Pennsylvania College of Technology

Employee Benefit Plan

and

SUMMARY PLAN DESCRIPTION

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 Pennsylvania College of Technology Employee Benefit Plan.
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1. INTRODUCTION

The Pennsylvania College of Technology values their Full-time Employees, Domestic Partners, Retirees (medical benefits (including prescription drugs) only) and their families and we are pleased to provide you with a comprehensive and cost effective benefit package.

Purpose of the Plan Document

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

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

Plan Benefits and Premium Contribution Requirements:

<table>
<thead>
<tr>
<th>Attachment #</th>
<th>Highmark Blue Cross Blue Shield Medical (including prescription drugs)</th>
<th>Self-Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1</td>
<td>PPO Blue Plan C Group Numbers: 10213035 – 10213039 <a href="http://www.highmark.com">www.highmark.com</a></td>
<td></td>
</tr>
<tr>
<td># 2</td>
<td>Highmark Blue Cross Blue Shield Medical (including prescription drugs) Classic Blue Group Numbers: 10213032 – 10213034 <a href="http://www.highmark.com">www.highmark.com</a></td>
<td>Self-Insured</td>
</tr>
<tr>
<td># 3</td>
<td>Highmark Blue Cross Blue Shield Medical (including prescription drugs) PPO Blue Bronze (This program is available exclusively to Eligible Variable Hourly Employees) Group Numbers: 10213040 - 10213041 <a href="http://www.highmark.com">www.highmark.com</a></td>
<td>Self-Insured</td>
</tr>
<tr>
<td># 4</td>
<td>Highmark Blue Cross Blue Shield Medical (including prescription drugs) with Health Savings Accounts PPO Blue Qualified High Deductible Health Plan (QHDHP) Group Numbers: 01780877, 01780878, 01780879, 01780880, 01780881 <a href="http://www.highmark.com">www.highmark.com</a></td>
<td>Self-Insured</td>
</tr>
<tr>
<td># 5</td>
<td>College Health Services – Wellness Clinic Medical care for faculty and staff. See the Human Resources Department for more information regarding routine services offered. Self-Funded</td>
<td></td>
</tr>
<tr>
<td># 6</td>
<td>Delta Dental Group Number: 01167 <a href="http://www.deltadental.com">www.deltadental.com</a></td>
<td>Self-Insured</td>
</tr>
<tr>
<td>Exhibit A</td>
<td>Health Reimbursement Arrangement (“HRA”) You must be a participant in the Qualified High Deductible Health Plan (QHDHP) medical (including prescription drugs) program and ineligible to open a Health Savings Account (HSA) in order to receive benefits from the HRA. Discovery Benefits Employer Number: 27499 <a href="http://www.discoverybenefits.com">www.discoverybenefits.com</a></td>
<td>Self-Funded</td>
</tr>
</tbody>
</table>
| Exhibit B | Flexible Spending Account Plan (“FSA”)  
Dependent Care Spending Accounts (DCAP)  
Discovery Benefits  
Employer Number: 27499  
www.discoverybenefits.com | Self-Funded |
|---|---|---|
| Exhibit C | Health Savings Account Program  
**You must be a participant in the PPO Blue Qualified High Deductible Health Plan (QHDHP) in order to participate in the Health Savings Account Program**  
Discovery Benefits  
Employer Number: 27499  
www.discoverybenefit.com | Self-Funded |
| Exhibit D | **Outline of Coverage:**  
PPO Blue Plan C  
Classic Blue  
PPO Blue Bronze  
PPO Blue Qualified High Deductible Plan (“QHDHP”) | N/A |
| Attachment # 7 | Schedule of Employee Premium Contribution Requirements (See the Human Resources Department for current premium contribution requirements.) | N/A |

A copy of each booklet, summary or other governing document is addressed in this document as Attachments noted above. Copies of all attachments for the Plan have been previously delivered to you and are on file at the Pennsylvania College of Technology’s Human Resources Department and are available to you with your written request. Copies are also available on the College’s Intranet for College employees at myPCT Portal (https://mypct.edu/departments/HumanResources/Benefits/default.aspx) for those individuals who have Intranet access. Retirees and COBRA participants can access the portal at myPCT Portal (https://public.pct.edu/humanresources/retireehealthbenefits.htm).

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.

Pennsylvania College of Technology fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason with appropriate notification requirements to eligible employees.

The purpose of the Plan is to provide Employees with the opportunity to choose among those benefits available to them under the Plan. All eligible employees contribute towards medical benefits (including prescription drugs) on a pre or tax basis through salary reduction and on a post-tax basis if a properly completed Pennsylvania College of Technology Premium Reduction Plan Enrollment Form is completed and submitted to the Human Resources Office.

The Plan is intended to qualify as a “cafeteria plan” under Internal Revenue Code Section 125, and regulations issued shall be interpreted to accomplish that objective. Not all benefits offered in the Plan are considered Section 125 / Cafeteria Plan benefits, specifically the Health Reimbursement Arrangement. Health Reimbursement Arrangements follow rules set forth under Internal Revenue Code § 105 and 106.

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.

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. Information regarding eligibility and participation can be found in the current collective bargaining agreements. The College currently has a collective bargaining agreement with the following collective bargaining unit: PA College Education Association – (Full-time faculty, counselors and librarians only).
Pennsylvania College of Technology fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason with the appropriate required notification requirements pursuant to eligible employees’ collective bargaining agreements.

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

When this Summary Plan Description uses the term “Plan Sponsor”, it is referring to the Pennsylvania College of Technology 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 or the Human Resources Office.

Employees of the following affiliated employer are eligible for benefits offered in the Plan:

Community Arts Center

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.

Participants are also responsible for timely reporting of any change in a Dependent’s status, marriage, divorce, or Domestic Partnership status within 30 days of the change in status.
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 basis.

<table>
<thead>
<tr>
<th>Benefit Period – Coverage</th>
<th>Plan/Policy Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (including prescription drugs), Health Reimbursement Arrangement (“HRA”), Health Savings Account Program (“HSA”), College Health Services, Dental, and Flexible Spending Account Plan (Dependent Care Expense Accounts)</td>
<td>7/1 to 6/30</td>
</tr>
</tbody>
</table>

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

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

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

College Health Services – Wellness Clinic means an available medical provider for faculty and staff who are not feeling well. The Clinic is open during office hours Monday through Friday and offers a variety of routine services. See the Human Resources Department for more information about this benefit.

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

Dependent – Medical means any child (including adopted child(ren), child(ren) under court-appointed guardianship, or step-child(ren)) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. The Pennsylvania College of Technology will provide benefits to eligible Dependents until the end of the month following the date the adult child reaches age 26.

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

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

Dependent – Dental means any individual who is a (a) an unmarried child of a Plan participant if the child is under age 19 and is primarily dependent on the participant for support; (b) an unmarried child of a Plan participant if the child is age 19 or over, by the end of the calendar year in which the dependent attains age 25 (limiting age) (verification of full-time status is required), (c) a full-time student in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, and primarily dependent on the participant for support; (d) any child of a Plan participant if the child is mentally or physically incapable of self-support and is dependent upon the participant for support, regardless of the child’s age, provided such mental or physical condition commenced prior to the attainment by the child of age 19, or by the end of the calendar year in which the dependent attains age 25 (limiting age) (verification of full-time status is required) if the child was age 19 or over and enrolled as a full-time student at the date of such commencement; (e) any child of a participant who does not qualify as a dependent under subsections (b), (c), or (d) above, solely because the child is not primarily dependent upon the participant for support so long as over half of the support of the child is received by the child from the participant.
pursuant to a multiple support agreement; (f) any other individual who is a dependent of the Plan participant described in Section 152(a) of the Internal Revenue Code and whose welfare is the legal responsibility of the Plan participant pursuant to legal guardianship, written divorce settlement, written separation agreement or a court order, including a Qualified Domestic Relations Order or National Medical Child Support Order.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter and maintains full-time student status the entire semester. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

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

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

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

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

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

**Dependent - Michelle’s Law** - allows for continuation of coverage for college students during a medical leave. Under this law, a group health plan must continue to provide coverage to a dependent that otherwise would lose coverage under the plan for failing to maintain full-time enrollment in a post-secondary institution in the event the dependent requires a medically necessary leave of absence. To qualify for coverage under the law, the dependent must suffer from a serious illness or injury and lose eligibility due to the medically-necessary leave. The dependent’s treating physician is required to certify that the dependent is suffering from a medical illness or injury and that the leave of absence is medically necessary. Coverage under Michelle’s Law must be extended for at least one year; however, coverage may end earlier for certain reasons such as aging out of the plan (i.e. exceeding the Plan’s normal dependent-eligibility age). Please see the Plan Administrator for necessary forms in the event your dependent child is entitled to extended coverage under this law.

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

**Domestic Partner** – means same-sex or opposite sex Domestic Partners who are defined in the Affidavit of Domestic Partnership – Faculty and Staff Form (“Affidavit”). In order to receive benefits in the Plan, both the Employee and the Domestic Partner must complete and sign the Affidavit verifying eligibility along with the appropriate enrollment forms. The Employee and Domestic Partner are solely responsible for any tax and/or legal implications or consequences arising out of the application for or receipt of domestic partnership benefits. Continuation of health care coverage is not required under federal COBRA law for Domestic Partners. The Pennsylvania College of Technology is providing “COBRA like” benefits under the same terms that apply to married Spouses.

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

**Eligible Person** – means a person entitled to be a Participant as specified in the Schedule of Eligibility.

**Employer** means the College, any of its Affiliates, and any other persons, firms, or organizations that have expressly adopted this Plan with the consent of Pennsylvania College of Technology.

**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.

**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.

**Health Reimbursement Arrangement ("HRA")** means an employee benefit program funded entirely by your Employer that reimburses you for out of pocket medical expenses, including deductibles in your medical (including prescription drugs) program. An HRA permits an employer to reimburse Eligible Employees for approved medical expenses not covered by your medical insurance program. Benefits paid must be provided on a non-discriminatory basis. HRA’s operate under Section 105(h) of the Internal Revenue Code.

**Health Savings Account ("HSA")** means a type of savings account that allows you to set aside money on a pre-tax basis to pay qualified medical expenses if you are enrolled in a high deductible health plan (HDHP). Combining a high deductible health plan with a health savings account allows you to pay for certain medical expenses, like your deductible and co-payments with untaxed dollars. HSA funds roll over from year to year if not spent. You can take the funds with you if you change jobs or leave the work force.

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

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

**National Medical Child Support Order** means the College 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 Pennsylvania College of Technology Employee Benefit Plan, which is a benefits plan for eligible employees of Pennsylvania College of Technology and is described in this document.

**Plan Administrator** means the individual named in the General Information about the Plan Section of this document. The Plan Administrator is not Highmark Blue Cross Blue Shield.

**Plan Year** means a twelve (12) consecutive month period that commences and ends on a date selected by the Sponsor and shown in the General Information Section of this Summary Plan Description.
**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 Pennsylvania College of Technology Premium Reduction Plan Enrollment for waiver of participation to the Human Resources Department.

**Pre-Tax Salary Reduction** means a separate written authorization of the Employee to have his or her after-tax salary reduced in exchange for the Employer making equivalent pre-tax contributions on the Employee’s behalf directly to the Insurer to pay for the level of health insurance coverage elected by the Employee for himself and his Dependents under the Health Insurance Program. The maximum Employer pre-tax contributions which can be made hereunder in consideration of a Salary Reduction cannot exceed the cost of the level of coverage elected by the Participant under the medical benefit, dental or vision program reduced by any Employer 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 components. In the case of a Qualifying Event, Qualified Beneficiary means an individual who on the day before the Qualifying Event is an Employee covered by the Plan.

**Qualifying Event under COBRA** means any of the following events: (a) death of an Employee; (b) the voluntary or involuntary termination (other than by reason of gross misconduct) of an Employee; (c) a change in an Employee’s status from an eligible to an ineligible status; (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 Employees who are eligible for and implement retirement consistent with the rules, regulations, provisions laws, as applicable to the retirement system (PSERS, SERS, TIAA/CREF) in which the Employee is enrolled. Please see the Plan Administrator or the Human Resources Office for more information regarding Retiree benefits and payment provisions.

**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 of an Employee 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: Pennsylvania College of Technology

Plan Name: Pennsylvania College of Technology Employee Benefit Plan

Employer Address: One College Avenue
Williamsport, PA 17701

Employer’s Telephone Number: 570-326-3761

Plan/Policy Years: July 1st to June 30th

Employer’s Federal Tax Identification Number: 23-2564508

Plan Sponsor: Pennsylvania College of Technology

Plan Administrator/Named Fiduciary
(Dental, College Health Services – Wellness Clinic, Health Reimbursement Arrangement, Health Savings Account Program, and the Flexible Spending Account Plan - DCAP):
Associate Vice President for Human Resources
Pennsylvania College of Technology
One College Avenue
Williamsport, PA 17701

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

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

Agent for Service of Legal Process:
Pennsylvania College of Technology
One College Avenue
Williamsport, PA 17701
Ann Pepperman, Esquire

Agent for Service of Legal Process: (Medical Benefits only)
Lycoming County Insurance Consortium
On behalf of:
Pennsylvania College of Technology
One College Avenue
Williamsport, PA 17701

Funding Medium and Type of Plan Administration:

The insurance companies, not Pennsylvania College of Technology, are responsible for paying claims with respect to these programs. Pennsylvania College of Technology shares responsibility with the insurance companies for administering these program benefits.

The following benefits under the Plan are self-insured or self-funded and paid through pre-tax salary reductions and/or the general assets of the employer. The employer pays the cost of operating the College Health Services – Wellness Clinic through the general assets of the employer. The employer pays benefit claims for the health reimbursement arrangement through the general assets of the employer:
<table>
<thead>
<tr>
<th>Benefits:</th>
<th>Administrative Services Provided by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (including prescription drugs):</td>
<td>Highmark Blue Cross Blue Shield</td>
</tr>
<tr>
<td>College Health Services – Wellness Clinic:</td>
<td>Pennsylvania College of Technology</td>
</tr>
<tr>
<td>Health Reimbursement Arrangement:</td>
<td>Discovery Benefits</td>
</tr>
<tr>
<td>Health Savings Account Program:</td>
<td>Discovery Benefits</td>
</tr>
<tr>
<td>Flexible Spending Account Plan (Dependent Care Spending Accounts)</td>
<td>Discovery Benefits</td>
</tr>
<tr>
<td>Dental:</td>
<td>Delta Dental</td>
</tr>
</tbody>
</table>

Insurance premiums for employees and their eligible family members are paid in part by Pennsylvania College of Technology out of its general assets and in part by employees’ pre or post-tax salary reductions. A schedule of required employee pre or post-tax contributions for coverage for the current Plan Year can be found in Attachment # 7.

The administrative service provider, not Pennsylvania College of Technology, is responsible for paying claims with respect to the self-funded programs. Pennsylvania College of Technology shares responsibility with the administrative services provider for administering these benefits.

**Discretion of the Plan Administrator**

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

Eligible Classifications

Eligibility for benefits includes coverage for Full-time Employees, Spouses, Domestic Partners, and eligible Dependents and Retirees and their Spouses (medical benefits (including prescription drugs) only).

<table>
<thead>
<tr>
<th>Component Benefit</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (including prescription drugs), College Health Services – Wellness Clinic, Health Reimbursement Arrangement, and Health Savings Account Program</td>
<td>Full-time employees regularly schedule to work 30 or more hours per week.</td>
</tr>
<tr>
<td>Dental and the Flexible Spending Account Plan (Dependent Care Spending Account)</td>
<td>Full-time employees regularly scheduled to work 37.5 or more hours per week</td>
</tr>
</tbody>
</table>

You are not eligible to participate if you are employed by the Employer on a part-time, per diem, or contingent basis; if you are providing services to the Employer pursuant to an agreement with a third party leasing organization; if you are an independent contractor who is not on an Employer payroll.

Dependent – Medical means any adult 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. The Pennsylvania College of Technology will provide benefits to eligible Dependents until the end of the month following the date the adult child reaches age 26.

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

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

Dependent – Dental means any individual who is a (a) an unmarried child of a Plan participant if the child is under age 19 and is primarily dependent on the participant for support; (b) an unmarried child of a Plan participant if the child is age 19 or over, by the end of the calendar year in which the dependent attains age 25 (limiting age) (verification of full-time status is required), (c) a full-time student in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, and primarily dependent on the participant for support; (d) any child of a Plan participant if the child is mentally or physically incapable of self-support and is dependent upon the participant for support, regardless of the child’s age, provided such mental or physical condition commenced prior to the attainment by the child of age 19, or by the end of the calendar year in which the dependent attains age 25 (limiting age) (verification of full-time status is required) if the child was age 19 or over and enrolled as a full-time student at the date of such commencement; (e) any child of a participant who does not qualify as a dependent under subsections (b), (c), or (d) above, solely because the child is not primarily dependent upon the participant for support so long as over half of the support of the child is received by the child from the participant pursuant to a multiple support agreement; (f) any other individual who is a dependent of the Plan participant described in Section 152(a) of the Internal Revenue Code and whose welfare is the legal responsibility of the Plan participant pursuant to legal guardianship, written divorce settlement, written separation agreement or a court order, including a Qualified Domestic Relations Order or National Medical Child Support Order.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter and maintains full-time student status the entire semester. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.
Your eligible Dependents can be enrolled in medical (including prescription drugs) or dental coverage under the Plan only if the Eligible Employee is enrolled.

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

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

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

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

**Spouse** means the Spouse of an Employee 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.

**Domestic Partner** – means same-sex or opposite sex Domestic Partners who are defined in the Affidavit of Domestic Partnership – Faculty and Staff Form (“Affidavit”). In order to receive benefits in the Plan, both the Employee and the Domestic Partner must complete and sign the Affidavit verifying eligibility along with the appropriate enrollment forms. The Employee and Domestic Partner are solely responsible for any tax and/or legal implications or consequences arising out of the application for or receipt of domestic partnership benefits.

**Retiree** means Employees who are eligible for and implement retirement consistent with the rules, regulations, provisions laws, as applicable to the retirement system (PSERS, SERS, TIAA/CREF) in which the Employee is enrolled. Please see the Plan Administrator or the Human Resources Office for more information regarding Retiree benefits and payment provisions.

**Medical Buyout Program**

The College has established a “medical buyout option” for those employees that may have duplicate medical coverage through a spouse or domestic partner working at the College, through a spouse or domestic partner working outside the College, or duplicate medical coverage from some other source outside the College.

This program allows employees with duplicate medical coverage to opt-out of the College’s medical insurance and receive an incentive for doing so. The following criteria drive the program:

- Provides an annual incentive to employees to opt-out of the College’s group medical insurance. This incentive is paid in equal installments through the biweekly pay process. Please see the Human Resources Department for the current amount of the annual incentive.
- Benefits begin on the first day of employment or July 1st if electing this option during Open Enrollment. May also be implemented within 30 days of a “life event”.
- The incentive amount received by the employee for waiving the health care coverage is considered taxable income and is treated accordingly.
- The incentive amount is not considered compensation for retirement purposes.
Employees choosing to opt-out are required to complete the “Waive of Group Medical Coverage” Form available in the Human Resources Department and return it to the Human Resources Department.

Once enrolled in the Medical Buyout Program, employees can renew coverage only during the Open Enrollment Period or within 30 days of a “life event”.

For more information regarding this program, please contact the Human Resources Department.

**Enrollment/Termination of Participants**

At the direction of the College, Highmark Blue Cross Blue Shield shall enroll as Participants hereunder those Eligible Persons who have been specified to Highmark Blue Cross Blue Shield by the College for enrollment. Coverage hereunder shall commence for individual Participants on the dates specified in writing or via other documented communication to Highmark Blue Cross Blue Shield by the College. The College shall promptly submit to Highmark Blue Cross Blue Shield enrollment data for individual Participants, and Highmark Blue Cross Blue Shield shall provide Identification Cards/Card Carriers for distribution to Participants. Identification Cards must be presented to Providers when services are requested.

Eligible full-time employees pay for a portion of the premiums for medical (including prescription drugs) and dental coverage. To find out your required premium contribution, please see Attachment # 7.

**Participation**

<table>
<thead>
<tr>
<th>Component Benefit</th>
<th>When Participation Begins</th>
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<tr>
<td>Medical (including prescription drugs), College Health Services – Wellness Clinic,</td>
<td>Date of Hire</td>
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<tr>
<td>Health Reimbursement Arrangement, Health Savings Account Program and the Flexible</td>
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<tr>
<td>Spending Account Plan (Dependent Care Spending Account)</td>
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<tr>
<td>Dental</td>
<td>1st day of the month following date of hire</td>
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The Patient Protection and Affordable Care Act (Health Care Reform) requires employers who sponsor group health plans (including prescription drugs) to determine the eligibility of what is called a Variable Hour and/or Seasonal Employee. Eligibility determinations are made on the basis of hours worked within a certain timeframe. See the Human Resources Department for additional information regarding eligibility in the medical (including prescription drug) benefits program. If it is determined you are eligible for benefits in the medical (including prescription drug) program you may enroll in the PPO Bronze Plan offered in the Plan.

Employees must be enrolled in benefits prior to enrolling their eligible family members. You may become a participant on your participation date, provided you properly submit an election form to the Human Resources Department prior to that date and during the period designated by the Human Resources Department as your initial “enrollment period” and provided Pennsylvania College of Technology determines you have the status of an active Employee of Pennsylvania College of Technology 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 Human Resources Department during an election period or for Special Enrollment Periods.

**Termination of Employment and Subsequent Rehire**

If you terminate your employment with Pennsylvania College of Technology and are subsequently rehired you will be eligible to participate in the Plan as stated above.
**Participant/Spouse Employment**

If both you and your Spouse are eligible employees of Pennsylvania College of Technology you may be covered under the Plan as an eligible employee or as a dependent of your Spouse.

**Leased or Temporary Employment**

Leased employees, persons classified by Pennsylvania College of Technology as temporary employees of Pennsylvania College of Technology (as determined by Pennsylvania College of Technology) are not eligible for benefits in the Plan. A person who is characterized by Pennsylvania College of Technology as a leased employee of Pennsylvania College of Technology, 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 Pennsylvania College of Technology.

**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 Pennsylvania College of Technology 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. Forms are available on Pennsylvania College of Technology’s Human Resources Office.

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

You must make an affirmative election each year in order to continue your participation in the Flexible Spending Account Plan (Dependent Care Spending Account) for the upcoming Plan Year.

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

You may waive your rights to coverage in the Health Reimbursement Arrangement at any time during the Plan Year.
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 and return, if coverage was revoked, 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 Pennsylvania College of Technology’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.

8. **Dependent Care.** You may make an election change to the contribution to your Dependent Care FSA that is due to a change in the provider of dependent care. You may also make an election change to the contribution to your Dependent Care FSA that is due to a change in cost of dependent care; so long as the provider of dependent care is not your relative.
If the employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year or coverage period (as determined by the Plan Sponsor), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

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

Additionally, the Administrator may modify your election(s) in the medical (including prescription drugs), dental, or flexible spending account (dependent care spending account) plan benefits of the Plan downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Internal Revenue Code), if necessary, to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Benefits for Adopted Children / Guardianship Agreements

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

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

Termination of Participation

| Medical (including prescription drugs), Health Reimbursement Arrangement, Health Savings Account Program¹, and Dental | Last day of the month in which termination occurred |
| College Health Services – Wellness Clinic, Flexible Spending Account Plan (dependent care spending account) | Last day of employment |

Coverage may also terminate if:

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

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

¹ Health Savings Accounts are portable. You may continue to contribute to your account after you are no longer employed but you must be enrolled in a high deductible health plan. If you are no longer enrolled in a high deductible health plan, you are no longer eligible to contribute to your account but may continue to spend down your account balance for qualified or non-qualified expenses.
Uniformed Services Employment and Re-employment Rights Act

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

You have the following rights under USERRA:

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

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

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

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

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

Termination of Participation in the Event of Long-Term Disability

For Employees who begin to receive Long-Term Disability benefits the College shall continue to pay the cost of the Employee’s group health insurance benefit and the Employee will continue to be responsible for their share of the premium during the first six (6) months of usage of the Long-Term Disability benefit or until the Employee terminates employment, whichever occurs first. Please see the Plan Administrator or the Human Resources Office for information regarding continuation of your benefits including payment procedures.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

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

When you enroll a family member in the Plan, you represent the following:
• The individual is eligible under the terms of the plan; and
• You will provide evidence of eligibility on request. Further, you The Plan is relying on your representation of eligibility in accepting the enrollment of your family members;
• Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
• Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual becomes ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan’s provisions on rescission of coverage.

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

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

**National Medical Child Support Orders**

With respect to benefits, Pennsylvania College of Technology 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 Human Resources Department 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:

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

The order must specify:

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

Upon receipt of a medical child support order, the Plan Administrator shall promptly notify the Employee and Alternate Payee. The Plan Administrator shall determine whether an order received meets the criteria and promptly notify the Employee 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 Pennsylvania College of Technology 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 Human Resources Office for questions regarding National Medical Support Orders.
5. COBRA RIGHTS

“Continuation Coverage” means you or 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). Pennsylvania College of Technology 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.

While Plan coverage can be added for Domestic Partners, as defined in the Definitions and Eligibility sections of this document, doing so does not grant them federal protections under COBRA rules. This applies since Domestic Partners are not recognized as Spouses under federal law. The Pennsylvania College of Technology does offer a “COBRA like” benefit under the same terms that apply to a married employee’s Spouse.

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 hand delivered or by first class mail. The General Notice will be considered “furnished” as of the mailing date.

Basic COBRA Continuation Coverage Rights

If Pennsylvania College of Technology 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 Pennsylvania College of Technology 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 Pennsylvania College of Technology 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 Pennsylvania College of Technology 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:

<table>
<thead>
<tr>
<th>Qualifying Event Resulting in a Loss of Coverage</th>
<th>Maximum Coverage Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s reduced work hours, except for a reduction in hours in connection with Family and Medical Leave</td>
<td>18 months</td>
</tr>
<tr>
<td>Employee’s termination (except for gross misconduct) or retirement</td>
<td>18 months</td>
</tr>
<tr>
<td>Employee’s death, divorce or legal separation of the employee and Spouse</td>
<td>36 months</td>
</tr>
<tr>
<td>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)</td>
<td>36 months</td>
</tr>
<tr>
<td>Dependent’s loss of coverage because employee enrolls in Medicare</td>
<td>36 months</td>
</tr>
</tbody>
</table>

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. Pennsylvania College of Technology 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 as 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 Pennsylvania College of Technology 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 Pennsylvania College of Technology within 60 days after the latest of:

1. The qualifying event date;
2. The qualified beneficiary’s loss of coverage date under the Plan due to the qualifying event; or
3. 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 Director of Compensation and Benefits, One College Avenue, Williamsport, PA 17701, unless you are notified by Pennsylvania College of Technology 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:

Director of Compensation and Benefits
One College Avenue, Williamsport, PA 17701 570-320-2400 ext. 7413

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 Plan Administrator at Pennsylvania College of Technology, Human Resources Office, One College Avenue, Williamsport, PA 17701.

**COBRA Notice Procedures**

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

Within 30 days of receiving the timely, written notice, Pennsylvania College of Technology 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:

Pennsylvania College of Technology
One College Avenue
Williamsport, PA 17701
570-320-2400 ext. 7413

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 Pennsylvania College of Technology, 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.

**Grace period for monthly payments**

Although monthly payments are due on the first day of each month of COBRA coverage, COBRA participants will be given a grace period of 30 days to make each monthly payment. COBRA coverage will be provided for each month as long as payment is made before the end of the grace period for that payment, but coverage is subject to being suspended as explained below.

If payment is made after the due date but before the end of the 30-day grace period for that month, health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim(s) submitted for reimbursement while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

**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 Pennsylvania College of Technology Employee Benefit Plan will continue your medical benefits, as required by law. This means the Pennsylvania College of Technology will continue your benefits on the same basis as if you were continuing your employment.

- Employees on unpaid leave are required to pay required premiums for medical (including prescription drugs), and flexible spending account (dependent care spending account) plan coverage during their leave. The method of payment will be chosen at the discretion of the Plan Administrator or the Human Resources Department.

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

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

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

- You can elect to increase your contributions for the remainder of the year following the leave so that your annual contribution to the flexible spending health care account will equal the annual contribution in effect prior to the leave.

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

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

- If you terminate your employment during your leave, the date of your qualifying event will be the day your employment ends with the Pennsylvania College of Technology.

Please contact the Human Resources Department 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

The College will pay the total cost of coverage for the following benefit(s):

- Health Reimbursement Arrangement (Employer Portion of Your Deductible)
- Health Savings Account Program (Employer Contributions)
- Dental

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

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

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

- Health Savings Account Program (pre-tax dollars) (Employee Contributions)
- Flexible Spending Account Plan (dependent care spending account) (pre-tax dollars)

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

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.

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 Pennsylvania College of Technology is the Plan Administrator for the medical (including prescription drugs) plan. The Associate Vice President for Human Resources has been designated to act as the Plan Administrator for all other benefits offered under the Plan.

**Discretion of the Plan Administrator**

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

**Duties of the Plan Administrator**

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 review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Plan Administrator determines shall be paid if the Plan Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Plan Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;
10) To appoint a Claims Supervisor to pay self-insured claims, or to appoint agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan; and
11) The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

**Plan Administrator Compensation**

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

**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.

Pennsylvania College of Technology has contracted with the following third party administrators to provide the following benefits:
<table>
<thead>
<tr>
<th>Company</th>
<th>Plan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highmark Blue Cross Blue Shield</td>
<td>Medical (including prescription drugs)</td>
</tr>
<tr>
<td>Delta Dental</td>
<td>Dental</td>
</tr>
<tr>
<td>Discovery Benefits</td>
<td>Flexible Spending Account Plan (dependent care spending account)</td>
</tr>
<tr>
<td>Discovery Benefits</td>
<td>Health Reimbursement Arrangement</td>
</tr>
<tr>
<td>Discovery Benefits</td>
<td>Health Savings Account Program</td>
</tr>
</tbody>
</table>

**Questions**

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

Pennsylvania College of Technology 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 Pennsylvania College of Technology or any of its delegates. Pennsylvania College of Technology 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 Associate Vice President for Human Resources signs administrative contracts for this Plan on behalf of Pennsylvania College of Technology, 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 Pennsylvania College of Technology to the effect that you will be employed for any specific period of time.
12. CLAIMS

CLAIMS EXPENSE AND OTHER CHARGES TO THE COLLEGE

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

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Timing for Claim Decision</th>
<th>Timing and Notification of Appeal Decision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicall Dental</strong></td>
<td>As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your claim by the Claims Administrator. Note that this notice may be given to you orally within the applicable time period, and a written or electronic notice will follow within three days of such oral notice.</td>
<td>As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review by the Claims Administrator.</td>
</tr>
<tr>
<td>Pre-Service Claims</td>
<td>Within a reasonable period of time appropriate to the medical circumstances but not later than 15 days after receipt of your claim by the Claims Administrator, unless an extension of up to an additional 15 days is necessary due to matters beyond the control of the Claims Administrator.</td>
<td>A reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review by the Claims Administrator.</td>
</tr>
<tr>
<td>Post-Service Claims</td>
<td>Within a reasonable period of time, but not later than 30 days after receipt of your claim by the Claims Administrator, unless an extension of up to an additional 15 days is necessary due to matters beyond the control of the Claims Administrator.</td>
<td>A reasonable period of time, but not later than 60 days after receipt of the request for review by the Claims Administrator.</td>
</tr>
<tr>
<td>Concurrent Care Claims</td>
<td>An extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above, but a claim for urgent care continuation submitted 24 hours before the end of the of the approved course of treatment must be processed within 24 hours instead of 72 hours.</td>
<td>An appeal for an extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above</td>
</tr>
<tr>
<td>All Eligibility Determinations and Other Benefits</td>
<td>Within a reasonable period of time, but not later than 90 days after receipt of your claim by the Claims Administrator.</td>
<td>A reasonable period of time, but not later than 60 days after receipt of the request for review by the Claims Administrator. May be extended for an additional 60 days.*</td>
</tr>
</tbody>
</table>

* Upon written notice explaining the special circumstances that create a need for an extension.
NOTICE OF DECISION OF A CLAIM

Claims under the Health Plan

If your claim for benefits under the Plan is denied, you will receive a written notice of the decision to deny the claim within 30 days after Highmark Blue Cross Blue Shield, Discovery Benefits, or Delta Dental (the designated claims processor) 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 Blue Cross Blue Shield as the Employer’s agent for purposes of subrogation only.

**B. Highmark Blue Cross Blue Shield’s Subrogation Duties**

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

In consideration for the advancement of benefits, Highmark Blue Cross Blue Shield is subrogated to all of the rights of the Participant against any party liable for the Participant's injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Participant under Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield may assert this right independently of the Participant. This right includes, but is not limited to, the Participant’s rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, or other insurance, as well as the Participant’s rights under Highmark Blue Cross Blue Shield to bring an action to clarify his or her rights under Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield shall be final and conclusive, unless overturned under a limited arbitrary and capricious standard of review.

**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 Blue Cross Blue Shield and/or under the law, set off from any future benefits otherwise payable under Highmark Blue Cross Blue Shield the value of benefits advanced under this section to the extent not recovered by Highmark Blue Cross Blue Shield.

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

E. Prohibited by Law

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

Claim Procedures for Self-Funded Flexible Spending Account Plan (Dependent Care Spending Account) and Health Reimbursement Arrangement

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

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

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

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim.
To receive any benefit under this Plan, a covered Employee, his or her covered Dependents, and any representative designated by the covered Employee or a covered Dependent must follow the Plan’s procedures for requesting benefits and filing claims. There are different types of claims. There are also different procedures that must be followed for each type of claim. Therefore, the covered Employee should read the procedures explained in this section of the document and ask questions about any procedures that he or she does not understand.

**Plan’s Failure to Follow Procedures**

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

**Insured Benefits and State Insurance Laws**

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

**Statute of Limitations for Plan Claims**

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 24 months for dental claims after the final review/appeal decision by the insurance company Claims Administrator has been rendered (or deemed rendered), one year from the actual date of service for medical (including prescription drug) benefits. Additionally, there is a four year time limit for any subsequent adjustments of claims from the original date of claim submission.
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 Pennsylvania College of Technology only upon receipt of a certification from Pennsylvania College of Technology 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 Pennsylvania College of Technology.
Pennsylvania College of Technology’s Obligations with Respect to PHI

With respect to PHI, Pennsylvania College of Technology agrees to certain conditions. Pennsylvania College of Technology 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 Pennsylvania College of Technology provides PHI received from the Plan agree to the same restrictions and conditions that apply to Pennsylvania College of Technology 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 Pennsylvania College of Technology 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
- Pennsylvania College of Technology 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 Pennsylvania College of Technology. 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 Pennsylvania College of Technology performs for the Plan. If the persons described herein or any other employees do not comply with the Summary Plan Description, Pennsylvania College of Technology shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. Pennsylvania College of Technology shall cooperate with the Plan to correct and mitigate any such noncompliance.

Privacy Official

The Privacy Official shall be responsible for compliance with Pennsylvania College of Technology 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.** Pennsylvania College of Technology 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 Pennsylvania College of Technology. Pennsylvania College of Technology 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 Pennsylvania College of Technology 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 Pennsylvania College of Technology, 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:

Pennsylvania College of Technology  
Privacy Officer – Associate Vice President for Human Resources

It has always been the goal of Pennsylvania College of Technology 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.

- You may obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator at the Human Resources Office. Pennsylvania College of Technology may make a reasonable charge for the copies. Copies may also be available on the College’s Intranet at myPCT Portal https://mypct.edu/departments/HumanResources/Benefits/default.aspx for those individuals who have Intranet access. Retired or COBRA participants can access the portal at the following address at myPCTPortal https://public.pct.edu/humanresources/retireehealthbenefits.htm.

- 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: __________________________________________
Pennsylvania College of Technology

Date: _________________________________________________________

Attest: _______________________________________________________
Before Tax Savings

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

Your actual tax savings will depend on how much you earn, your federal income rate, and how much you spend on before-tax benefits. Suppose that you earn $25,000 and are married; that your rate on your joint tax return is 28%; and that you decide to pay $1,000 for dependent care coverage. You would calculate your savings (based on 2016 federal income tax and Social Security tax rates) as follows:

\[
\text{Social Security tax rate} \times \text{Federal income tax rate} = \text{Total tax savings rate}
\]

\[
7.65\% + 28.00\% = 35.65\%
\]

\[
35.65\% \times $1,000 = $356.50 \text{ total savings.}
\]

If your compensation is greater than the Social Security taxable wage base in any year ($118,500 in 2016), you will have lower Social Security tax savings. This is because the old age portion of the Social Security tax (6.2% out of 7.65%) is not applied to compensation in excess of the taxable wage base for a year. The Medicare portion of Social Security tax (1.45% out of 7.65%) continues to apply to compensation in excess of the taxable wage base for the year. Therefore, your tax “savings” are reduced with respect to compensation in excess of the taxable wage base. However, you will still save federal income tax and possibly state and local income tax (see below). Most states do not impose an income tax on employee before-tax contributions to plans such as the Cafeteria Plan.

Please consult your tax advisor on whether these amounts are taxable by municipal taxing authorities.

Examples of Tax Advantages When Participating in the Plan

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

| 1. Gross Income | $50,000 | $50,000 |
| 2. Salary Reductions for Premiums | $2,400 (pretax) | $0 |
| 3. Adjusted Gross Income | $47,600 | $50,000 |
| 4. Standard Deduction | ($9,700) | ($9,700) |
| 5. Exemptions | ($9,300) | ($9,300) |
| 6. Taxable Income | $28,600 | $31,000 |
| 7. Federal Income Tax (Line 6 x applicable tax schedule) | ($3,590) | ($3,904) |
| 8. FICA Tax (7.65% x Line 3 Amount) | ($3,641) | ($3,825) |
| 9. After-tax Contributions | ($0) | ($2,400) |
| 10. Pay After Taxes and Contributions | $40,365 | $39,821 |
| 11. Take Home Pay Difference | $544 | |
Wages which are reported to the Social Security Administration (SSA) will not include your payroll reductions under the Section 125 Cafeteria Plan. Wages reported to the SSA are eventually used to determine the average compensation on which your Social Security benefit is based. Consequently, you may have a slightly reduced Social Security retirement or disability benefit. This will happen if your taxable wages after before-tax contributions are less than the Social Security taxable wage base ($118,500 indexed for 2016). However, the current tax advantages should more than offset any reduction in your Social Security benefit.

**Flexible Spending Accounts**

If you contribute to the Flexible Spending Account Plan (dependent care spending account) Discovery Benefits will establish an account in your name under the applicable plan(s). Your contributions for dependent care assistance will be allocated to your dependent care flexible spending account.

**Contributions**

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

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

**Special Rule for Dependent Care Spending Account Contributions**

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

**Eligible dependent care expenses that exceed my account balance**

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

**Balance at the end of the year**

You must use all of the money in your dependent care spending account for claims incurred during a Plan Year or the unused balance is forfeited. You may file claims incurred in the Plan Year within 90 days after the end of the Plan Year.

**Eligible expenses reimbursable from dependent care spending accounts**

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

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

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

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

If the care is provided by a facility that cares for more than six children, the facility must be licensed.
If the dependent is an adult or an older dependent child, the following rules also apply:

The dependent must be physically or mentally incapable of caring for him or herself;
He or she must either be your spouse or be dependent upon you for at least 50% of his financial support;
He or she must live with you for more than one-half of the calendar year;
He or she must not have gross income in excess of a specified amount; this does not apply to a spouse.
He or she must not be someone else’s “qualifying child” for federal income tax purposes;

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

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

**Dependent care provider in your home**

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

**Reimbursements under the dependent care account and taxation**

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

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

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

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

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual’s social security number. Your care provider should be made aware of this reporting
requirement.

Other income tax considerations affecting participation in the dependent care account

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

The Federal Dependent Care Tax Credit

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

Therefore, you must determine whether it is more advantageous for you not to establish a dependent care account in order to avail yourself of the federal tax credit. In making this determination, it is important to consider that the amount of compensation you elect to reduce under the Plan is not subject to federal income tax, but also is not subject to Social Security withholding tax (FICA) (7.65% up to $118,500 in 2015).

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

The Federal Earned Income Credit

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

Special rules for highly compensated and key employees

Under the Internal Revenue Code, certain employees are considered “highly compensated employees” and “key employees”. To prevent discrimination in favor of these employees, the Plan Administrator may limit or reduce their contributions in a uniform and nondiscriminatory manner. If you are a highly compensated and/or a key employee, the Plan Administrator will notify you if it becomes necessary to modify the amount of your contributions.

Incorrect amounts in connection with the Plan

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

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

You can submit a claim for an eligible medical expense at any time during the Plan Year. Claims for expenses should be submitted to:

**Discovery Benefits, Inc.**  
P.O. Box 2926  
Fargo, ND 58108-2926

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

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

The money deposited in your account for the Plan Year will be used to reimburse you for eligible expenses incurred during that year only. An expense is incurred when the care is provided, and not when the bill is sent or payment is made. There is no extension of the claims incurrence period for the Dependent Care Spending Account.

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

**Change in Employment Status or Death of a Participant**

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

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

**Denial of benefit in the Flexible Spending Account Plan Dependent Care Spending Account**

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

The written notice of denial will include the following information:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect his or her claim and an explanation as to why such information is necessary;
- in the case of a medical account claim, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at the claimant’s request; and
- a description of the Plan’s appeals procedures and the time limits applicable for such procedures (such description will include a statement that the claimant is eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal).
If an initial claim for benefits is denied by the Plan Administrator or Third Party Administrator, you or your duly authorized representative may appeal the denial by filing a written request with the Plan Administrator or Third Party Administrator within sixty (60) days (in the case of a dependent care account claim) or one hundred eighty (180) days (in the case of a medical account claim) after receipt of the notice denying the initial claim for benefits. Upon your decision to appeal a denied claim for benefits, you or your duly authorized representative will be able to submit written comments, documents, records, and other information relating to his or her claim for benefits (regardless of whether such information was considered in the initial claim for benefits) to the Plan Administrator or Third Party Administrator for review and consideration. You or your duly authorized representative will be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the appeal.

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

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

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the claim and/or appeal for benefits;
- in the case of a medical account claim, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you or your duly authorized representative free of charge at his or her request; and
- a statement that the claimant is entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue his or her claim for benefits.

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

Pennsylvania College of Technology
Health Reimbursement Arrangement (HRA)

Purpose of the Plan

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

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

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

Plan Year

A twelve month period beginning July 1st each year and ending on June 30th.

Participation

An individual is eligible to participate in the program if the individual is an Employee; regularly works 30 or more hours per week; and is eligible to participate in and is enrolled in the Pennsylvania College of Technology’s group health insurance program.

Cessation of Participation

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

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

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

Provision of Benefits

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

Employee Contributions

There are no employee contributions for benefits under the program.
Employer Contributions

The Employer funds claims for each Participant as they occur. The Participant is required to complete a HRA Reimbursement Form for Pennsylvania College of Technology in order to receive benefits in the program.

Nondiscrimination

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

Benefits

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

Eligible Medical Care Expenses

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

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

Maximum Benefits

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

Substantiation of Expenses

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

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

Carryover of Accounts

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

Ineligible Expenses

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

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

Balances at the End of the Plan Year

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

Health Savings Account Program

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

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

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

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

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

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

- 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

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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3 This list is not all inclusive of non-qualified medical expenses. See Publications 502 and 969 for a comprehensive listing of non-qualified medical expenses.
Exhibit D

Outline of Coverage

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

Outline of Coverage:

PPO Blue Plan C
Classic Blue
PPO Blue Bronze (Available to: Variable Hour Employees Only)
PPO Blue Qualified High Deductible Plan (“QHDHP”)
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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Provisions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benefit Period</strong></td>
<td>Calendar Year</td>
<td></td>
</tr>
<tr>
<td><strong>Deductible (per benefit period)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>$200</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$600</td>
</tr>
<tr>
<td><strong>Plan Pays – payment based on the plan allowance</strong></td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only)</strong></td>
<td>$6,850</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Individual</td>
<td>$13,700</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Office/Clinic/Urgent Care Visits**         |         |                |
| 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      |

| **Preventive Care**                          |         |                |
| 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% after deductible |
| Diagnostic services and procedures           | 100%    | 80% after deductible |

| **Emergency Services**                       |         |                |
| Emergency Room Services                      | 100% after $50 copay (waived if admitted) |                |
| Ambulance – Emergency                        | 100%    | 80% after deductible |
| Ambulance – Non-Emergency                    | 100%    | 80% after deductible |

| **Hospital and Medical/Surgical Expenses (including maternity)** |         |                |
| Hospital Inpatient                            | 100%    | 80% after deductible |
| Hospital Outpatient                           | 100%    | 80% after deductible |
| Maternity (non-preventive facility & professional services) including dependent daughter | 100%    | 80% after deductible |
| Medical Care (including inpatient visits and consultations)/Surgical Expenses | 100%    | 80% after deductible |

<p>| <strong>Therapy and Rehabilitation Services</strong>      |         |                |
| Physical Medicine                            | 100% after $20 copay | 80% after deductible |
| Limit: 20 visits/benefit period              |         |                |
| Respiratory Therapy                          | 100%    | 80% after deductible |
| Speech &amp; Occupational Therapy                | 100% after $20 copay | 80% after deductible |
| Limit: 12 visits per therapy/benefit period  |         |                |</p>
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapy and Rehabilitation Services (cont.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>100% after $20 copay</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Inpatient Detoxification/Rehabilitation</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient (includes virtual behavioral health visits)</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Extracts and Injections</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Autism Spectrum Disorder including Applied Behavior Analysis(5)</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Assisted Fertilization Procedures</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dental Services Related to Accidental Injury</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Imaging (MRI, CAT, PET scan, etc.)</td>
<td>100% after $75 copay</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment, Orthotics and Prosthetics</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Infertility Counseling, Testing and Treatment(6)</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Pre-certification Requirements(7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Program(8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft Mandatory Generic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(31/60/90-day Supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3 low cost generic copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10 standard generic copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20 formulary brand copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$35 non-formulary brand copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maintenance Drugs through Mail Order</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(90-day Supply)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$6 low cost generic copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20 standard generic copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$40 formulary brand copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$70 non-formulary brand copay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/plan documents, as limitations and exclusions apply. The policy/plan documents control in the event of a conflict with this benefits summary.

1. Your group's benefit period is based on a Calendar Year. The Calendar Year is a consecutive 12-month period beginning on your employer's effective date.
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.
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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Hospital</th>
<th>Medical/Surgical</th>
<th>Major Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Provisions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benefit Period (1)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible (per benefit period)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Plan Pays – payment based on the plan allowance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,600 Medical; $250 Rx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$12,950 Medical; $750 Rx</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Office/Clinic/Urgent Care Visits**

- Retail Clinic Visits & Virtual Visits: Not Covered, Not Covered, 80% after deductible
- Primary Care Provider Office Visits & Virtual Visits: Not Covered, Not Covered, 80% after deductible
- Specialist Office & Virtual Visits: Not Covered, Not Covered, 80% after deductible
- Virtual Visit Originating Site Fee: Not Covered, Not Covered, 80% after deductible
- Urgent Care Center Visits: Not Covered, Not Covered, 80% after deductible
- Telemedicine Services (3): Not Covered, Not Covered, 80% after deductible

**Preventive Care (4)**

- Routine Adult Physical exams: 100%, 100%, 100% (deductible does not apply)
- Adult immunizations: 100%, 100%, 100% (deductible does not apply)
- Colorectal cancer screening: 100%, 100%, 100% (deductible does not apply)
- Routine gynecological exams, including a Pap test: 100%, 100%, 100% (deductible does not apply)
- Mammograms, annual routine: 100%, 100%, 100% (deductible does not apply)
- Mammograms, medically necessary: 100%, 100%, 100% (deductible does not apply)
- Diagnostic services and procedures: 100%, 100%, 100% (deductible does not apply)
- Routine Pediatric Physical exams: 100%, 100%, 100% (deductible does not apply)
- Pediatric immunizations: 100%, 100%, 100% (deductible does not apply)
- Diagnostic services and procedures: 100%, 100%, 100% (deductible does not apply)

**Hospital and Medical/Surgical Expenses (including Maternity)**

- Hospital Inpatient: 100%, 100%, 80% after deductible
- Hospital Outpatient: 100%, Not Covered, 80% after deductible
- Maternity (non-preventive facility & professional services) including dependent daughter: 100%, 100%, 80% after deductible
- Medical Care (including inpatient visits and consultations)/Surgical Expenses: Not Applicable, 100%, 80% after deductible

**Emergency Room Services**

- Emergency Room Services: 100%, 100%, 80% after deductible
- Ambulance: 100%, Not Covered, Not Covered

**Therapy and Rehabilitation Services**

- Physical Medicine: 100%, Limit: 20 visits/benefit period, Not Covered, 80% after deductible
- Respiratory Therapy: 100%, Not Covered, Not Covered, 80% after deductible
- Spinal Manipulations: Not Covered, Not Covered, 80% after deductible
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Hospital</th>
<th>Medical/Surgical</th>
<th>Major Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech &amp; Occupational Therapy</td>
<td>100%</td>
<td>Not Covered</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Therapy and Rehabilitation Services (Cont.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</td>
<td>100% (Cardiac Rehab: Not Covered)</td>
<td>100% (Cardiac Rehab &amp; Infusion Therapy: Not Covered)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Inpatient Mental Health</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Inpatient Detoxification/Rehabilitation</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient Mental Health (includes virtual behavioral health visits)</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>100% (deductible does not apply)</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>100%</td>
<td>Not Covered</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Allergy Extracts and Injections</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Autism Spectrum Disorder including Applied Behavior Analysis(5)</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Assisted Fertilization Procedures – limited to artificial insemination – 3 attempts/lifetime</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Dental Services Related to Accidental Injury</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Imaging (MRI, CAT, PET scan, etc.)</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>All Other Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment, Orthotics and Prosthetics</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
<td>Not Covered</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>100%</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infertility Counseling, Testing and Treatment(6)</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>(Treatment includes coverage for the correction of a physical or medical problem associated with infertility.).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>100%</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Precertification Requirements(7)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Prescription Drugs**

<table>
<thead>
<tr>
<th>Prescription Drug Deductible</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50</td>
<td>$150</td>
<td></td>
</tr>
</tbody>
</table>

**Retail Drugs (31/60/90-day Supply)**

- 80% after deductible

**Maintenance Drugs through Mail Order (90-day Supply)**

- 80% after deductible

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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.

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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.
Penn College of Technology  PPO Blue Bronze
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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>General Provisions</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period(1)</td>
<td>Calendar Year</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Deductible (per benefit period)</td>
<td></td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Pays – payment based on the plan allowance</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)</td>
<td></td>
<td>None</td>
<td>$5,000</td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td>$10,000</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td>$6,850</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td>$13,700</td>
</tr>
<tr>
<td>Office/Clinic/Urgent Care Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Clinic Visits &amp; Virtual Visits</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider Office Visits &amp; Virtual Visits</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Specialist Office &amp; Virtual Visits</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Virtual Visit Originating Site Fee</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center Visits</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Telemedicine Services (3)</td>
<td>50% after deductible</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Preventive Care(4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Adult Physical exams</td>
<td>100% (deductible does not apply)</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Adult immunizations</td>
<td>100% (deductible does not apply)</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>100% (deductible does not apply)</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Routine gynecological exams, including a Pap Test</td>
<td>100% (deductible does not apply)</td>
<td>50% (deductible does not apply)</td>
<td></td>
</tr>
<tr>
<td>Mammograms, annual routine</td>
<td>100% (deductible does not apply)</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Mammograms, medically necessary</td>
<td>100% (deductible does not apply)</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Diagnostic services and procedures</td>
<td>100% (deductible does not apply)</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Routine Pediatric Physical exams</td>
<td>100% (deductible does not apply)</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Pediatric immunizations</td>
<td>100% (deductible does not apply)</td>
<td>50% (deductible does not apply)</td>
<td></td>
</tr>
<tr>
<td>Diagnostic services and procedures</td>
<td>100% (deductible does not apply)</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Emergency Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>50% after deductible (waived if admitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance - Emergency</td>
<td>50% (deductible does not apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance – Non-Emergency</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Hospital and Medical/Surgical Expenses (including maternity)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Maternity (non-preventive facility &amp; professional services) including dependent daughter</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Medical Care (including inpatient visits and consultations)/Surgical Expenses</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Therapy and Rehabilitation Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Speech &amp; Occupational Therapy</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Limit: 20 visits/benefit period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limit: 12 visits per therapy/benefit period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Network</td>
<td>Out-of-Network</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Therapy and Rehabilitation Services (cont.)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Inpatient Detoxification/Rehabilitation</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient (includes virtual behavioral health visits)</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Extracts and Injections</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Autism Spectrum Disorder including Applied Behavior Analysis(5)</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Assisted Fertilization Procedures Limited to Artificial Insemination - 3 attempts per lifetime</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Dental Services Related to Accidental Injury</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Imaging (MRI, CAT, PET scan, etc.)</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment, Orthotics and Prosthetics</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Infertility Counseling, Testing and Treatment(6)</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Transplant Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precertification Requirements(7)</td>
<td>50% after deductible</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Program(8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft Mandatory Generic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defined by the National Pharmacy Network - Not Physician Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriptions filled at a non-network pharmacy are not covered.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail Drugs (31/60/90-day Supply)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3/$6/$9 cost generic copayment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$30/$60/$90 standard generic copayment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$90/$180/$270 formulary brand copayment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$150/$300/$450 non-formulary brand copayment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maintenance Drugs through Mail Order (90-day Supply)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$6 low cost generic copayment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$60 standard generic copayment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$180 formulary brand copayment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$300 non-formulary brand copayment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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.
PPO Blue QHDHP $1,300 90/70 Rx Benefit Summary
PPO Blue 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.

<table>
<thead>
<tr>
<th>Benefit Period(1)</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (per benefit period)</td>
<td>$1,300</td>
<td>$2,500</td>
</tr>
<tr>
<td>Employee Only Plan</td>
<td>$2,600</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Pays – payment based on the plan allowance</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period)</td>
<td>$700</td>
<td>$4,000</td>
</tr>
<tr>
<td>Employee Only Plan</td>
<td>$1,400</td>
<td></td>
</tr>
<tr>
<td>Family Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>$2,000</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Employee Only Plan</td>
<td>$4,000</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Office/Clinic/Urgent Care Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Clinic Visits &amp; Virtual Visits</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Primary Care Provider Office Visits &amp; Virtual Visits</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Specialist Office &amp; Virtual Visits</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Virtual Visit Originating Site Fee</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Urgent Care Center Visits</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Telemedicine Services(3)</td>
<td>90% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preventive Care(4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Adult Physical exams</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Adult immunizations</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Routine gynecological exams, including a Pap Test</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
</tr>
<tr>
<td>Mammograms, annual routine</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Mammograms, medically necessary</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Diagnostic services and procedures</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Routine Pediatric Physical exams</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Pediatric immunizations</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
</tr>
<tr>
<td>Diagnostic services and procedures</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Hospital and Medical/Surgical Expenses (Including maternity)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Maternity (non-preventive facility &amp; professional services) including dependent daughter</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Medical Care (including inpatient visits and consultations)/Surgical Expenses</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Emergency Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>90% after network deductible</td>
<td></td>
</tr>
<tr>
<td>Ambulance - Emergency</td>
<td>90% after network deductible</td>
<td></td>
</tr>
<tr>
<td>Ambulance – Non-Emergency</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Therapy and Rehabilitation Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Speech &amp; Occupational Therapy</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

Limit: 20 visits/benefit period

Limit: 12 visits per therapy/benefit period
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy and Rehabilitation Services (cont.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Inpatient Detoxification/Rehabilitation</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Outpatient (includes virtual behavioral health visits)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Extracts and Injections</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Autism Spectrum Disorder including Applied Behavior Analysis(5)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Assisted Fertilization Procedures</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dental Services Related to Accidental Injury</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Advanced Imaging (MRI, CAT, PET scan, etc.)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment, Orthotics and Prosthetics</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Infertility Treatment (coverage will be provided for correction of a medical problem associated with Infertility.)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>90% after deductible, limit: 60 days/benefit period</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Precertification Requirements(7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Deductible</td>
<td>Integrated with medical deductible</td>
<td>Integrated with medical deductible</td>
</tr>
<tr>
<td>Individual Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Program(8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defined by the National Pharmacy Network - Not Physician Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriptions filled at a non-network pharmacy are not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your plan uses the Comprehensive Formulary with an Open Benefit Design.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Drugs (31/60/90-day Supply)</td>
<td>$3 low cost generic copay after deductible</td>
<td></td>
</tr>
<tr>
<td>Maintenance Drugs through Mail Order (90-day Supply)</td>
<td>$6 low cost generic copay after deductible</td>
<td></td>
</tr>
<tr>
<td>$10 standard generic copay after deductible</td>
<td>$20 standard generic copay after deductible</td>
<td></td>
</tr>
<tr>
<td>$25 formulary brand copay after deductible</td>
<td>$50 formulary brand copay after deductible</td>
<td></td>
</tr>
<tr>
<td>$50 non-formulary brand copay after deductible</td>
<td>$100 non-formulary brand copay after deductible</td>
<td></td>
</tr>
</tbody>
</table>

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 $6,850 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 enrolling 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.