Employee Benefit Plan

and

SUMMARY PLAN DESCRIPTION

Amended and Restated

Effective

October 1, 2017

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 Clearfield Area School District Employee Benefit Plan.

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1. INTRODUCTION

The Clearfield Area School District ("District") values their employees and their families and we are pleased to provide you with a comprehensive and cost effective benefit package.

The Plan provides benefits to Eligible Employees, Spouses, and Dependents. Domestic Partners, same or opposite sex are not eligible to participate in benefit programs offered in the Plan.

Grandfathered Status under Health Care Reform Law
Clearfield Area School District believes that the medical benefit option under the plan is considered a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. However, your health plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and dependent coverage to age 26, and no cost-sharing on preventive care services. Questions regarding which protections apply to a non-grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, US Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. **Note**: Health Care Reform applies only to the medical and prescription drug benefits that are being offered under the Plan.

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

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

Attachment # 1	**Highmark Blue Cross Blue Shield – PPO Blue Medical Plan (including prescription drugs)** Group Number: 84043
Attachment # 2	**Highmark Blue Cross Blue Shield – High Deductible Health Plan (HDHP) with Health Savings Accounts**[1] Group Number: 84043
Attachment # 3	**United Concordia Company, Inc. – Dental Plan** Group Number: 130
Attachment # 4	**National Vision Administrators ("NVA") – Vision Plan** Group Number: 51792
Attachment # 5	**Sun Life Financial – Life & AD&D Insurance** Group Number: 16555
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Attachment # 7	**Colonial Life Insurance Company – Supplemental / Optional Life Insurance**
Attachment # 8	**Flexible Spending Account Program** (including Medical and Dependent Care Spending Accounts)[2] Self-Insured with Administrative Services Provided by Security Benefit Life Insurance Company
Attachment # 9	**Health Savings Account Program** Self-Insured with Administrative Service Provided by Acclaris, Inc.
Attachment # 10	**Premium Share / Cost of Benefits** – Collective Bargaining Agreements / Open Enrollment Materials / New Hire Packets

[1] You must be enrolled in a High Deductible Health Plan (HDHP) to be eligible to open a Health Savings Account. You are not permitted to participate in the Flexible Spending Account Program if you have a Health Savings Account.
[2] The Flexible Spending Account Program is available only to employees enrolled in the Highmark Blue Cross Blue Shield PPO Blue Medical Plan.

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.

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

Collective Bargaining Units: Clearfield Education Association; Clearfield Area Custodial, Maintenance, Cleaning and Food Service Technicians Education Support Professionals; and Clearfield Education Support Professionals Association.

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

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

The purpose of the Plan is to provide Employees with the opportunity to choose among those benefits available to them under the Plan. All Full-Time Eligible Employees contribute towards medical (including prescription drugs) and the cost of family vision benefits with pre-tax salary reductions. Part-Time Employees are eligible to participate in the medical (including prescription drugs), dental, vision, and supplemental / optional life insurance benefits. Part-Time Employees who elect to participate in any benefit program available to them in the plan are required to pay the full premium cost of participation with pre or post tax dollars. Full or Part-Time Employees who participate in the Supplemental / Optional Life Insurance Program pay the full cost of premiums with post-tax payroll deductions.

A schedule of employee premium contribution requirements for coverage can be found in your collective bargaining agreement or Attachment # 10. Please see the Plan Administrator for more information regarding the cost and availability of coverage.

The Plan is intended to qualify as a "cafeteria plan" under Internal Revenue Code Section 125, and regulations issued shall be interpreted to accomplish that objective.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another governing document prepared by the Insurance Company. A copy of each booklet, summary or other governing document is addressed in this document as Attachments # 1 to # 9 noted above. Copies of all documents for the Plan are on file at the Clearfield Area School District Business Office and are available to you with your written request.

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

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 Clearfield Area School District which sponsors the Plan.

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

Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator, the Plan Sponsor, and the Insurance Company with his or her current address. If required by the Insurance Company, each employee who is a Participant shall be responsible for providing the Insurance Company with the address of a covered spouse and each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The

Insurance Company, the Plan Administrator, and the Plan Sponsor shall have no obligation or duty to locate a Participant.

Section 125 / Cafeteria Plan Benefits

Before Tax Savings

When you elect to make contributions to the Medical or Vision Plans 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 25%; and that you decide to pay $1,000 for dependent care coverage. You would calculate your savings (based on 2017 federal income tax and Social Security tax rates) as follows:

7.65% (Social Security tax rate) + 25% (Federal income tax rate) = 32.65%
32.65% x $1,000 = $326.50 total savings

If your compensation is greater than the Social Security taxable wage base in any year ($127,200 indexed for 2017), 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.

Example of Tax Advantages When Participating in the Plan

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 major medical insurance plan). You earn $50,000 and your Spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan		If you do not participate in the Cafeteria Plan
1. Gross Income	$50,000		$50,000
2. Salary Reductions for Premiums	$2,400 (pretax)		$0
3. Adjusted Gross Income	$47,600		$50,000
4. Standard Deduction	($9,700)		($9,700)
5. Exemptions	($9,300)		($9,300)
6. Taxable Income	$28,600		$31,000
7. Federal Income Tax (Line 6 x applicable tax schedule)	($3,590)		($3,904)
8. FICA Tax (7.65% x Line 3 Amount)	($3,641)		($3,825)
9. After-tax Contributions	($0)		($2,400)
10. Pay After Taxes and Contributions	$40,365		$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 ($127,200 indexed for 2017). However, the current tax advantages should more than offset any reduction in your Social Security benefit.

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.

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. Clearfield Area School District cannot overrule this determination.

AD & D means accidental death and dismemberment insurance.

Benefit Period –

Coverage	Plan/Policy Year
Medical (including prescription drugs) – Highmark Blue Cross Blue Shield	7/1 through 6/30
Dental – United Concordia Company, Inc.	7/1 through 6/30
Vision – National Vision Administrators	7/1 through 6/30
Life & AD&D – Sun Life Assurance Company	7/1 through 6/30
Supplemental / Optional Life Insurance – Colonial Life Insurance Company	7/1 through 6/30
Long Term Disability – Sun Life Assurance Company	7/1 through 6/30

Coinsurance – A specific percentage amount of the allowable charge set forth in the Outline of Coverage, for which the Participant is responsible after the deduction of a Deductible or Copayment, if applicable.

Copayment – The amount, if any, a Participant must pay directly to Providers in connection with covered services set forth in the Agreement and in the Outline of Coverage.

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

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

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

Dependent – Medical Benefits means any child (including adopted child(ren) or child(ren) under court-appointed guardianship) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. Coverage in the Plan will terminate at the end of the month in which the dependent reaches their 26th birthday.

Dependent – Dental and Vision Benefits means any individual who is:

(a) the Spouse of the Plan participant;

(b) an unmarried child of a Plan participant if the child is under age 19 and is primarily dependent on the participant for support;

(c) an unmarried child of a Plan participant if the child is age 19 or over, by the end of the month in which the dependent attains age 25 (limiting age) for dental coverage, 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 (verification of full-time status is required), 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) for dental coverage if the child was age 19 or over and enrolled as a full-time student at the date of such commencement (verification of full-time status is required);

(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.

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.

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 Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

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.

District means Clearfield Area School District.

Eligible Employee means any full-time or part-time individual employed by the Employer or Affiliated Employer as a common law employee. An individual shall be considered to be employed by the Employer or Affiliated Employer as a common-law employee only if the Employer or Affiliated Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer or Affiliated Employer, and such individual is determined by the Employer or Affiliated Employer to be a common-law employee for purposes of the Employer's or Affiliated Employer's payroll records. It is expressly provided that any individual who is treated as an independent contractor, seasonal, or temporary 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 Medical Expense for Flexible Spending Account Plan Benefits means any expense incurred by a Participant or any of his/her Dependents qualifies as an expense incurred by the Participants or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125(ii) is excluded from gross income of the Participant under Code Section 105(b)(iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, or from any other source.

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

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

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

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

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

Health Savings Account ("HSA") means a tax-advantaged account created for individuals who are covered under a high-deductible health plan ("HDHP") to save for medical expenses the HDHP does not cover. Contributions are made into the account by the individual or the individual's Employer and are limited to a maximum amount each year as defined by the Internal Revenue Code. Contributions are invested over time and can be used to pay for qualified medical expenses.

Highly Compensated Individual means an individual defined under Code § 105(h), 125(e) or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

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

Illness means a bodily disorder, disease, physical sickness or mental disorder, Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Insurance Program means the insured welfare benefit plan sponsored by the Employer providing benefits.

Key Employee means an individual who is a "key employee" as defined in Code § 125(b)(2), as amended.

Medical Flexible Spending Account means a type of self-insured ERISA welfare benefit plan that reimburses eligible medical expenses that are not reimbursed through other sources. Section 125 Cafeteria Plans are authorized by Section 125 of the Internal Revenue Code and allows payments for certain benefits on a pre-tax basis.

Medically Necessary or Medical Necessity means services or supplies rendered by a provider that the medical insurance program determines are:

a. Appropriate for the symptoms and diagnosis or treatment of the Participant's condition, illness, disease or injury;
b. Provided for the diagnosis, or the direct care and treatment of the Participant's condition, illness, disease or injury;
c. In accordance with current standards of medical practice;
d. Not primarily for the convenience of the Participant, or the Participant's Provider; and
e. The most appropriate source or level of service that can safely be provided to the Participant. When applied to hospitalization, this further means that the Participant requires acute care as an inpatient due to the nature of the services rendered or the Participant's condition, and the Participant cannot receive safe or adequate care as an Outpatient.

Medicare means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

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

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

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

Plan means Clearfield Area School District Employee Benefit Plan, which is a benefits plan for Eligible Employees of Clearfield Area School District and is described in this document.

Plan Administrator means the individual named in the General Information about the Plan Section of this document.

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.

Policy means any insurance policy and any other group insurance contract maintained by Clearfield Area School District for the benefit of Employees.

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 or dental 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, dental, vision, or flexible spending account plan components. In the case of a Qualifying Event, Qualified Beneficiary means an individual who on the day before the Qualifying Event is an individual covered by the Plan.

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

Retiree means a former Employee of the Employer who is eligible for continuation of medical, dental, and vision benefits under the provisions of Act 110/43 provided by the Pennsylvania State Legislature. Retirees are eligible for benefits until they reach the age of 65 and eligible for Medicare.

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

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

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

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: Clearfield Area School District

Plan Name: Clearfield Area School District Employee Benefit Plan

Employer Address: 2831 Washington Avenue Clearfield, PA 16830

Employer's Telephone Number: (814) 765-5511

Plan/Policy Years:

Coverage	Plan/Policy Year
Medical (including prescription drugs) – Highmark Blue Cross Blue Shield	7/1 through 6/30
Dental – United Concordia Company, Inc.	7/1 through 6/30
Vision – National Vision Administrators	7/1 through 6/30
Life & AD&D – Sun Life Financial	7/1 through 6/30
Supplemental / Optional Life Insurance – Colonial Life Insurance Company	7/1 through 6/30
Long Term Disability – Sun Life Financial	7/1 through 6/30

Employer's Federal Tax Identification Number: 25-6003772

Plan Sponsor: Board of School Directors of the Clearfield Area School District

Plan Administrator/Named Fiduciary: Employee Payroll and Benefits Specialist Clearfield Area School District

Agent for Service of Legal Process: Business Administrator Clearfield Area School District

Funding Medium and Type of Plan Administration:

The following benefits under the Plan are fully insured through insurance contracts:

Dental Insurance:	United Concordia Company, Inc.
Vision Insurance:	National Vision Administrators (NVA)
Group Term Life Insurance and AD&D:	Sun Life Financial
Supplemental / Voluntary Life Insurance:	Colonial Life Insurance Company
Long Term Disability Insurance:	Sun Life Financial

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

The following benefits under the Plan are self-funded and paid with Eligible Employee contributions to their flexible spending accounts or health savings accounts through pre-tax salary reductions deposited into the general assets of the District. Premiums paid in part by Eligible Employees for medical (including prescription drugs) and the cost of family vision benefits through pre-tax salary reduction and the District from the District's general assets.

Medical Insurance (including prescription drugs):	Highmark Blue Cross Blue Shield
Flexible Spending Account Program (including medical and dependent care spending accounts:	Security Benefit Life Insurance Company
Health Savings Account Program (HSA)	Acclaris, Inc.

A schedule of required employee pre-tax contributions can be found in your collective bargaining agreement and/or Attachment # 10.

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

4. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

Eligibility for benefits includes coverage for Eligible Full Time Employees working 30 or more hours per week, Retirees continuing medical (including prescription drugs), dental and vision benefits only, Spouses and/or dependents. Eligible Part Time Employees may enroll in benefit programs offered in the Plan and are required to pay the full premium cost of participation.

Component Benefit	When Participation Begins
Medical (including prescription drugs), Health Savings Account Program, Dental, Vision, Life, AD&D, Supplemental/Voluntary Life and AD&D, Long Term Disability, and Flexible Spending Account Program (including medical and dependent care spending accounts)	If your date of hire is between the 1st and the 15th of the month, benefits will begin on the 1st of the month. If your date of hire is on the 16th of the month or after, benefits will begin the 1st of the month following your date of hire.

The Patient Protection and Affordable Care Act (Health Care Reform) requires employers who sponsor group health plans (including prescription drugs) to determine the eligibility of what is called a Variable Hour and/or Seasonal Employee. Eligibility determinations are made on the basis of hours worked within a 12-month timeframe. See Exhibit A in this Summary Plan Description for additional information regarding eligibility in the medical (including prescription drug) benefits program.

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

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

Employee Waiver of Right to Coverage

Eligible Employees who wish to waive their rights to coverage in the medical (including prescription drugs) benefit may be entitled to an opt-out award. See the Plan Administration for more information regarding waiver of coverage in the Plan.

Leased or Temporary Employment

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

Special Enrollment Periods

Special Enrollment Rights - 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 Clearfield Area School District Employee Benefits Plan medical plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within 30 days after the applicable event. Furthermore, whether you are participating or not, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and newly-acquired Dependent, provided that you request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

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

Change in Election Events

If a Change in Election Event (including a Change in Status) occurs, you must inform the Business Office and complete a new election form within 30 days of the occurrence. Your election will be effective as of the first of the month after the election form is completed and received by the Business Office. Special enrollments in the event of birth, adoption, or placement for adoption will be effective back to the date of the birth, adoption, or placement for adoption, as long as timely notice is given to the Plan. Forms are available in the Business Office.

Generally, you cannot change your election to participate in the medical (including prescription drugs) and the vision 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 Employer. Of course, you can change your elections for benefits and salary reductions during the annual open enrollment period for medical (including prescription drugs) and vision benefits but that will apply only for the upcoming Plan Year.

You must make an annual election to continue participation in the Flexible Spending Account Program (including medical and dependent care spending accounts).

You may make changes to your election in the Health Savings Account Program monthly.

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

1. **FMLA Leave.** You may change an election under the Plan upon commencement of or return from FMLA leave.
2. **Change in Status.** If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:
   - A change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). *"Spouse"* means the person who is legally married to you and is treated as a Spouse under the Internal Revenue Code *(Code)*;
   - A change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). *"Dependent"* means your tax dependent under the Code;
   - Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility including (this Plan or other employee benefit plan of you, your Spouse, or your Dependents). Such events include any of the following changes in employment status, termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave absence, a change in work site, switching from salaried to hourly paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of Employment; or any other similar change which makes the individual become (or cease to be) eligible for benefit;
   - An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a benefit (such as attaining a specified age, student status, or similar circumstance); and
   - A change in your, your Spouse's or your Dependent's place of residence.
3. **Change in Status-Other Requirements.** If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status listed above. 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 eligibility for coverage. 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 or dental insurance), 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 or dental 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 coverage. The 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 change 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 to obtain cost information for the District's Plan.

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

5. **Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage under the Health Insurance Plan. Similarly, if you, or 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.

A change must be "on account of and correspond with" a Change in Status Event. To meet this requirement, the change that you wish to make must be on account of and correspond with a Change in Status Event that affects eligibility for coverage under the Plan. This rule is satisfied as to the Dependent Care Spending Account in the Flexible Spending Account Plan if the Change in Status Event affects expenses under that Account, such as when the child become 13 years old and is no longer a qualifying individual. The determination of whether a requested change is "on account of and consistent with" a Change in Status Event will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the Internal Revenue Service.

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

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

No Participant may reduce his or her election for benefits under the Flexible Spending Account Plan option below the amount already reimbursed under the Flexible Spending Account Plan for the period of coverage.

Benefits for Adopted Children / Guardianship Agreements

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

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

Termination of Participation

Medical (including prescription drugs), Health Savings Account, Dental, and Vision	The last day of the month in which employment ends
Life, Optional Life Insurance, AD&D, and Disability Insurance	The date employment ends
Flexible Spending Account Program (including medical and dependent care spending accounts)	Deposits stop with the last paycheck received after termination. Reimbursement is made for eligible expenses incurred up to date termination. Participants have 90 days following their date of termination to submit claims incurred up to their date of termination.

Refer to the plan summaries or booklets for the applicable benefit in the event of your termination of employment. To obtain information regarding your rights to conversion of your life and medical (including prescription drugs) insurance coverage to an individual policy, please contact the appropriate insurance carrier. Also see Section 5 – COBRA for continuation of your medical (including prescription drugs), vision, dental and flexible spending account (medical account) plan benefits.

Expenses for the flexible spending account program or the health savings account program[3] must be submitted within 90 days following your termination of employment.

Coverage may also terminate if:

- Your hours drop below any required hourly threshold;
- You submit false claims;
- The District discontinues the plan for any reason;
- If you are covered under a collectively bargained agreement that has changed eligibility for benefits under contract;
- The day on which an eligible dependent ceases to be an eligible dependent;
- 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;

Employees on Military Leave

Uniformed Services Employment and Re-employment Rights Act

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

You have the following rights under USERRA:

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

2. If the military leave period is for 31 days or more, you have the right to elect USERRA continuation coverage for yourself and your dependents that were covered under the health plan. The maximum period is 24 months.

[3] Health Savings Accounts are considered "portable". If you terminate your employment with the District, you may continue to contribute to your health savings account as long as you remain enrolled in a High Deductible Health Plan. If you are no longer enrolled in a High Deductible Health Plan, you may not contribute to your account, qualified or non-qualified withdrawals are permitted.

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 School District. See the COBRA section of this document for more information on continuation of coverage through COBRA.

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

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

Please contact the Plan Administrator if you have questions about coverage during periods of military service.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

The Employer reserves the right to terminate coverage for you, your Spouse, or Dependent(s) prospectively without notice for cause or if you, your Spouse, or Dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you, your Spouse, or Dependent(s) 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, or Dependent's coverage retroactively to the date of the fraud or misrepresentation upon 30 day notice. Failure to inform the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, as applicable, that you, your Spouse, or Dependent(s) is covered under another plan constitutes fraud under the Plan.

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

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

Further, you understand that:

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

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

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

National Medical Child Support Orders

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

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

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

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

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

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

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

Please see the Plan Administrator for questions regarding National Medical Support Orders.

5. COBRA RIGHTS

"Continuation Coverage" means your right, or your Spouse's and your Dependents' right, to continue the same coverage under any medical, dental, vision or flexible spending medical account benefit plan (COBRA extensions for the flexible spending account program extend to the end of the plan year in which your qualifying event occurs) 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). Clearfield Area School District is subject to COBRA.

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

Initial COBRA Notification

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

• Ninety days from the date on which the Employee first becomes or his or her Dependent Spouse first becomes covered under the Plan, or
• The first date after coverage starts that the Employee or his or her Dependent Spouse or Dependent Child is required to be furnished with a qualifying event notice.

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

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

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

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

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

Basic COBRA Continuation Coverage Rights

If Clearfield Area School District amends the medical benefits for active employees and their family members during your COBRA Coverage period, your COBRA Coverage under the plan will be amended in the same manner.

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

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

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

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

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

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

A summary of the length of your coverage periods follows:

Qualifying Event Resulting in a Loss of Coverage	**Maximum Coverage Period**
Employee's reduced work hours, except for a reduction in hours in connection with Family and Medical Leave	18 months
Employee's termination (except for gross misconduct) or retirement	18 months
Employee's death, divorce or legal separation of the employee and Spouse	36 months
Dependent child's loss of eligibility (for example, by reaching the age limit, no longer being a full-time student, getting married or becoming a full-time employee)	36 months
Dependent's loss of coverage because employee enrolls in Medicare	36 months

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

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

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

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

The Trade Preferences Extension Act of 2015 and COBRA

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

COBRA Premium Payments

You do not have to 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 health plans.

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.

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 the District within 60 days after the latest of:

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

Send all premium payments for COBRA coverage to the COBRA Administrator. As of the date of this SPD, the COBRA Plan Administrator is Clearfield Area School District, unless you are notified by Clearfield Area School District of a different COBRA Administrator.

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

Completed Election Forms and Premium Payments (check or money order only) must be remitted to the address below:

Clearfield Area School District
2831 Washington Avenue
Clearfield, PA 16830

814-765-5511

Satisfactory notice must be made by 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 Clearfield Area School District.

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 the District, in its sole discretion, may require.

Within 30 days of receiving the timely, written notice, the District will forward the notice to the District's Benefits Department. Within 14 days of being notified of the qualifying event, the Benefits Department 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.

Completed Election Forms and Premium Payments (check or money order only) must be remitted to the address below:

Clearfield Area School District
2831 Washington Avenue
Clearfield, PA 16830

Satisfactory notice must be made by 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 the District, in its sole discretion, may require.

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

Consequences of Providing Incomplete Notices

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

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 Clearfield Area School District Employee Benefit Plan will continue your medical benefits, as required by law. This means the Clearfield Area School District will continue your benefits on the same basis as if you were continuing your employment.

- Employees on unpaid leave are required to pay required premiums for medical (including prescription drugs), vision, flexible spending account plan (including health and dependent care spending accounts), or supplemental life insurance coverage during their leave. Premiums can be paid during your leave with post-tax dollars. The method of payment will be chosen at the discretion of the Plan Administrator.

  If you elect to cease participation in the coverage you have elected to participate in, expenses incurred while participation has lapsed will not be eligible for reimbursement. If you elect to continue participation in the dependent care spending account, expenses incurred during the leave would not be eligible for reimbursement because you are not working, but contributions could be made during the leave and applied to expenses incurred after you return from leave.

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

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

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

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

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 INFORMATION NON-DISCRIMINATION ACT ("GINA"), NON ASSIGNMENT OF BENEFITS, CONTINUATION AND CONVERSION RIGHTS

Contributions for Coverage

The District will make a contribution to or pay the total premium cost of your coverage under the following programs:

- Health Savings Account – Employer Contribution[4]
- Group Term Life and AD&D
- Long Term Disability
- Dental
- Vision – Employee Only Coverage

You will pay a portion of the total premium cost of your coverage under the following programs (see your collective bargaining agreement for information regarding cost of coverage):

- Medical (including prescription drugs) – (pre-tax dollars)
- Vision – (pre-tax dollars) – The Premium Cost Difference Between Individual and Family Coverage

You will pay the total elected contribution or premium costs in the following programs:

- Health Savings Account (pre-tax dollars) Employee Contribution
- Supplemental / Optional Life Insurance – (post-tax dollars)
- Flexible Spending Account Program (including medical and dependent care spending accounts) – (pre-tax dollars)

Eligible Part-Time Employees may participate in medical (including prescription drugs), vision, dental and supplemental / optional life insurance benefits and are required to pay the full premium cost of benefits in which they elect to participate.

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, PPACA and WHCRA.

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:

[4] The District currently makes contributions to your Health Savings Account but reserves the right to discontinue contributions at any time.

- 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 and life insurance 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 Plan Administrator.

8. HOW THE PLAN IS ADMINISTERED

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Employee Payroll and Benefits Specialist has been designated to act as the Plan Administrator.

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.

Right to Receive and Release Necessary Information

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

Duties of the Plan Administrator

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

Plan Administrator Compensation

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

The School District will bear the incidental costs of administering the Plan.

Power and Authority of the Insurance Company

Certain benefits under the Plan are fully insured and provided by contract with an insurance company. The Plan Administrator has delegated authority to the insurance company and they 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.

Clearfield Area School District has insurance contracts to provide for the following benefits:

Sun Life Financial	Life & AD&D Insurance, Long Term Disability
Colonial Life Insurance Company	Supplemental / Optional Life Insurance
United Concordia Company, Inc.	Dental
National Vision Administrators	Vision

Power and Authority of the Plan Administrator

The Plan has benefits that are self-insured with administrative services provided by insurance companies. The Plan Administrator has delegated authority to the insurance companies and they 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.

Clearfield Area School District has contracted with the following insurance companies to provide the following benefits:

Highmark Blue Cross Blue Shield	Medical (including prescription drugs)
Security Life Insurance Company of America	Flexible Spending Account Program (including medical and dependent care spending accounts)
Acclaris, Inc.	Health Savings Account Program

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under the plan, please contact 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

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

The Business Administrator signs administrative contracts for this Plan on behalf of the District, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

11. NO CONTRACT OF EMPLOYMENT

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

12. PROCEDURES FOR REQUESTING BENEFITS AND FILING CLAIMS

This Summary Plan Description is intended to provide summary information regarding claims procedures. Always review the attached insurance carrier booklets, summary plan descriptions or governing documents for more information about how to file a claim and for details regarding the insurance companies claim procedures.

Claims for Fully-Insured Component Benefits

You must follow the procedures described below in order to make a claim for benefits under the Plan. You or your authorized representative (on your behalf) may submit an initial claim for benefits under the Plan or may submit a claim for review if the claim has been denied. The insurance Claims Administrator will, in its sole discretion, determine whether an individual has been authorized to act on your behalf.

CLAIMS AND APPEALS TIMETABLE

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

	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
All Eligibility Determinations and Other Benefits	Life Insurance and Dependent Care Spending Accounts	Within a reasonable period of time, but not later than **90 days** after receipt of your claim by the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator. May be extended for an additional **60 days.***
Long Term Disability		Within a reasonable period of time, but not later than 45 days after receipt of your claim by the Claims Administrator, unless an extension of up to an additional 30 days is necessary due to matters beyond the control of the Claims Plan Administrator.	A reasonable period of time, but not later than 45 days after receipt of your request for review by the Claims Administrator. May be extended for an additional 45 days.*

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

Notice of Decision of Claim

Claims under the Health, Dental or Vision Plans

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, United Concordia, and NVA (the designated claims processors) receipt of the claim, unless special circumstances require an extension of up to 15 additional days to process the claim. If such an extension of time for processing the claim is required, as determined in the designated claims processor's sole discretion, you will receive written notice of the extension before the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the designated claims processor expects to render a benefit determination.

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

Claims Made Under the Long Term Disability Plan

If your claim for benefits under the LTD Plan is denied, you will receive a written notice of the decision to deny the claim within 45 days after the receipt of the claim by the Sun Life Financial or any successor thereto ("Disability Claims Processor"), unless the Disability Claims Processor determines that matters beyond the control of the Plan necessitate an extension of up to 30 days to process the claim. If the Disability Claims Processor determines that a decision cannot be rendered during the first 30-day extension period due to matters beyond the control of the Plan, the period for making a determination regarding your claim may be extended for an additional 30 days. You will be provided with an explanation of the circumstances requiring the extension of time including:

- The date by which the Disability Claims Processor expects to render a decision on the claim;
- An explanation of the standards on which entitlement to a benefit is based;
- A description of the unresolved issues that prevent a decision on the claim; and
- A description of additional information needed to resolve such issues.

If the extension notice requires you to provide additional information to process your claim, you must provide the information to the Disability Claims Processor within 45 days after the date the notice is sent to you. If an extension notice requests specific information, the extension period will not begin to run until you respond to the Disability Claims Processor's request for information. If you do not respond to the Disability Claims Processor's request for additional information within 45 days, your claim will be decided without such information.

If your claim for benefits under the LTD Plan is denied, the written notice of denial shall include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material and information is necessary;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the
- If the adverse benefit determination is based on a medical necessity or experimental treatment or adverse determination, a statement that a copy of such rule, guideline, protocol, or other criterion was relied upon in making the adverse determination will be provided to the claimant free of charge upon request; and other similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to the claimant's medical circumstances will be provided to the claimant free of charge upon request.

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.

Rights to an External Appeal – Medical (including prescription drug) Benefits

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if insurance company has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

You will lose your right to an external appeal if you do not file an application for an external appeal within a period of time stated in the attached insurance contract.

The external appeal program is a voluntary program. Please refer to the appropriate attachment to this document for more information on requesting an external appeal.

Review of Claims Made under the Long-Term Disability Plan

The following claims review procedures apply to the review of claims denied under the LTD Plans without regard to any conflicting claims appeal or review procedures described in the attached booklet.

Appeal. If your claim for benefits under the LTD Plan 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 under the LTD Plan or no notification as to an extension of the determination period within 45 days after submission of the claim to the Disability Claims Processor, the claim 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 with the Claims Administrator a written request for review, provided that your request for review of a claim must be submitted within 180 days after (a) your receipt of the written notice of the denial or (b) the date of the deemed denial of the claim.

Review. The Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The Claims Administrator will render a decision regarding the claim within 45 days after the date the Claims Administrator receives your request for review, unless the Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case the Claims Administrator will render a decision as soon as possible, but not later than 90 days after the Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 45-day period; such notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a determination on review. The Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim. If you request that the Claims Administrator review your claim, you may submit written comments, documents, records and other information relating to the claim.

Additionally, you shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, provided that the Claims Administrator shall determine, in its sole discretion, whether documents, records and information are relevant to your claim, subject to applicable regulations.

In reviewing your claim, the Claims Administrator shall take into account all comments, documents, records, and other information you submit that relates to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additionally, the Claims Administrator's review of your claim shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination regarding your claim nor a subordinate of such individual. In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, provided that such health care professional shall not be the individual who was consulted in connection with the initial adverse benefit determination regarding the claim or a subordinate of such individual.

Disposition on Review. You will receive written notification of the 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;
- Reference to the specific Plan provisions on which the benefit determination is based; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits, provided that the Claims Administrator shall, in its sole discretion, determine whether documents, records and information are relevant to your claim under applicable regulations;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request;
- A statement of your right to bring an action under ERISA;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your medical circumstances will be provided free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Claim Procedures for Self-Funded Plans – Flexible Spending Account Program

Self-insured benefits listed in this Summary Plan Description follow rules and guidelines listed in the Section titled Requesting Benefits and Filing Claims. Claim decisions for self-funded benefits have been delegated by the Plan Administrator to the insurance companies.

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

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

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

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

Who Can Request Benefits and File Claims?

Covered Employees, covered Dependents and eligible Spouses can request benefits and file claims. Covered Employees, covered Dependents, and eligible spouses are called "Claimants." A Claimant can choose a representative to act on his or her behalf in pursuing a benefit claim or appealing a negative benefit decision. The insurance company Claims Administrator has a written form for this purpose. The Claimant must call the insurance company Claims Administrator to request the form, then complete and return it to the insurance company Claims Administrator at the mailing address provided in the section of the document called "Important Facts about the Plan." The Plan will then recognize the level of authority granted to the representative by the Claimant. An assignment of payment of benefits to a provider is not an automatic grant of authority to act on a Claimant's behalf in pursuing and appealing a benefit decision under the Plan.

When Does the Time Period for Making an Initial Decision on a Claim Start to Run?

The time for making an initial claim decision begins to run when a claim is filed according to the Plan's filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim at the time of the filing.

If a claim is denied, in whole or in part, the Claimant or Claimant's representative is to be provided with written notice (by first-class mail or hand delivery) or electronic notification (provided according to required regulation) of the negative benefit decision.

Plan's Failure to Follow Procedures

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

Insured Benefits and State Insurance Laws

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

Statute of Limitations for Plan Claims

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

Subrogation/Right of Reimbursement

As a condition to receiving medical, disability or any other benefits under the Plan, covered person(s), including all Dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person received any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefit paid by it (i.e. the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability, or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full

recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

Coordination of Benefits and Right of Recovery

Coordination of Benefits

Except as otherwise described in an applicable Evidence of Coverage or Benefits Booklet, in the event that a Participant is entitled to benefits from another plan or policy or medical benefits under workers compensation, benefits under this Plan may be reduced to an amount, which together with all other amounts paid under any other plan or policy, will not exceed the benefits that would in fact be eligible for reimbursement under this Plan.

Medicare benefits will be secondary to health plan coverage with respect to covered individuals who receive Plan coverage by virtue of current employment status during a mandatory Medicare secondary period. In all other circumstances, Medicare benefits will be primary and the Plan will coordinate with Medicare to the extent permitted under applicable law.

Right of Recovery

Whenever benefits have been paid with respect to covered expenses in a total amount at any time in excess of the amount of payment necessary, the Plan Administrator shall have the right to recover such payments to the extent of such excess from among any one or more of the following, as the Plan Administrator shall determine: (i) any persons (including, without limitation, an Employee, a Covered Dependent, a trust, or an estate) to, for or with respect to whom such payments were made, (ii) any insurance companies, or (iii) any other organizations. The Plan Administrator shall have the right to pay any amount it shall determine to be warranted to satisfy the intent of this Section to any organization making payments under other plans which should have been made under this Plan.

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

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

Clearfield Area School District's Obligations with Respect to PHI

With respect to PHI, Clearfield Area School District agrees to certain conditions. The District agrees to:

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

Access to PHI within Employer

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

Privacy Official

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

1. Appointment, Resignation and Removal of Privacy Official. The District shall appoint one or more individuals to act as Privacy Official on matters regarding the health component benefits. The individual appointed as Privacy Official may resign by giving 30-day notice in writing to Clearfield Area School District. The District shall have the power to remove that individual for any or no reason.
2. Policies and Procedures. The Privacy Official shall from time to time formulate and issue to Participants and the District such policies and procedures as he or she deems necessary for substantive provision of the health component benefits. Additionally, such policies and procedures must be accepted by the Plan Administrator.
3. Privacy Notice. The Privacy Official shall be responsible for arranging with the District, the Plan Administrator and any third-party administrator for the issuance of, and any changes to the Privacy Notice under the health component benefits.
4. Complaint Contact Person. The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this section and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the health component benefits HIPAA Privacy Notice.

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

Clearfield Area School District
Privacy Officer – Employee Payroll and Benefits Specialist and the Human Resources Secretary

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

HIPAA Security Standards

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

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

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

14. PARTICIPANT RIGHTS TO DOCUMENTS:

Plan Participants shall be entitled to:

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

• Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator at the Business Office. The District may make a reasonable charge for the copies.

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

Exhibit A

Your Health Plan Eligibility and the Affordable Care Act (ACA)

Your rights to enroll in and maintain coverage under the benefit programs are described in detail in this Summary Plan Description and Annual Enrollment Materials provided by the Employer. This Exhibit provides you with additional general information regarding how eligibility is determined for enrollment in your medical (including prescription drug) program based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA).

If you are full-time employee as defined in the regulations, your Employer has to offer you the opportunity to participate in the Employer's medical (including prescription drug) program. In general, you are a full-time employee if you average at least 30 hours of service per week (or 130 hours of service in a calendar month). As a full-time employee you may also elect coverage for your dependent children up to age 26. Please refer to the applicable Benefit Plan Descriptions, Insurance Contracts or enrollment materials provided by the Employer and incorporated by reference in this document for information on other individuals (e.g., your Spouse) that may be eligible for coverage.

If you are hired as a regular full-time non-seasonal employee your Employer has hired you to perform 30 or more hours of service per week (or 130 hours of service in a calendar month). Your eligibility and the eligibility of your dependents and other individuals (e.g., your Spouse) for coverage under the medical (including prescription drug) program is set forth in the Benefit Plan Description(s) or enrollment materials as provided by your Employer and incorporated by reference in this document. These materials will address any waiting period, enrollment procedures and other pertinent information. You will continue to be treated as a full-time employee as long as you maintain hours of service in keeping with the full-time definition outlined above.

If you are not hired as regular full-time non-seasonal employee, but are hired as a variable hour, part-time or seasonal employee, your Employer will use a Look-Back Measurement Method to determine if you are a full-time employee for purposes of Plan coverage. This Look-Back Measurement Method is used to provide greater predictability for Plan coverage determinations.

The Look-Back Measurement Method involves three different periods:

- A Measurement Period for counting your hours of service to determine your status as a full-time employee eligible for health coverage.
    - If you are an ongoing variable hour, part time or seasonal employee, this Measurement Period (which is also called the "Standard Measurement Period') will be used in determining your eligibility for health coverage during the Standard Stability Period. The Standard Measurement Period used by your Employer is the 12 month period beginning July 1st each year and ending the following June 30th.
    - If you are a new variable hour, part-time or seasonal employee, the Measurement Period (which is also known as the "Initial Measurement Period") will be used in determining your eligibility for health coverage during the Initial Stability Period. The Initial Measurement Period used by your Employer is the 12 month period beginning on the first day of the calendar month following your start date.
- A Stability Period is a period that follows a Measurement Period and is the period during which you will be entitled to health coverage if you are determined-to be a full-time employee. Your hours of service during the Measurement Period will determine whether you are a full-time employee who is eligible for, coverage during the Stability Period. As a general rule, your status as a full- time employee or a non-full-time employee is "locked in" for the Stability Period, regardless of how many hours you work during the Stability Period, as long as you remain an employee of the Employer. For an employee determined to be a full-time employee during the Measurement Period, the Stability Period would be a period of at least six consecutive calendar months that follows the Measurement Period and is no shorter in duration than the measurement period.
    - If you are an on-going variable hour, part-time or seasonal employee, the Stability Period (which is also known as the "Standard Stability Period") used by your Employer is the twelve month period beginning July 1st each year and ending the following June 30th.

- If you are a new variable hour, part-time or seasonal employee, the Stability Period (which is also known as the "Initial Stability Period") used by your Employer is a twelve month period.

- An Administrative Period is a short period between the Measurement Period and the Stability Period when your Employer performs administrative tasks such as determining eligibility for health coverage and facilitating Plan enrollment.

    - If you are an ongoing variable hour, part-time or seasonal employee, the Administrative Period (which is also known as the" Standard Administrative Period") used by your Employer is a maximum of the three month period prior to the beginning of the Plan Year each year.
    - If you are a new variable hour, part-time or seasonal employee, the Administrative Period (which is also known as the "Initial Administrative Period") used by your Employer is the three month period after the Initial Measurement Period and prior to the Initial Stability Period.

Special rules apply when an employee is rehired by the Employer or returns from an unpaid leave.

The rules for the Look-Back Measurement Method are very complex. Keep in mind that this is just a general overview of how the rules work. More complex rules may apply to your situation. The District intends to follow the IRS final regulations (including any future guidance issued by the IRS) when administering the Look-Back Measurement Method. If you have any questions about this measurement method and how it applies to you, please 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: Kenneth J. Mauro CPA
Clearfield Area School District

Date: 11-20-17

Attest: Becki Soult