-formulary brand copay	

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- Your group's benefit period is based on a Calendar Year. The Calendar 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.
- 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. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed \$6,850 for individual and \$13,700 for two or more persons.
- 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 Outpatient Mental Health/Substance Abuse benefit.
- Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- 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.
- 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.
- Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copay or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copay or coinsurance amounts, which may apply.



# Montoursville ASD PPO Blue Bronze

Group #10213023

**PPO Blue Sharing-50%/50%; \$2,500/\$5,000 Network Deductible;  
50% OV Copay; 50% ER Copay**

**Rx - \$3/\$30/\$90/\$150 Retail; \$6/\$60/\$180/\$300 MS; Comprehensive**

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	Network	Out-of-Network
<b>General Provisions</b>		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$2,500	\$5,000
Family	\$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	None	\$5,000
Family	None	\$10,000
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	\$6,850	Not Applicable
Family	\$13,700	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
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 & 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% after deductible	Not Covered
<b>Preventive Care(4)</b>		
Routine Adult Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening	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
<b>Emergency Services</b>		
Emergency Room Services	50% after deductible (waived if admitted)	
Ambulance - Emergency	50% (deductible does not apply)	
Ambulance – Non-Emergency	50% after deductible	50% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
Hospital Inpatient	50% after deductible	50% after deductible
Hospital Outpatient	50% after deductible	50% after deductible
Maternity (non-preventive facility & professional 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
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	50% after deductible	50% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	50% after deductible	50% after deductible
Speech & Occupational Therapy	50% after deductible	50% after deductible
	Limit: 12 visits per therapy/benefit period	

Benefit	Network	Out-of-Network
<b>Therapy and Rehabilitation Services (cont.)</b>		
Spinal Manipulations	50% after deductible	50% after deductible
	Limit: 12 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	50% after deductible	50% after deductible
<b>Mental Health/Substance Abuse</b>		
Inpatient	50% after deductible	50% after deductible
Inpatient Detoxification/Rehabilitation	50% after deductible	50% after deductible
Outpatient (includes virtual behavioral health visits)	50% after deductible	50% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	50% after deductible	50% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(5)	50% after deductible	50% after deductible
Assisted Fertilization Procedures Limited to Artificial Insemination - 3 attempts per lifetime	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
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	
<b>Prescription Drugs</b>		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program(8) Soft 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.	<b>Retail Drugs (31/60/90-day Supply)</b> \$3 low cost generic copayment \$30 standard generic copayment \$90 formulary brand copayment \$150 non-formulary brand copayment  <b>Maintenance Drugs through Mail Order (90-day Supply)</b> \$6 low cost generic copayment \$60 standard generic copayment \$180 formulary brand copayment \$300 non-formulary brand copayment	

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- 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/Substance Abuse benefit.
- Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- 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.
- 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.
- Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

## Montoursville Area SD QHDHP \$1,300 90/70

**Healthy Savings-90%/70%; \$1,300/\$2,600 Network Deductible;**

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	Network	Out-of-Network
<b>General Provisions</b>		
Benefit Period(1)	Contract Year	
Deductible (per benefit period)		
Employee Only Plan	\$1,300	\$2,500
Family Plan	\$2,600	\$5,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible <sup>6</sup>
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Employee Only Plan	\$700	\$4,000
Family Plan	\$1,400	\$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	\$2,000	Not Applicable
Family Plan	\$4,000	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
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 & 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
<b>Preventive Care(4)</b>		
Routine Adult		
Physical exams	100% (deductible does not apply)	70% after deductible
Adult immunizations	100% (deductible does not apply)	70% after deductible
Colorectal cancer screening	100% (deductible does not apply)	70% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, annual routine	100% (deductible does not apply)	70% after deductible
Mammograms, medically necessary	90% after deductible	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
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional 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
<b>Emergency Services</b>		
Emergency Room Services	90% after network deductible	
Ambulance - Emergency	90% after network deductible	
Ambulance – Non-Emergency	90% after deductible	70% after deductible
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	90% after deductible	70% after deductible
Speech & Occupational Therapy	90% after deductible	70% after deductible
	Limit: 12 visits per therapy/benefit period	

Benefit	Network	Out-of-Network
<b>Therapy and Rehabilitation Services (cont.)</b>		
Spinal Manipulations	90% after deductible Limit: 12 visits/benefit period	70% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
<b>Mental Health/Substance Abuse</b>		
Inpatient	90% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	90% after deductible	70% after deductible
Outpatient (includes virtual behavioral health visits)	90% after deductible	70% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(5)	90% after deductible	70% after deductible
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
Infertility Treatment (coverage will be provided for correction of a medical problem associated with Infertility.)	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	
<b>Prescription Drugs</b>		
Prescription Drug Deductible	Integrated with medical deductible	
Individual	Integrated with medical deductible	
Family	Integrated with medical deductible	
Prescription Drug Program(8) 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 Open Benefit Design.	<p style="text-align: center;"><b>Retail Drugs (31/60/90-day Supply)</b></p> <p style="text-align: center;">\$3 low cost generic copay after deductible \$10 standard generic copay after deductible \$25 formulary brand copay after deductible \$50 non-formulary brand copay after deductible</p> <p style="text-align: center;"><b>Maintenance Drugs through Mail Order (90-day Supply)</b></p> <p style="text-align: center;">\$6 low cost generic copay after deductible \$20 standard generic copay after deductible \$50 formulary brand copay after deductible \$100 non-formulary brand copay after deductible</p>	

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 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. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed \$6,550 for individual and \$13,100 for two or more persons. In addition, new regulations for 2016 do not allow a member within a family plan to exceed \$6,850 in cost sharing. If you are enrolled as an individual, the deductible, out-of-pocket maximum and Total Maximum Out-of-Pocket (TMOOP) for the Employee Only plan apply. If you are enrolled in a Family plan, the entire family deductible must be satisfied before any claim reimbursement begins. In addition the entire family out-of-pocket maximum must be satisfied for additional claim reimbursement. Once the entire family TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the family, regardless of whether the individual deductible, individual out-of-pocket maximum and individual TMOOP have been satisfied.
- (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/Substance Abuse benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits 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) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (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.

## Montoursville ASD PPO Blue Plan E

Group #'s: 10213012, 10213013, 10213014

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	Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> <sup>(1)</sup>	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	\$250	\$500
Family	\$750	\$1,500
<b>Plan Pays</b> – payment based on the plan allowance	100%	80% after deductible
<b>Out-of-Pocket Limit</b> (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$2,000
Family	None	\$6,000
<b>Total Maximum Out-of-Pocket</b> (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) <sup>(2)</sup> Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$6,850	Not Applicable
Family	\$13,700	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits &amp; Virtual Visits</b>	100% after \$10 copayment	80% after deductible
<b>Primary Care Provider Office Visits &amp; Virtual Visits</b>	100% after \$10 copayment	80% after deductible
<b>Specialist Office &amp; Virtual Visits</b>	100% after \$20 copayment	80% after deductible
Virtual Visit Originating Site Fee	100%	80% after deductible
<b>Urgent Care Center Visits</b>	100% after \$20 copayment	80% after deductible
<b>Telemedicine Service</b> <sup>(3)</sup>	100% after \$5 copayment	Not Covered
<b>Preventive Care</b> <sup>(4)</sup>		
<b>Routine Adult</b>		
Physical exams	100%	80% after deductible
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% Medically Necessary: 100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
<b>Routine Pediatric</b>		
Physical exams	100%	80% after deductible
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible
<b>Emergency Services</b>		
<b>Emergency Room Services</b>	100% after \$50 copayment (waived if admitted)	
<b>Ambulance - Emergency</b>	100%	
<b>Ambulance – Non-Emergency</b>	100% after deductible	80% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>	100% after deductible	80% after deductible
<b>Hospital Outpatient</b>	100% after deductible	80% after deductible
<b>Maternity</b> (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
<b>Medical Care</b> (including inpatient visits and consultations)/ <b>Surgical Expenses</b>	100% after deductible	80% after deductible
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Medicine</b>	100% after \$20 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Respiratory Therapy</b>	100% after deductible	80% after deductible
<b>Speech &amp; Occupational Therapy</b>	100% after \$20 copayment	80% after deductible
	Limit: 12 visits per therapy/benefit period	
<b>Spinal Manipulations</b>	100% after \$20 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
<b>Mental Health/Substance Abuse</b>		

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Inpatient</b>	100% after deductible	80% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>	100% after deductible	80% after deductible
<b>Outpatient - Includes Virtual Behavioral Health Visits</b>	100% after deductible	80% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>	100% after deductible	80% after deductible
<b>Autism Spectrum Disorder including Applied Behavior Analysis<sup>(5)</sup></b>	100% after deductible	80% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	Not Covered
<b>Dental Services Related to Accidental Injury</b>	100% after deductible	80% after deductible
<b>Diagnostic Services</b>		
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	\$75 copay per test	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% after deductible	80% after deductible
<b>Home Health Care</b>	100% after deductible	80% after deductible
	Limit: 90 visits/benefit period	
<b>Hospice</b>	100% after deductible	80% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(6)</sup></b>	100% after deductible	80% after deductible
<b>Private Duty Nursing</b>	Not Covered	Not Covered
<b>Skilled Nursing Facility Care</b>	100% after deductible	80% after deductible
	Limit: 60 days/benefit period	
<b>Transplant Services</b>	100% after deductible	80% after deductible
<b>Precertification Requirements<sup>(7)</sup></b>	Yes	
<b>Prescription Drugs</b>		
<b>Prescription Drug Deductible</b>		
Individual	None	
Family	None	
<b>Prescription Drug Program<sup>(8)</sup></b>		
Soft Mandatory Generic		
<i>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>		
<i>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.</i>		
	<b>Retail Drugs (31/60/90-day Supply)</b>	
	\$3 low cost generic copay	
	\$10 standard generic copay	
	\$20 formulary brand copay	
	\$35 non-formulary brand copay	
	<b>Maintenance Drugs through Mail Order (90-day Supply)</b>	
	\$6 low cost generic copay	
	\$20 standard generic copay	
	\$40 formulary brand copay	
	\$70 non-formulary brand copay	

- 1) Your group's benefit period is based on a Calendar Year. The Calendar 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.
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- 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/Substance Abuse benefit.
- 4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits 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) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- 8) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

*This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.*