Summary Plan Description for Certain Health and Welfare Benefits

For the

California Area School District

Effective as of July 1, 2016

This document together with the Certificates of Coverage or the Component Benefit Plans and other documents identified in this document constitutes the Summary Plan Description.

California Area School District
Benefit Plan
SUMMARY PLAN DESCRIPTION
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Introduction

California Area School District (the "Employer") hereby establishes the California Area School District Benefit Plan for Medical, Vision and Dental Benefits (the "Plan"). The purpose of this document is to combine in one Summary Plan Description ("SPD") provisions of certain health and welfare benefit plans (the "Component Benefit Plans") provided by California Area School District, and to provide uniform administration of these Benefits. The Component Benefit Plans are listed in **Appendix A** to this SPD. This SPD reflects and summarizes the terms of the Plan in effect on July 1, 2016. Employees are eligible to participate in the Plan.

The insurance contracts (including Certificates of Coverage), summary plan descriptions, policies and procedures, and any other documents making up the Component Benefit Plans are not affected by the establishment of the Plan, and the terms of the Component Benefit Plans will continue to control for purposes of determining your benefits. (References in this document to insurance contracts, insurance policies and insurance generally will include HMO contracts (if any) or similar arrangements.) The terms of each Component Benefit Plan are incorporated into this SPD by reference and will continue to act as the primary source of information for each Component Benefit Plan. However, if a conflict of language exists between the Component Benefit Plan and the Plan or the SPD, the Component Benefit Plan will control as long as the Component Benefit Plan is not inconsistent with Federal law and regulations.

Note: Every effort has been made to accurately describe the Plan in this SPD. However, if the Plan is required to operate in a different manner to comply with Federal laws and regulations, the appropriate Federal laws and regulations will control.

If you have not received a Certificate of Coverage (which also may be known as a certificate of insurance or evidence of coverage) or other document that summarizes in detail a Component Benefit Plan, you may request the Certificate of Coverage or other document which will be made available by the Plan Administrator (identified under the heading "Plan Administrator") to you or your beneficiaries without cost.

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address or email and the addresses of any family members who are covered by the Plan.

General Information Pertaining to the Plan

Plan Name, Sponsor and Employer EIN

The name of the Plan is California Area School District Benefit Plan for Certain Health and Welfare Benefits. California Area School District is the Plan Sponsor. The Employer's address is 11 Trojan Way, Coal Center, PA 15423. The Employer's telephone number is 724-785-5800 x1213. The Employer's Federal employer identification number (EIN) is 25-1158474.

Plan Year

For recordkeeping purposes, the Plan Year for the Plan is the 12 month period beginning on July 1 and ending June 30.

Type of Welfare Benefit Plan(s)

The Plan may provide various welfare benefits under the Component Benefit Plan(s) listed in **Appendix A** to this SPD.

Funding

Benefits under the Plan are funded by one or more of the following methods selected by California Area School District for a Component Benefit Plan: insured benefits, self-funded benefits (these are benefits funded by general assets of the Employer or through a trust), or a combination of insured benefits, self-funded benefits and trust benefits. For details on the funding status of Component Benefit Plans, see **Appendix A**.

California Area School District has the right to pay Benefits from its general assets, insure any Benefits under the Plan, and establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or pursuant to its Trust Agreement with the Intermediate Unit 1, Health Insurance Consortium Trust (Consortium). In addition, subject to applicable law and the Trust Agreement, California Area School District has the right to alter, modify or terminate any method or methods used to fund the payment of benefits under the Plan, including, but not limited to, any trust or insurance policy. If any Benefit or portion of the Benefit is funded by the purchase of insurance, the Benefit or portion of the Benefit will be payable solely by the insurance company.

Plan Administrator

The Plan Administrator is the Consortium, One Intermediate Unit Drive, Coal Center, PA 15423, Telephone: 724-938-3241. The Consortium, or its designee, may administer the Component Benefit Plan. The entities shown in **Appendix A** are responsible for considering, accepting or denying, and ordering payment of claims for Benefits. The indicated entity is responsible for considering any appeals to the insured Benefits made following a Component Benefit Plan's claim procedures and, if applicable, the claim procedures indicated in this SPD. Any third-party administrator responsible for administering a Component Benefit Plan not funded through insurance may be listed in **Appendix A**. Therefore, the Plan Sponsor is the administrator of the Component Benefit Plan, unless otherwise specified in **Appendix A**, which identifies the administrator as the "Sponsor" or the "Insurer" or the "Contract Administrator." In addition, if a party has accepted named fiduciary status in considering, accepting or denying, and paying claims (including any appeals relating to such claims), that party (also referred to as a "Claim Fiduciary") is identified in **Appendix A.**

Agent for Service of Legal Process

The agent for service of legal process is California Area School District. Service may also be made on the Plan Administrator.

Named Fiduciary

The Plan Administrator is the primary named fiduciary of the Plan and has the exclusive and express discretionary authority to interpret the terms of the Plan and the terms of all the Component Benefit Plans to the extent not delegated to another named fiduciary, such as the Employer. For insured Component Benefit Plans, certain insurance companies may also be named fiduciaries under the Plan as to the determination of the amount of, and entitlement to, insured benefits with the full power to interpret and apply the terms of the Plan as they relate to the Benefits provided under the insurance policy.

Insurance Company Refund

As to any insurance company refund/rebate received by California Area School District that is subject to the Medical Loss Ratio ("MLR") provisions of the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act" or "ACA"), the Plan Administrator will determine what portion (if any) of such rebate must be treated as "Plan assets". If any portion of the rebate must be treated as "Plan assets," the Plan Administrator will determine, in its sole discretion, the manner in which such amounts will be used by the Plan or applied to the benefit of the Participants (the Participants need not be the same as those who made contributions under the policy that issued the rebate). Any portion of the rebate that is not treated as a 'plan asset' will be allocated to any employer or, if applicable, among one or more employer(s) as the Plan Sponsor in its sole discretion determines appropriate.

Coverage for Spouses, Dependents

One or more Component Benefit Plans covered under the Plan may identify spouses, dependents/children and others as eligible non-employee participants on **Appendix A**. The provisions relating to that coverage should be detailed in the Certificates of Coverage or other Component Benefit Plan documents. Note that you have an obligation to notify the Employer promptly of any loss of dependent status.

No Guarantee of Non-Taxability

The Plan provides benefits often intended to be non-taxable. The Plan Administrator or any fiduciary or party associated with the Plan will not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

No Guarantee of Employment

The offering of the Component Benefit Plans under the Plan is not a commitment or guarantee of employment by any Employer and does not affect any Employer's rights to discharge any employee.

Eligibility, Participation and Benefits

No Guarantee of Employment

Eligibility for participation and benefits under the Plan is determined under the written terms of the Plan and each Component Benefit Plan. See a summary for more information regarding eligibility and participation in **Appendix A**.

If you previously participated in the Plan and are rehired, you **may** be eligible to become a Participant on the same terms as if you were a newly hired employee. However, in most instances, group health plans offered by an "applicable large employer" (generally, an employer that employs an average of at least 50 (100 for the 2015 plan year in certain cases) full-time employees (including full-time equivalent employees) are subject to the ACA and have special rehire rules. These rules are as follows: if your Employer is subject to the ACA and you return to work after a period during which you were not credited with any hours of service, you may be treated as having terminated employment and been rehired as a new Employee only if the following conditions apply:

> (i) you had no hours of service for a period of at least 13 consecutive weeks (26 for educational organization employers); and (ii) you had a break in service of a shorter period of at least four consecutive weeks with no credited hours of service, and that period exceeded the number of weeks of your period of employment. These provisions are intended to comply with the ACA and are not intended to expand the rights or benefits of employees for any other purpose and should be so construed.

If your Employer believes it is an "applicable large employer" under the ACA, it may elect to take advantage of the look-back provisions of the ACA as to any variable hour or seasonal employees. See **Appendix B** for details.

Insurance carriers sometimes impose an "actively at work" requirement for certain types of insurance (for example, life and disability). Therefore, your participation in those benefits may be delayed or otherwise affected. This requirement would be reflected in your Certificate of Coverage. This may also be the case in which you are rehired as an employee.

Note that the "actively at work" requirement does not apply to a Group Health Plan unless there is an exception for individuals who are absent from work due to a health factor (e.g., individual is out on sick leave on the day the coverage would otherwise become effective).

For Plan Years beginning on or after January 1, 2014, as to any Component Benefit Plan that is a group health plan (other than one offering only HIPAA-excepted coverage), any otherwise eligible employee must wait no longer than ninety (90) days to begin coverage under such Component Benefit Plan.

Contributions

The cost of the benefits provided through the Component Benefit Plans may be funded in part by Employer contributions and in part by your contributions. In some instances, a Component Benefit Plan may require only you or California Area School District to contribute. If specified in **Appendix A**, the cost of benefits provided through a Component Benefit Plan may be funded pre-tax through a cafeteria plan under Section 125 of the Internal Revenue Code. The sources of Plan contributions are listed in **Appendix A.** California Area School District will periodically communicate your share of the cost

of the benefits provided through each Component Benefit Plan, and it may change that determination at any time. California Area School District will make any Employer's contributions in an amount that in the Employer's sole discretion is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. California Area School District will pay its contribution and your contributions to an insurance company or, for benefits that are self-funded, will use these contributions to pay benefits directly to or on behalf of you or your eligible family members. Your contributions will be used in their entirety prior to using Employer contributions to pay for the cost of that benefit. Where relevant to a Component Benefit Plan, you will receive during the open enrollment period notice of the amount for which you are responsible. If your cost for a Component Benefit Plan is adjusted during the Plan Year, you will be notified of that adjustment unless the Component Benefit Plan provides otherwise.

The Plan Administrator will have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual, organization or anyone else benefiting from the improper payment.

Benefits Available

The benefits available under the Plan consist of the benefits available under the Component Benefit Plans, including all limitations and exclusions for each Component Benefit Plan's benefits. The benefits available under each Component Benefit Plan are set forth in the Component Benefit Plan documents. The availability of benefits is subject to your payment of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Component Benefit Plan.

Where a health benefit involves the use of "network providers" (also sometimes referred to as "PPO", "EPO" or "preferred providers"), you will receive listings of such providers without charge. The listings may be provided in one or more separate documents or by electronic document access via the Internet.

Where a network is involved, a benefit document will include provisions governing the use of such providers, primary care providers or providers of specialty services, the composition of the network and whether and under what circumstances coverage is provided for emergency and out-of-network services.

Loss of Benefits

Your benefits (and the benefits of your eligible dependents) generally will cease when your participation in the Plan terminates. Benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. The insurance contracts (including the Certificates of Coverage), plans, and other governing documents of the Component Benefit Plans provide additional information. The subrogation provisions of the Plan are discussed in more detail in the section "Employer's Right of Reimbursement."

Benefit Elections

Electing Your Benefits for the Plan Year Under a Component Benefit Plan

Some of the Component Benefit Plans may require you to make an annual election to enroll for coverage for the next plan year prior to the beginning of that year. The plan year for each Component Benefit Plan should be set forth in that plan and may be different than the Plan Year for this Plan. Thus, the discussion below regarding plan year refers to the relevant Component Benefit Plan's plan year.

If you first become eligible to participate in a Component Benefit Plan during a plan year in progress, your initial elections pertain to the remaining part of that plan year. Then, before each new plan year begins, you will have an opportunity to change or cancel your elections during the annual open enrollment period. The annual open enrollment period is described below.

Making Your Elections

In making your elections, you may elect and enroll for some or all of the benefits available under a Component Benefit Plan. You may also elect not to participate in a Component Benefit Plan for which annual elections are then being made.

Benefits are elected by completing and submitting an election form in a format approved by the Plan Administrator (whether in paper or electronic format) before the end of the annual open enrollment period. When you make your elections, you also authorize the necessary payroll deductions for paying your part of the cost of the benefits you elect.

Once you are a participant in the Plan, if you become eligible for additional benefits during a plan year, you will be given an opportunity to elect and enroll in the benefits for which you are newly eligible.

Annual Election Period

Before the beginning of each Plan Year, the California Area School District often may hold an annual open enrollment period. In that case, the Consortium will notify you when the dates for the annual open enrollment period will occur each year. During this time, you may make new elections for the upcoming Plan Year. Your elections from the prior year may roll forward to the current year. You should consult with material provided to you during the annual open enrollment period to determine whether an election is required.

Changing Your Elections During a Plan Year

Where a Component Benefit Plan is funded through a cafeteria plan, once you have made your elections for a Plan Year, it pertains to the entire Plan Year as it applies to that Component Benefit Plan and cannot be changed or cancelled during that time except in certain limited situations that are described in the cafeteria plan. Other election restrictions may apply to Component Benefit Plans. For example, if you elect not to participate in the health plan when first eligible, you may need to wait until an open enrollment period as specified in the Component Benefit Plan.

If you, your spouse, or your dependent child experience a "change in status," and that change in status makes you, your spouse, or your dependent child eligible or ineligible for any of the pre-tax benefits, or for any of the benefit options sponsored by your spouse's or your eligible dependent child's employer, you may change the amount of your election in a way that is consistent with that "change in status," provided you notify the Plan Administrator of such change within 30 days of such change. The determination of whether you have experienced an event that would permit an election change and whether your requested election change is consistent with such an event shall be made in

the sole discretion of the Plan Administrator.

A "change in status" includes a change in the following:

(a) marriage;
(b) other changes in your legal marital status (for example, your divorce, annulment, or legal separation, or the death of your spouse);
(c) birth or adoption of a child, including placement for adoption;
(d) other changes in the number of your dependents (for example, legal guardianship for a child);
(e) you, your spouse's or your dependent child's employment status (for example, terminating or beginning a job; changing the number of hours worked, such as switching from full-time to part-time, or vice versa);
(f) you, your spouse or your dependent child begins or returns from certain types of unpaid leave of absence (FMLA or USERRA) or change in worksite;
(g) your dependent satisfies or ceases to satisfy eligibility requirements (for example, attainment of the limiting age, loss of student status, or similar circumstances);
(h) your (or your spouse's or dependent's) residence that results in gaining or losing eligibility for a health care option (such as moving out of an HMO service area); and
(i) any other event specified under the Employer's cafeteria plan that is consistent with IRS regulations and pronouncements, such as the specific situations related to the availability of coverage through a Health Insurance Exchange (or Marketplace) as provided in IRS Notice 2014-55, which allows prospective revocation of the employee's election under certain circumstances.

Claims Procedures

Benefits Administered by Insurers and TPAs

Claims for benefits that are insured or administered by a third-party administrator must be filed in accordance with the specific procedures contained in the insurance policies, Component Benefit Plans or the third party administrative services agreement.

The name (and in the case of group health plan claims, the address) of the individual insurance company providing benefits and reviewing claims relating to its insurance policy is set forth in **Appendix A**. Further, the name and address of the third-party administrator (if any) that reviews claims made under a Component Benefit Plan may be set forth in **Appendix A**. All other general claims or requests should be directed to the Plan Administrator.

Personal Representative

You may exercise your rights directly or through an authorized personal representative. You may only have one representative at a time to assist in submitting an individual claim or appealing an unfavorable claim determination.

Your personal representative will be required to produce evidence of his or her authority to act on your behalf. The Plan may require you to execute a form relating to the representative's authority before that person will be given access to your protected health information ("PHI") or allowed to take any action for you. (A mere assignment of your benefits does not constitute a designation of an authorized personal representative. Such a delegation must be clearly stated in a form acceptable to the Plan.) This authority may be proved by one of the following:

(a) A power of attorney for health care purposes, notarized by a notary public;
(b) A court order of appointment of the person as the conservator or guardian of the individual; or
(c) An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

General Claims Procedure

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself.

If you receive medications from a network pharmacy and present your ID card, you will not have to file a claim. If you forget your ID card when you go to a network pharmacy, the pharmacy may ask you to pay in full for the prescription.

The procedure is simple. Just take the following steps:

- ***Know Your Benefits*.** Review this information to see if the services you received are eligible under your medical program.
- ***Get an Itemized Bill*.** Itemized bills must include:

  - The name and address of the service or pharmacy provider;
  - The patient's full name;
  - The date of service or supply or purchase;
  - A description of the service or medication/supply;
  - The amount charged;
  - For a medical service, the diagnosis or nature of illness;
  - For durable medical equipment, the doctor's certification;
  - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
  - For ambulance services, the total mileage;
  - Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- ***Copy Itemized Bills*.** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms can be downloaded from blog.highmark.com by entering "forms" in the search box. Claim forms are also available from your employee benefits department, or call the Member Service telephone number on the back of your ID card.*

- ***Attach Itemized Bills to the Claim Form and Mail*.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

Remember: Multiple services or medications for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

Your claims must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.

Your Explanation of Benefits Statement

When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists:

- the provider's actual charge;
- the allowable amount as determined by the Claims Administrator;
- the copayment; deductible and coinsurance amounts, if any, that you are required to pay;
- total benefits payable; and
- the total amount you owe.

In those instances where you are not required to submit a claim because, for example, the network provider will submit the bill as a claim for payment under its contract with The Claims Administrator, you will receive an EOB only when you are required to pay amounts other than your required copayment.

If you do not have access to a computer or prefer to continue receiving printed EOBs, please notify Member Service by calling the number on the back of your ID card.

How to Voice a Complaint

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding participating health care providers, coverage, operations or management policies, please contact the Claims Administrator via the toll-free Member Service telephone number located on the back of your ID card or by mail at the following address: Claims, P.O. Box 890062, Camp Hill, PA 17089-0062. Please include your identification and group numbers as displayed on your ID card.

A representative will review, research and respond to your inquiry as quickly as possible.

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by our Member Grievance and Appeals Department. For details about how this process works, please refer to the Appeal Procedure section of this booklet or call Member Service at the number on your member ID card.

Fraud or Provider Abuse

If you think that a provider is committing fraud, please let us know. Examples of fraud include: Submitting claims for services that you did not get; Adding extra charges for services that you did not get; Giving you treatment for services you did not need. Please call the local state toll-free Fraud Hotline.

Additional Information on How to File a Claim

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the Member Service Department using the telephone number on your ID card.

Filing Benefit Claims

- ***Authorized Representatives***

  You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- ***Requests for Precertification and Other Pre-Service Claims***

  For a description of how to file a request for precertification or other pre-service claim, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Healthcare Management section of the benefit booklet issued by the Claims Administrator.

- ***Requests for Reimbursement and Other Post-Service Claims***

  When a hospital, physician or other provider submits its own reimbursement claim, the amount paid to that provider will be determined in accordance with the provider's agreement with The Claims Administrator. The Claims Administrator will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in that EOB or notice. If you believe that the copayment, coinsurance or deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with The Claims Administrator. For instructions on ***how*** to file such claims, you should contact the Member Service Department using the telephone number on your ID card.

Determinations on Benefit Claims

- ***Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims***

  For a description of the time frames in which requests for precertification or other pre-service claims will be determined by the Claims Administrator and the notice you will receive concerning its decision, whether adverse or not, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Healthcare Management section of the benefit booklet issued by the Claims Administrator.

- ***Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims***

  The Claims Administrator will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by The Claims Administrator for an additional 15 days, provided the Claims Administrator determines the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for the Claims Administrator to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim, see the Appeal Procedure subsection below.

Appeal Procedure

Your benefit program maintains an appeal process involving one level of review. At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify the Claims Administrator in writing of the designation.

For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by the Claims Administrator shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact the Member Service Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

If you receive notification that a claim has been denied by the Claims Administrator, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to the Claims Administrator, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review the appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Appeal Review Department will take into account all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the Claims Administrator. The Appeal Review Department will also afford no deference to any previous adverse benefit determination on the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including determinations of whether a requested benefit is medically necessary and appropriate or

experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;

- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 60 days following receipt of the appeal.

In the event the Claims Administrator renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and a statement regarding your right to request an external review or pursue a court action.

External Review

You have four months from the date you receive notice of a final Claims Administrator adverse benefit determination to file a request for an external review with the Claims Administrator. To be eligible for external review, the decision of the Claims Administrator must have involved (i) a claim that was denied involving medical judgment, including application of the Claims Administrator's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; or (ii) a determination made by your plan administrator to rescind your coverage.

In the case of a denied claim, the request for external review may be filed by either you or a health care provider with your written consent in the format required by or acceptable to the Claims Administrator. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

Preliminary Review

The Claims Administrator will conduct a preliminary review of your external review request within five business days following the date on which the Claims Administrator receives the request. The Claims Administrator's preliminary review will determine whether:

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan's eligibility requirements;
- You exhausted the above-described appeal process; and

- You submitted all required information or forms necessary for processing the external review.

The Claims Administrator will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request. If your request is not complete, the Claims Administrator's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review, whichever is later.

In the event that the external review request is complete but not eligible for external review, notification by the Claims Administrator will include the reasons why the request is ineligible for external review and contact information that you may use to receive additional information and assistance.

Referral to an Independent Review Organization (IRO)

The Claims Administrator will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, the Claims Administrator will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse the Claims Administrator's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you with at least 10 business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and the Claims Administrator. The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon the Claims Administrator's receipt of the IRO's notice of a final external review decision from the IRO that reverses the Claims Administrator's prior final internal adverse benefit determination.

Expedited External Review (Applies to Urgent Care Claims Only)

You are entitled to the same procedural rights to an external review as described above on an expedited basis:

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- Following a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, the Claims Administrator will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request. If your request is not complete, the Claims Administrator's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Special Rules for Disability Claims

A disability claim requires the Plan to determine if you are disabled for purposes of eligibility for disability benefits under a Component Benefit Plan. The Plan will notify you of its determination within 45 days after its receipt of your claim. This period can be extended for 2 additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator. If more information is requested during either extension period, you will have at least 45 days to supply it. You may appeal the Plan's determination within 180 days following receipt of an adverse determination. The Plan will notify you of its determination on review within 45 days and in accordance with the procedures fully set forth in Highmark's applicable Benefit Booklet, which is available on Highmark's website, www.highmarkbcbs.com. Otherwise, the general claims procedures apply, including the provisions relating to any Plan fiduciary's rights and responsibilities and the claims limitation period.

Coverage While on Leave of Absence

Certain Federal laws only apply based on factors such as the number of employees or Participants relating to an Employer's control group or for other reasons. In this regard, the following laws may be applicable. The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any individual, and such language should be interpreted accordingly.

Family and Medical Leave Act Coverage

The Family and Medical Leave Act ("FMLA") of 1993 generally applies to employers with 50 or more

employees within a 75 mile radius. FMLA also requires you to have worked a certain number of hours and months in order to be eligible. If you have questions about whether or how FMLA applies to you, you should contact the Plan Administrator for more details. Where applicable it provides certain rights and options relating to your health plan coverage. Generally, this law requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees. This family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee's child after birth or placement for adoption or foster care; care for the employee's spouse, child or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform the employee's job.

Parent: Parent means a biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the employee when the employee was a son or daughter. This term does not include parents "in law."

Son or Daughter: Son or daughter means a biological, adopted, or foster child, a stepchild a legal ward, or a child of a person standing in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of mental or physical disability at the time that FMLA leave is to commence.

In Loco Parentis: A child under the FMLA includes not only a biological or adopted child, but also a foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis. The FMLA regulations define in loco parentis as including those with day- to-day responsibilities to care and financially support a child. Employees who have no biological or legal relationship with a child may nonetheless stand in loco parentis to the child and be entitled to FMLA leave. For example, an uncle who is caring for his young niece and nephew when their single parent has been called to active military duty or an employee who is co-parenting a child with his or her same- sex partner may exercise their right to FMLA leave. Also, an eligible employee is entitled to take FMLA leave to care for a person who stood in loco parentis to the employee when the employee was a child.

FMLA was expanded for an eligible employee's parents or immediate family members being called to active military duty status or in active military duty in the following ways: (1) the events for triggering family leave now include "qualifying exigencies" of covered service members (see your Employer for details); and (2) eligible employees can take up to 26 weeks of job-protected leave in a single 12-month period to care for covered service members with a serious injury or illness.

If you are eligible and choose to take FMLA leave, your Employer must maintain your health coverage under any "group health plan" on the same terms as if you had continued to work. Any changes to the group health plan during the time you are on FMLA leave apply to you. Your Employer must also provide you with notice of any opportunity to change plans or benefits during your FMLA leave period.

Depending on your payment of plan premiums, you may be required to continue to pay premiums during FMLA leave. If you are 30 or more days late in making payment and your employer has given you written notice at least 15 days in advance advising that coverage will cease if payment is not received, you will be no longer covered, but upon your return to employment, the employer is required to restore your coverage. However, if you take FMLA leave and do not return to work after leave for a reason other than medical necessity, then you may be required to reimburse your employer for the payments made for your coverage during your leave.

You have the right to choose not to retain health coverage during FMLA leave. Upon return from FMLA leave, most employees must still be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of your leave. In addition, your Employer cannot require you to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

If you drop health coverage during your FMLA leave, any days without health coverage while on leave will not count toward a 63-day break in coverage relating to another health plan. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends. Therefore, if you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

Coverage provided under FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an Employer's obligation to maintain health benefits under FMLA ceases, such as if you notify the Employer of your intent not to return to work.

Military Service Leave (USERRA Coverage)

Any participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") will continue to participate and be eligible to receive benefits under any Component Benefit Plan that is a group health plan in accordance with USERRA rules and regulations.

If you were covered under a Component Benefit Plan which is a group health plan immediately prior to taking a leave for service in the uniformed services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service begins, if you pay any required contributions toward the cost of your group health plan coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

(a) You fail to make a premium payment (or premium equivalent) within the required time;
(b) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
(c) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or fewer, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "Other Continuation/Conversion Privileges."

If your coverage under the Plan terminated because of your service in the uniformed services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period required by USERRA. See the Plan Administrator for details.

Certain Federal Rights of Individuals Under Health Plans

Certain Federal laws only apply based on factors such as the number of employees or Participants

relating to an Employer's control group or for other reasons. In this regard, the following laws may be applicable. The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any individual, and such language should be interpreted accordingly.

Benefits for Adopted Children

If the group health plan under which you are covered provides benefits for dependent children, The California Area School District group health plan will extend benefits to dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants.

Children's Health Insurance Program Reconciliation Act

The Children's Health Insurance Program ("CHIP") was created to provide affordable health coverage to certain individuals and their dependents who are not eligible for Medicaid yet cannot get private coverage. In the case of group health plans, an amendment to CHIP designated "CHIPRA" allows states to subsidize premiums for employer-provided group health coverage for eligible employees and their dependents. Each state in which an employee resides will choose whether it will implement this optional subsidy. CHIPRA also allows for a special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage.

Generally, if you are eligible, you may be able to enroll in the employer's group health plan within 60 days of losing coverage under the Medicaid or CHIP plan or within 60 days of becoming eligible for premium assistance under the Medicaid or CHIP plan. Find out if your state has CHIP and/or Medicaid available, and speak with your Plan Administrator for further details.

COBRA Rights

Employers who employ 20 or more employees are subject to the group health plan continuation provisions of Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Generally, where COBRA applies, if you or your eligible family members' group health plan coverage ceases because of certain "qualifying events" specified in COBRA (such as termination of employment for reasons other than gross misconduct, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you or your eligible family members may have the right to purchase continuation coverage for a temporary period of time. You may also have coverage continuation rights under state insurance laws, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Information on State insurance law continuations is contained in the Certificate of Coverage (or its equivalent) which is incorporated by reference in **Appendix A**.

If you, your spouse, or your dependents lose coverage under the Plan because you experience a life event known as a "qualifying event," you and/or your spouse and dependents may be eligible to elect continuation coverage under COBRA for the portions of the Plan that are a "group health plan" (e.g., medical, dental, vision and health care flexible spending account ("health care FSA") benefits).

You, your spouse, or your dependents experience a "qualifying event" under COBRA if your employment terminates (or your hours are reduced making you ineligible for participation) for reasons other than gross misconduct. Additionally, your spouse or your dependents may experience a "qualifying event" due to your divorce, legal separation, death, or entitlement to Medicare. If you (or your spouse or your dependents) experience one of these qualifying events, and as a result lose

coverage under the Plan, you (or your spouse or your dependents) may be eligible for COBRA.

To be eligible for COBRA in the event of a divorce or legal separation, or if your dependents become ineligible under the Plan, you, your spouse, and/or your dependents must notify the Plan Administrator as soon as possible after the qualifying event occurs, and no later than 60 days after the qualifying event occurs. You must provide this notice, in writing to the Plan Administrator. In order to protect your rights, you should keep the Plan Administrator informed of any changes in the address of you, your spouse, and/or your dependents.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed below. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA. You may elect COBRA on behalf of your spouse, and you or your spouse may elect COBRA on behalf of your children.

The Plan Administrator will provide qualified beneficiaries with a COBRA election form. Qualified beneficiaries must elect to continue participation within 60 days after your participation ends or you receive this form, whichever is later. The Plan will offer COBRA continuation coverage only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is your death, your entitlement to Medicare benefits, your divorce or legal separation, or a dependent's losing eligibility as a dependent, COBRA continuation coverage may last for up to a total of 36 months. When the qualifying event is your termination of employment or reduction of hours of employment and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA for qualified beneficiaries (other than you) may last for up to 36 months after the date of Medicare entitlement. In some situations (described below), COBRA may last up to 29 or 36 months. Otherwise, when the qualifying event is your termination of employment or reduction of hours, COBRA generally lasts for up to a total of 18 months. There are 2 ways in which the 18-month period of COBRA can be extended:

Disability Extension. If you or any of your covered dependents is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator in a timely fashion, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA and must last at least until the end of the 18 month period of COBRA. To be eligible for this disability extension, you must notify the Plan Administrator of the SSA's determination within 60 days of receiving it and prior to the end of the initial 18-month COBRA period. If the SSA determines that the individual is no longer totally disabled, continuation coverage ends. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator within 30 days after the SSA's determination.

Second Qualifying Event Extension. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependents can get up

to 18 additional months of COBRA coverage, for a total maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the occurrence of the second qualifying event. This extension may be available to your spouse and dependents receiving COBRA if you die, become entitled to Medicare benefits, get divorced or legally separated, or if your dependent stops being eligible under the Plan as a dependent, but only if the event would have caused your spouse or dependent to lose coverage under the Plan had the first qualifying event not occurred.

There are a few cases in which a COBRA participant or qualified beneficiary could lose COBRA coverage early. Such person is no longer entitled to COBRA if the participant who becomes covered under another group health plan, fails to make the required contributions on time, becomes entitled to Medicare benefits (under Part A and/or Part B or both, including if someone has also enrolled in Medicare Advantage), or the Employer ceases to provide any health plan benefits.

To continue your group health coverage, you and/or your covered dependents may be charged up to 102% of the full cost of coverage (or 150% in the case of an 11-month extension due to disability). You make this payment monthly during the 18, 29 or 36-month period of continuation coverage. The first premium payment must be received by the COBRA administrator within 45 days after the date of the COBRA election and must include your COBRA payment for the entire period from the date coverage ended through the month of the payment. Subsequent premiums must be received by the COBRA administrator within 29 days after the premium due date. Premium payments should be sent to the Plan Administrator's address.

If health care FSA coverage is offered under the Plan, COBRA continuation for such coverage ends on the last day of the health care FSA plan year in which the qualifying event occurs. However, COBRA will not be provided under the health care FSA if, as of the date of the qualifying event, you would not receive (during the remainder of the Plan Year) a benefit under the health care FSA that is more than the amount you would pay for COBRA for the remainder of that Plan Year.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a 'special enrollment period.' Some of these options may cost less than COBRA continuation coverage.

For more information about your rights under COBRA, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov/.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act ("GINA") states that health benefit plans may not discriminate on the basis of genetic information relating to eligibility, premiums and contributions. In this regard, GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by an employer, health plan, or "business associate" of the employer. One exception to this rule is that a minimum amount of genetic testing results may be used if necessary to make a determination regarding a claims payment.

You should be aware that where GINA applies, genetic information is treated as protected health

information ("PHI") under another Federal law called "HIPAA." The plan must provide that an employer cannot request or require that you reveal whether you have had genetic testing. Neither can your Employer require you to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums.

HIPAA Rules

Information you provide for purposes of a health plan sponsored by the Employer may be PHI under Privacy Standards established under the Health Insurance Portability and Accountability Act ("HIPAA"). Where HIPAA applies, such plan will be operated in accordance with such law and laws that affect this law such as GINA, which makes it clear that genetic information is also PHI. If you have questions about this law, you should contact the Plan Administrator.

Regarding HIPAA portability, some group health plans are subject to HIPAA portability rules while others are not. Group health plans that are generally not subject to HIPAA (and therefore are considered "HIPAA-excepted coverage") include for example certain limited dental and vision plans.

In addition, a group health plan that is subject to HIPAA portability must comply with the following:

> If a group health plan provides benefits for a type of injury, it may not deny benefits otherwise provided for the treatment of that injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Note that pre-existing condition exclusions are now prohibited for group health plans.

Mental Health Parity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") generally applies to employers that employ more than 50 employees and its health plan provides for mental health and substance abuse benefits. (Thus, if your Plan does not currently offer any mental health or substance abuse benefits, then MHPAEA does not apply.) These group health plans must cover mental health and substance abuse services in a manner equal to their coverage of predominant medical and surgical services.

Financial and treatment limits for mental health/substance abuse, such as deductibles, co-payments, co-insurance and out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars, scope, or duration of treatment may not be substantially more limited than for medical/surgical benefits. For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

To the extent that non-Grandfathered small group plans are required to provide essential health benefits, including mental health and substance abuse disorder benefits, for plan years beginning on or after July 1, 2014, such benefits must comply with the final rules issued by the DOL on November 13, 2013.

Michelle's Law

Many health plans extend health coverage to dependents of an employee where they have dependent full-time college students under a certain age. In such a case, a certification of student status may be required by the Plan Administrator for continued coverage under the health plan. Group health plans must provide extended coverage to any of the Participant's dependents who are full-time students in a postsecondary educational institution that would otherwise lose coverage

because of taking medically necessary leave due to a serious illness or injury.

If you have a dependent who is a full-time student with a serious illness or injury, that dependent may be eligible for protection under Michelle's Law. Your Employer may require you to provide written certification of the condition from the child's treating physician in order for your child to be eligible.

If your child is deemed eligible under Michelle's Law, extension of coverage is required for up to 12 months or, if earlier, the date the coverage would otherwise end under the Component Benefit Plan.

While the Affordable Care Act provision that requires extension of coverage for dependents until age 26 will often make reliance upon Michelle's Law unnecessary, Michelle's Law still will have relevance in certain circumstances such as its applicability to HIPAA-excepted coverage (to which the ACA does not apply).

Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or 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 insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of the above periods.

Qualified Medical Child Support Orders

The Employer's group health plans will provide benefits as required by any qualified medical child support order.

The Employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Patient Protection and Affordable Care Act

The ACA requires the modification of group health plans in a number of ways. Some of these significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for group health plans *that are not HIPAA-excepted coverage*:

(a) If you need to receive emergency services in the emergency department of a hospital, you do not need prior authorization, and your cost-sharing obligations (including co-payments and co-insurance) will be the same whether you are treated at a hospital that is in-network or out-of-network. You are not required to receive prior approval as would be applied to care received by preferred providers; however, you may be responsible for the allowed amount under your plan and what is billed by a non-network provider, to the extent permitted by the ACA;

(b) Coverage of minimum preventive care services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force must be provided without cost-sharing by the covered person and which also include special provisions for first dollar coverage of certain immunizations, preventive care and screening for infants, children, adolescents, and women;

(c) If your health plan requires you to select a primary care physician ("PCP"), the group

health plan or health insurer may designate one for you automatically. In some circumstances, you can designate any participating PCP (who participates in the network and who is accepting new patients) as your PCP; additionally, a participating physician specializing in pediatrics may be selected as the PCP for a covered dependent child; if the group health plan designates a PCP automatically, until you make this designation, the group health plan or health insurer will designate one for you. Where selection of a PCP is required or allowed, contact the Plan Administrator or insurer at the telephone numbers listed as contacts under **Appendix A** for information on the selection process;

(d) A female covered person is permitted to receive services for OB/GYN care without referral by a PCP. That is, prior authorization from a health plan or insurer or from any other person (including a primary care provider) is not necessary in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator or insurer at the telephone numbers listed as contacts under **Appendix A**; and

(e) Internal appeal and external review claim procedures are revised as provided in the "Claims Procedures" section of this SPD.

Significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for health plans that are not HIPAA-excepted coverage:

(a) Any lifetime or annual maximum may not be imposed on the following benefits to the extent that they are covered under the Plan: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (collectively, "Essential Health Benefits");

(b) No rescissions in health plan coverage will be allowed except for fraud or an intentional misrepresentation of a material fact and will require 30 calendar days' advance notice to an individual before coverage is rescinded; and

(c) If you have elected coverage for your dependents under your health plan, your child (including step-child, legally adopted child, a child placed for adoption and a child under a QMCSO or National Support Notice) can be covered until the child turns age 26 regardless of the child's tax dependent status.

The above includes certain minimum provisions of the ACA. In certain cases, a Component Benefit Plan's Certificate of Coverage may be more generous than the ACA requires. Therefore, you should review the Certificate of Coverage for details.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage in a manner determined in consultation with the attending physician and the patient for (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to provide symmetrical appearance; (3) prostheses; and (4)

treatment of physical complications of the mastectomy, including lymphedema. Where this law applies, these benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable Component Benefit Plan identified in **Appendix A.** Call your Plan Administrator for more information.

Wellness Program

In some circumstances, the Plan may offer wellness programs designed to promote the health and well-being of all employees. Some examples of wellness programs include, but are not limited to, providing financial incentives to engage in activities that encourage health lifestyle changes, providing you with information about your current health condition by undergoing health screenings or answering questionnaires, giving you the opportunity to receive health coaching, and participating in disease management programs.

These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and the Employer money.

Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of open enrollment material or other communications.

Any wellness program related to financial incentives offered under the Plan must comply with the requirements and limitations of HIPAA, the ACA and related guidance. For example, where a wellness program subject to HIPAA is offered under the Plan, a reward may be offered based on certain standards of achievement. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Plan Administrator, and we will work with you to develop another way to qualify for the reward.

Employer's Rights Under the Plan

Employer's Right to Change or End the Plan

California Area School District reserves the right to terminate, suspend, withdraw, amend or modify the Plan, or any Component Benefit Plan, in whole or in part at any time. The Employer reserves the right to withdraw from and terminate its participation in the Plan or Component Benefit Plan, thereby terminating, suspending, amending or modifying the Plan as to its Plan participants. Generally, any amounts remaining in the Plan at termination will be distributed pursuant to the Trust Agreement between the Consortium and the Employer.

Employer's Right to Interpret the Plan

California Area School District has the right to appoint the Plan Administrator of the Plan as set forth in the Trust Agreement. The Plan Administrator has discretion to interpret the provisions of the Plan and any Component Benefit Plan.

The Plan Administrator's interpretations and decisions are conclusive and binding on all Plan participants.

Employer's Right of Reimbursement

To the extent not inconsistent with the provisions of any underlying documents incorporated by reference in the Plan, the following provisions will control as to any medical or dental Component Benefit Plan.

If an employee, spouse, or dependent, or any other person specified as an "Eligible Non-Employee" in **Appendix A** incurs medical or dental expenses or receives benefits from the Plan or its carrier as a result of an injury or accident, immediately upon payment of any benefits under the Plan, the Plan and Plan Administrator will be subrogated (substituted) to all rights of recovery against any person or organization whose conduct or action caused or contributed to the loss for which payment was made by the Plan.

If an employee, spouse, or dependent, or any other person specified as an "Eligible Non-Employee" in **Appendix A** receives any reimbursement from any party as a result of an injury, the Plan has the right to recover the amounts the Plan has paid and will pay as a result of that injury, from any amounts an employee, spouse, or dependent, or any other person specified as an "Eligible Non-Employee" in **Appendix A** received from any party. Similarly, if any person, including any natural person or entity, other than if an employee, spouse, or dependent, or any other person specified as an "Eligible Non- Employee" in **Appendix A** has possession of funds recovered from a third party as to which you, your spouse, or any of your dependents has or had a claim, then the Plan will be subrogated to that claim and will have a right to recover directly from the person that is holding the funds. An employee, spouse, or dependent, or any other person specified as an "Eligible Non-Employee" in **Appendix A** agrees to assist the Plan in its attempt to recover from that person. In the event that you, your spouse, or any of your dependents is deceased, the Plan has a right to recover funds from the estate pursuant to this reimbursement provision. The Plan will not pay attorney fees or costs associated with your, your spouse's, or any of your dependents' claims without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

You, and individuals acting on your behalf, including attorneys, will do nothing to prejudice the Plan's subrogation and reimbursement rights and will, when requested, provide the Plan with information and cooperate with the Plan in the enforcement of its subrogation and reimbursement rights. It is your duty, and the duty of individuals acting on your behalf, to notify the Plan Administrator within 45 days of the date of the injury or the date when you give notice to any other party, including an attorney, of your intention to pursue or investigate a claim to recover damages on behalf of you, your spouse, or your dependent, or any other person specified as an "Eligible Non-Employee" in **Appendix A**.

For purposes of this section, "reimbursement" includes all direct and indirect payments to you, your spouse, your covered dependents, or other person specified as an "Eligible Non-Employee" in **Appendix A** for injury or illness from any source, by way of settlement, judgment, or any other means, including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no-fault automobile insurance coverage, and homeowner's insurance.

Union Agreement's Limits to Employer's Rights

The Employer has entered into collective bargaining agreement(s) with the following union(s): The Pennsylvania State Education Association, 400 North 3rd Street, Harrisburg, PA 17105 (the "Union

Agreement"). The applicable Union Agreement may have restrictions relating to the Employer's rights, and Union members may also have certain rights under their Union Agreement with respect to changing the Plan during the term of the Union Agreement. If you are subject to the Union Agreement, any questions in this regard should be referred to a Union representative.

Other Continuation / Conversion Privileges

You may be eligible for continuation of coverage under a COBRA-type continuation of coverage arrangement mandated in the state to which your coverage applies (for example, California, New York, or Georgia) for certain insured benefits. The availability of this continuation coverage and the rules concerning eligibility should be set forth in the policy of the insurance company allowing the continuation of coverage. Since the time period for exercising your right to elect continuation of coverage may be limited, you must inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Plan.

Also, when you are no longer eligible under the Plan (either as an active participant or as a qualified beneficiary receiving continuation coverage), you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility should be set forth in the policy of the insurance company allowing the conversion privilege. Since the time period for exercising your conversion privileges may be limited, you should inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Plan.

You are entitled to certain rights and protections. Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including any applicable insurance contracts and collective bargaining agreements, if any.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any applicable insurance contracts, and collective bargaining agreements, if any. The Plan Administrator may make a reasonable charge for the copies.
- Continue health care coverage for yourself or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the group health plans for the rules governing your COBRA continuation coverage rights.

The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so 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 your benefits under the Plan.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

- If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed under the heading Claims Procedure), you may file suit in a state or federal court. In addition, if you disagree with the

Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your benefits or the Plan, you should contact the Plan Administrator. If you have any questions about this statement, you should contact the nearest Area Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Appendix A: Component Benefit Plans

The information below is effective July 1, 2016, unless otherwise indicated below.

Component Benefit Plans Offered Under the Plan

Below is a list of each Component Benefit Plan and the eligibility and participation requirements of those plans. Also listed is the name (and in the case of group health plan claims, the address and telephone number) of the individual insurance company that provides benefits (if any) and reviews claims relating to its insurance policy. Also below may be a list of the name and address of the third-party administrator (if any) that reviews claims made under a Component Benefit Plan as well as the telephone number to call for questions regarding claims procedures and forms.

Generally, unless otherwise indicated below or as provided in Appendix B (relating to certain variable hour or seasonal employees), an eligible employee under the Plan is any regular common-law employee of California Area School District who is not a leased employee, contract worker or independent contractor, seasonal employee, variable hour employee, or former employee, and such regular common- law employee is eligible to participate in and receive benefits under one or more of the Component Benefit Plans. Non-resident aliens are also not eligible unless specifically included under "Eligible Employees" below. To determine whether you are eligible to participate in a Component Benefit Plan, please read the eligibility information below for the applicable Component Benefit Plan.

APPENDIX A

Health with Prescription Drug Attachment 1	
Eligible Employees *	All Employees Who Work a Minimum of 30 Hours per Week
Participation Begins *	1st day of the month following hire for all classes eligible for benefits.
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	Dependents/Children and Spouses
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes
Funding Arrangements	Self-funded
Plan Administered By	Intermediate Unit 1, Health Insurance Consortium Trust 724-938-6665
Third Party Administrator	Highmark, 120 Fifth Avenue, Pittsburgh, PA 15222; 1-800-241-5704
Claim Fiduciary	Plan Administrator/Employer
Trustee	Yes
Grandfathered Health Plan	**Yes** Group Numbers: 12179-05; 12178-11; 11783-23 50975-73; 80913-24 **No** Group Numbers: 11782-20; 11782-89; 11783-82 12179=24
Look-Back Provisions	Yes; See Exhibit B
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

APPENDIX A

Dental Attachment 2	
Eligible Employees *	All Employees Who Work a Minimum of 30 Hours per Week
Participation Begins *	1st day of the month following hire for all classes eligible for benefits.
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	Dependents/Children and Spouses
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes
Funding Arrangements	Cost Plus
Plan Administered By	Intermediate Unit 1, Health Insurance Consortium Trust
Third Party Administrator	United Concordia, 4401 Deer Path Road, Harrisburg, PA 17110 ; 1-800-332-0366
Claim Fiduciary	Plan Administrator/Employer
Trustee	Yes
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Vision Attachment 3	
Eligible Employees *	All Employees Who Work a Minimum of 30 Hours per Week
Participation Begins *	1st day of the month following hire for all classes eligible for benefits.
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	Dependents/Children and Spouses
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes
Funding Arrangements	Insured Benefit Program
Plan Administered By	Intermediate Unit 1, Health Insurance Consortium Trust
Third Party Administrator	Davis Vision, 175 East Houston Street, San Antonio, TX [***zip code?***], 1-800-328-4728
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Appendix B: Look-Back Provisions (Variable Hour Employees)

The Employee's hours of service will be tracked over a period of 12-month Initial Measurement Period that begins on the first of the month following date of hire to determine whether the Employee averages 30 or more hours of service per week. Employees who average 30 or more hours of service per week during the Initial Measurement Period will be considered Full-Time and coverage will begin on the first of the month following the end of the Initial Measurement Period, which is also the first day of the Initial Stability Period. Coverage will continue at least until the end of the Initial Stability Period, provided the Employee remains employed. Employees who average fewer 30 hours of service per week during the Initial Measurement Period will not be offered coverage.