GREENCASTLE-ANTRIM SCHOOL DISTRICT

EMPLOYEE HEALTHCARE BENEFIT PLAN

WRAP PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

EFFECTIVE October 1, 2016

Lincoln Benefit Trust
Self Funded Health Benefits

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INTRODUCTION

The Greencastle-Antrim School District Employee Healthcare Benefit Plan (the "Plan") provides health and welfare benefits for the eligible employees and dependents of the Greencastle-Antrim School District (the "District"). Each benefit offered by the Plan is called a "Benefit" in this Wrap Plan Document and Summary Plan Description (the "Wrap SPD"). These Benefits are described in more detail in separate booklets, certificates of insurance, and evidences of coverage and/or similar documents (the Benefit Descriptions"). These Benefit Descriptions are incorporated by reference into this Wrap SPD and are a part of the Plan. The Benefit Descriptions may be provided along with this document or may be provided separately by the District.

There are certain eligibility provisions and member rights that this Wrap SPD does not address. Additional information about benefits, eligibility, exclusions and limitations of the Plan can be found in the Benefit Descriptions or the district's respective collective bargaining agreement. This Plan Document and Summary Plan Description are intended to supplement these Benefit Descriptions on those important points. In the event of any difference between this Wrap SPD and the Benefit Descriptions, the terms of the collective bargaining agreement will govern.

The Greencastle-Antrim School District Employee Healthcare Benefit Plan (the "Plan") includes the following benefits:

- Medical and Prescription Drug Plan(s)
- Dental Plan
- Vision Plan

The names and contract information of the claims administrators for these Benefits can be found under "Assistance with Your Questions" below and in the Benefit Descriptions.

This Plan Document and Summary Plan Description is written in simple, direct language and is designed to help you understand the details of the benefits available, the eligibility requirements, and general information about the benefit plans. We urge you to become familiar with the contents of this document so that you and your Dependents can fully utilize, whenever necessary, the benefits that are available to eligible Participants.

ELIGIBILITY FOR PARTICIPATION

Employees and Retirees, in eligible classes as defined by the District, are eligible to enroll in coverage.

Employees are eligible to participate on the date show below:

Professional Staff, Administrators, Directors - on the first date of employment

Support Staff - You must be an employee of Greencastle-Antrim School District for 90 days

In order to participate, eligible employees must meet:

1) The eligibility requirements of the Benefit

2) The enrollment requirements of Benefit

The term spouse shall mean the covered employee's legally married spouse as recognized under Pennsylvania law. An eligible dependent means a child, adopted child or step child who has not attained age 26.

Spouse or dependent coverage will take effect for any Benefit that includes this coverage on the day that:

1) The eligibility requirements of the Benefit are met;

2) The employee is covered under the Benefit; and

3) All enrollment requirements of the Benefit are met.

Mental or Physical Handicap

An unmarried child who is unable to earn his own living due to physical or mental Illness or handicap, and is at or reaches a terminating age under the terms of the Plan, will be eligible for coverage if the Plan receives proof, satisfactory to the Plan Administrator, that he is unable to earn his own living.

Qualified Medical Child Support Orders

With respect to Benefits under the Plan that are group health plans, the Plan will provide benefits as required by any Qualified Medical Child Support Order ("QMCSO") as required under ERISA Section 609. In order for the child to become covered, the Plan Administrator must receive, from the court which has jurisdiction over the divorce, a Qualified Medical Child Support Order (QMCSO).

BENEFITS

Important information about your health benefits can be found in the Benefit Descriptions. Within each Benefit Description you will find a summary of the benefits, the services that are covered, the services that are excluded, how the plan works, how to file a claim, how to appeal a benefit determination, member rights and responsibilities, who to call if you have questions and general information.

OPEN ENROLLMENT

Prior to October 1st of each year an open enrollment period will occur. Each employee will be given an opportunity to review the Benefit options that are available and make changes if desired. This open enrollment period is also an opportunity to add or delete dependents from the coverage.

For the medical/prescription plan, benefit choices made during the open enrollment period will become effective October 1st and remain in effect until September 30. For the dental and vision plans, benefit choices made during the open enrollment period will become effective January 1st and remain in effect until December 31st. Unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. (See Group Health Plan Special Enrollment Rights section below), benefit choices will remain during those dates.

A Plan Participant who fails to make an election during open enrollment will automatically retain the coverage that is currently in force.

Plan Participants will receive detailed information regarding open enrollment from the District.

Group Health Plan Special Enrollment Rights

It is important that you understand your right to apply for group health insurance coverage outside of the annual open enrollment period. The Health Insurance Portability and Accountability Act (HIPAA) requires that employees be allowed to enroll themselves and/or their dependent(s) in the District's group health plan under certain circumstances, described below, provided that the employee notifies the District within 30 days of the occurrence of any following events:

- Loss of health coverage under another employer plan (including exhaustion of COBRA coverage);
- Acquiring a spouse through marriage; or
- Acquiring a dependent child through birth, adoption or placement for adoption.

In addition to the special enrollment rights set forth above, all group health plans must also permit eligible employees and their dependent(s) to enroll in the Plan if the employee requests enrollment within 60 days of the occurrence of following events:

- Loss of coverage under Medicaid or a state child health plan: If you or your dependent(s) lose coverage under Medicaid or a state child health plan ("CHIP"), you may request to enroll yourself and/or your dependent(s) in our group health plan not later than 60 days after the date coverage ends under Medicaid or CHIP.

- Gaining eligibility for coverage under Medicaid or CHIP: If you and/or your dependent(s) become eligible for premium assistance from Medicaid or CHIP, you may request to enroll yourself and/or your dependent(s) under our group health plan, provided that your request is made not later than 60 days after the date that Medicaid or CHIP notifies you that you and/ or your dependent(s) are eligible for such premium assistance. If you and/or your dependent(s) are currently enrolled in our group health plan, you have the option of terminating your and/or your dependent's (s') enrollment in our group health plan and enroll in Medicaid or CHIP.

Please note that once you terminate your enrollment in our group health plan, any dependent's enrollment will be also terminated.

Failure to notify us of your loss or gain of eligibility for coverage under Medicaid or CHIP within 60 days, will prevent you from enrolling in our plans and/or from making any changes to your coverage elections until our next open enrollment period

IMPORTANT DISCLOSURES

Maternity and Newborn Length of Stay

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a 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 48 hours (or 96 hours as applicable). In any case, 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 48 hours (or 96 hours).

Coverage for Reconstructive Surgery Following Mastectomy

Group health plans and health insurance issuers that offer coverage for mastectomy, under Federal law, must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. This coverage applies to both men and women. It is to include:

- All stages 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 at all stages of the mastectomy, including lymphedemas (loss of normal lymph channel drainage).

Mental Health Parity and Addiction Equity

Group health plans and health insurance issuers that offer coverage for mental health benefits (including substance use disorder benefits), under Federal law, must provide that restrictions on these benefits are no more restrictive than the most common or frequent requirements that apply to substantially all medical and surgical benefits covered under the plan including 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. This equality or parity requirement applies to:

- Financial requirements including deductibles, co-payments, co-insurance, and out-of-pocket expenses;

- Treatment limitations including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment; and

- Out-of-network benefits

Upon request, you or your provider are entitled to receive the criteria for medical necessity determinations for mental health or substance use disorder benefits. The reasons for any denial of such benefits must also be made available upon request.

Genetic Information

Group health plans and health insurance issuers generally may not, under Federal law, obtain or use genetic information when determining premium charges, coverage, benefits, or any other purpose. This rule is not violated if the plan or issuer receives the information inadvertently or for use in monitoring the effects of toxic substances in the workplace. Also, you are free to authorize the disclosure of genetic information when making a FMLA or health-related claim.

Genetic information includes any information about (i) an individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual.

COBRA CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) may provide you with rights to health care continuation coverage. If you are covered by our group health plan, COBRA may give you the right to stay covered even if something happens, like losing your job, which would otherwise cause you to lose coverage. This continuation coverage under a group health plan is called "COBRA continuation coverage." COBRA continuation coverage lasts only for a limited time, and you have to pay for it.

Qualifying Beneficiaries and Qualifying Events

If you are covered by our group health plan, you, your spouse, and your dependent children may have rights under COBRA as "qualified beneficiaries" if:

- You lose or leave your job (other than by reason of your gross misconduct) (if you take an FMLA leave of absence and do not return to active employment, the qualifying event of termination of employment occurs at the end of the leave); or

- You work less hours and our group health plan says this makes you ineligible for coverage.

Your dependent children may include any child who is born to or placed for adoption with you during a period of COBRA continuation coverage, if certain requirements are met.

Your spouse and your dependent children have the right to be qualified beneficiaries for COBRA continuation coverage following your death or divorce or legal separation if they are covered by our group health plan and would lose coverage because of the qualifying event.

COBRA gives your dependent child the right to COBRA continuation coverage for up to 36 months if he or she is covered by our group health plan and would lose coverage because he or she has reached an age or satisfied a condition that causes dependent coverage to end. If you become entitled to Medicare benefits (under Part A, Part B, or both), this would be a qualifying event for your spouse and dependent children. You are not "entitled" to Medicare until you have actually completed the Medicare enrollment and you have been notified your Medicare coverage is in effect.

Notice of the Qualifying Event and COBRA Election

Notice from Us – The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. We are required to notify the Plan Administrator of the qualifying event when you lose or leave your job, your hours are reduced, you die, we commence bankruptcy proceedings, or you become entitled to Medicare benefits.

Notice from you – In order for the COBRA rights notice and election forms to be provided, the Plan Administrator must be notified if:

- there is a divorce or legal separation;
- a child, adopted child or stepchild attains age 26;
- an individual receiving COBRA continuation coverage qualifies for or loses Social Security disability benefits.

You or any qualifying beneficiary are required to give notice within 60 days of the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

Notice is to be given in writing. The group health plan may require that a specific form be completed.

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

If COBRA continuation coverage is desired, it must be elected within 60 days after the later of:

- The date the qualified beneficiary would lose coverage on account of the qualifying event; or
- The date notice is provided to the qualified beneficiary of the right to elect COBRA continuation coverage.

If the Plan Administrator receives notice from you (or someone else who believes he/she is a qualified beneficiary) but determines that no COBRA continuation coverage is required, the Plan Administrator will provide you with a written explanation as to why you are not entitled to continuation coverage. This explanation will be provided within 14 days of the Plan's receipt of your notice.

Cost of Coverage - The group health plan is required to continue the same coverage. All costs of coverage are payable by you after the termination of your employment or by your spouse or child and are made on an after-tax basis. The charge would be equal to the entire cost of coverage, plus a small (2%) additional charge for administration. (If you are getting a longer period of coverage because of disability, you may have to pay more. If the coverage would not be required to be made available in the absence of a disability extension, the COBRA continuation coverage premium can be 150% of the regular cost of coverage.) COBRA continuation coverage charges can be paid in monthly installments.

Timely Payment – Coverage will cease if payment is not made timely. For the first payment, the plan must give you (or the qualified beneficiary) at least 45 days after the date of the election. Thereafter, timely payment usually means within 30 days after the first day of that coverage period. The group health plan may permit a later date; read its COBRA coverage notice. If you are receiving severance pay in connection with a termination of employment, you may choose to have your severance pay applied toward your COBRA coverage payments.

Period of Coverage - If COBRA continuation coverage is elected, coverage generally begins as of the date that coverage would otherwise have been lost. Coverage will then continue until the earliest of the following dates (unless it is terminated for cause):

- The last day of the 36-month maximum coverage period. This does not apply if the qualifying event was termination of employment or a reduction of hours of employment.
- The last day of the 18-month maximum coverage period required where the qualifying event was termination of employment or a reduction of hours of employment. This is subject to a "Disability Extension" or a "Second Qualifying Event Extension."
- You (or the qualified beneficiary) fail to make timely payment.
- The date we cease to provide any group health plan to any employee.
- The date, after the date of the election, as of which the qualified beneficiary first becomes covered under any other group health plan.
- The date, after the date of the election, as of which the qualified beneficiary first becomes entitled to Medicare benefits.

Special Medicare Related Coverage Period – If you become entitled to Medicare benefits less than 18 months before the qualifying event and the qualifying event is termination of employment or a reduction of hours of employment, COBRA continuation coverage for your spouse and your dependents (but not you) will continue until 36 months after the date of your Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date you terminate employment, COBRA continuation coverage for your spouse and children will last 28 months after your termination (36 months minus 8 months).

Disability Extension – Under certain circumstances a disabled qualified beneficiary will receive 29 months of coverage, instead of 18 months. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. In order to qualify, the disability would have to have started at some time before the 60th day of COBRA continuation coverage.

In order for notice to be properly and timely given to the Plan, notice must be given in writing to the Plan Administrator and must be accompanied by a copy of the Social Security Administration determination. The group health plan may require that a specific form be completed. You or any qualifying beneficiary are required to give notice within 60 days of the latest of:

- The date of the disability determination by the Social Security Administration;
- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

However, if the notice is not given during the first 18 months of COBRA continuation coverage, it will be too late and COBRA coverage will not be extended.

If the Social Security Administration determines that the person is no longer disabled, notice is required to be given to the Plan Administrator within 30 days of this determination. Coverage will end as of the later of: (1) 30 days after the final determination; or (2) the end of the maximum coverage period that would have applied without regard to the disability extension.

Second Qualifying Event Extension – If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to them if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if a dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In order for notice to be properly given to the Plan, notice must be given in writing to the Plan Administrator. The group health plan may require that a specific form be completed. You or any qualifying beneficiary are required to give notice within 60 days of the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

More Information on COBRA

COBRA has a number of special rules, and the information above does not cover everything in the governing regulations. The Plan Administrator is required to answer your questions about your COBRA rights. If you have any questions about your COBRA rights or would like additional information about COBRA and your group health plan, contact the appropriate plan administrator.

If you want to know more, the Department of Labor has a booklet called "Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)." You can request this booklet free of charge by calling 1-800-998-7542. The booklet is also available on the Internet at: http://www.dol.gov/ebsa.

GENERAL CLAIM PROCEDURES

Claims Payment / Denial Appeals Process

If you have a claim against a particular welfare benefit program, you will need to reference that particular plan under the claim procedure set out in the applicable Benefit Description. If you have a claim against this Plan, you may file a written claim with the Plan Administrator describing the specifics of your claim.

For appeals that involve medical or prescription drug benefits, please refer to the process outlined in the medical and prescription drug Benefit Descriptions. Once you have exhausted the initial review process, and are still dissatisfied with the decision, you may request an appeal to Plan Trustees for a full and fair review.

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

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

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

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

You have the right to have your appeal reviewed through the two-level process described below. However, when an appeal involves an urgent care claim, a single level review process is available. The review of an urgent care claim must be completed before you can institute an action in law or in equity in a court of competent jurisdiction as may be appropriate.

With the exception of pre-service claims, the second level review is mandatory and must be exhausted before you can institute an action in law or in equity in a court of competent jurisdiction as may be appropriate.

Initial Review

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

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

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

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

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

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

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

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

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event Claims Administrator renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to request an external review or pursue a court action.

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before pursuing a court action. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to the court action will not commence (i.e. run) during the second level review; and

- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of pre-service claims, you should contact Member Services using the telephone number on your ID card.

Second Level Review – Lincoln Benefit Trust Board of Trustees

If you are dissatisfied with the decision following the initial review of your appeal, you may request to have the decision reviewed by Lincoln Benefit Trust Board of Trustees (except for medical necessity determinations which are addressed below). Such request must be made to Claims Administrator in writing and received by Claims Administrator within 60 days of receipt of the response to the Initial Review. Claims Administrator must submit such request for appeal to the Lincoln Benefit Trust Manager for placement on the agenda of the next regularly scheduled meeting of the Board of Trustees, which will in no case be more than 120 days after the request for appeal, is received by the Trust Manager. The appeal will be submitted to the Plan Trustees on the basis of the records submitted by the appellant and will be heard by the Plan Trustees on a "John Doe" or anonymous basis. The written decision of the Plan Trustees will be made by Claims Administrator to the Employee within 30 days of the Plan Trustees meeting where action was taken on such appeal and will include specific reasons for the decision and specific reference to the Plan provisions on which the decision is based. The decision by the Plan Trustees (except for medically necessary appeals) will be the final action by Lincoln Benefit Trust Plan Trustees on such appeal.

Second Level Review (medical necessity only)

If you are dissatisfied with the decision following the initial review of your appeal involving determinations regarding medical necessity, you may request to have the decision reviewed by Claims Administrator's physician for a second opinion. The decision will be made within 5 business days of receiving the 2nd level appeal. If you are dissatisfied with the decision following the Second Level Review of a determination involving medical necessity, you may follow the steps for an External Review.

External Review

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

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

Preliminary Review

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

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan's eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

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

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

Referral to an Independent Review Organization (IRO)

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

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

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

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

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

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

Expedited External Review (Applies to Urgent Care Claims Only)

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

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or

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

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

Referral to an Independent Review Organization (IRO)

Claims Administrator will, randomly or by rotation, select an IRO to perform an external review of your claim if your request found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Claims Administrator will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.)

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

The assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for the external review. The IRO must provide written notice of its final external review decision to you and to Claims Administrator, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of:

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

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

If you experience any difficulty determining your benefits under the group health plan or having a claim processed, you should contact the insurer's help desk. Due to the federal health information privacy rules, we are not able to assist you.

AMENDMENT AND TERMINATION OF COVERAGE

You may elect to terminate any Benefit as provided under the applicable Benefit Description. We may terminate a Benefit for all or any employees, at our discretion, as described below. Coverage under all Benefits will terminate with your termination of employment unless the Plan specifically provides for retiree benefits and except as otherwise permitted under COBRA. Coverage will also terminate if you fail to pay your required portion of the premium.

Medicare or Medicaid Coverage

If you become (or your spouse or your dependent becomes) entitled to Medicare or Medicaid coverage, you may make a prospective election to cancel or reduce coverage for the affected person under the Plan. In addition, if you lose (or your spouse or your dependent loses) eligibility for such coverage, you may make a prospective election to begin or increase coverage for the affected person under the Plan.

Family Medical Leave Act

Regardless of the established leave policies, this Plan shall at all times comply with the Family and Medical Leave Act (FMLA) of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the District will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Military Leave

If you take an unpaid leave of absence due to military service that is protected by the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA), special rules will apply. If you are employed in Pennsylvania, we will pay your group health plan premiums for the first 30 days. If you are absent for 31 days or more, you will need to arrange to pay for your full premium costs. We will not pay any portion of the premium. You may pay to continue your coverage for up to 24 months. If you are not employed in Pennsylvania, your cost will include a small (2%) additional charge for administration.

If You Die

If you die while you are actively employed, your spouse or estate can file claims for benefits. If no COBRA Continuation Coverage is elected, the claims must have been incurred before the termination of coverage due to your death.

Plan Sponsor Amendment or Termination

The Plan Sponsor has the right to amend or terminate the Plan at any time. However, no amendment or termination can retroactively diminish a Participant's right to obtain Plan benefits.

PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

The Plan will use a Participant's or Dependent's protected health information ("PHI"), in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), only to make disclosures related to treatment, payment for healthcare, or the Healthcare Operations of the Plan or to make any other disclosures that are required by law. However, if a Participant or Dependent requests to see the information or provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the request or the authorization.

With respect to PHI, the District will:

- Not use or further disclose PHI other than as permitted or required by this Wrap SPD or as required by law;
- Ensure that any agent or vendor, to whom the District or Plan provides PHI agrees to the same restrictions and conditions that apply to the District with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the District unless authorized by the individual that is the subject of the PHI;
- 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 upon request an accounting of disclosures;
- Make available to the Secretary of the Department of Health and Human Services internal practices, books and records relating to the use and disclosure of PHI received from the Plan, for purposes of determining the Plan's compliance with HIPAA;
- Provide written notice or a substitute notice (if the last known contact address is insufficient) for each individual within 60 days following discovery of any breach of Unsecured PHI. The notice will include:
    - A brief description of what happened including the date of the breach and the date of discovery, if known;
    - A description of the types of unsecured PHI that were involved in the breach;
    - Any steps the individual should take to protect him/herself from potential harm resulting from the breach;
    - A brief description of what the District is doing to investigate the breach in accordance with HIPAA breach notification requirements;
    - Contact procedures for individuals to ask questions or learn additional information
- If a breach of Unsecured PHI involves more than 500 residents of a state, provide notice to local media outlets serving the state within 60 days of discovering the breach;
- If a breach of unsecured PHI involves more than 500 covered persons, provide notice to the DHHS not later than 60 days after the end of the calendar year in with the breach occurred;
- If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made; and
- Use DHHS approved methods to secure and destroy PHI.

With respect to Electronic PHI, the District will, if PHI is or has been stored on the District's computer system:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or vendor to whom the District provides electronic PHI agrees to comply with the HIPAA Security Requirements and to provide notice to the Plan of any Breach of Unsecured PHI, once the Breach is known to the agent or vendor or should reasonably have been known to the agent or business associate;
- Report to the Plan any security incident of which the District becomes aware; and
- Use methods to encrypt ePHI that are approved by the Department of Health and Human Services.

Only specified employees of the District may be given access to PHI, and they may use and disclose PHI only for plan administration functions (which includes both Payment and Health Care Operations) that the District performs for the Plan. The employees include all Human Resources Employees.

If any of these persons do not comply with the HIPAA provisions of this Plan Document, the District will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

ADDITIONAL INFORMATION

Compliance with State and Federal Mandates

With respect to the Benefits and as applicable, the Plan will comply with the requirements of all applicable laws. If for some reason the information presented in this Wrap SPD differs from the actual requirements of any law, the Plan reserves the right to administer the Plan in accordance with those requirements.

No Contract of Employment

Nothing in this Plan shall be construed as a contract of employment between the District and any Employee or Participant, or as a guarantee of any Employee or Participant to be continued in the employment of the District, nor as a limitation on the right of the District to discharge any of its Employees with or without cause.

Plan Document

The official plan document includes this Wrap Plan Document and SPD, along with the Benefit Descriptions that are incorporated by reference.

Benefit Descriptions

The following additional information about the Benefits is included in the Benefit Descriptions for the benefit (if applicable):

- Any additional procedures for enrolling in the Plan;
- A summary of benefits, though this may be provided as a separate document;
- A description of any premiums, deductibles, coinsurance or copayment amounts. The schedule of your contributions, if any, to the premium payment will be provided to you by the District;
- A description of any annual or lifetime caps or other limits on benefits;
- Whether and under what circumstances preventive services are covered;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers (if any). If there is a network, the Benefit Description will contain a general description of the provider network and you will receive automatically, without charge, a list of providers in the network from the carrier or administrator;
- Whether and under what circumstances coverage is provided for any out-of- network services;
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any services requiring preauthorization or utilization review as a condition to obtaining a benefit service;
- A summary of the claim procedures. However, if the claims procedures are not included in the Benefit Description, a copy will be provided to you automatically, without charge from the insurance carrier or administrator;
- Provisions describing the coordination of benefits with the benefits provided under another similar plan in which you or another plan participant are enrolled;
- Any subrogation or reimbursement rights that prevent duplicate payments for your health care; and
- Any other benefit limitations and exclusions.

Assistance With Your Questions

If you have any questions eligibility or other general information, contact the Human Resources office. For information about claims payment, you should contact the Claims Administrator:

Medical and Prescription Drug
Highmark Blue Shield
P.O. Box 890173
Camp Hill, PA 17089-0173
www.highmarkblueshield.com
1-866-727-4943

Dental
Delta Dental
One Delta Drive
Mechanicsburg, PA 17055-6999
www.deltadentalins.com
1-800-932-0783

Vision
DavisVision
175 East Houston Street
San Antonio, TX 78205
www.davisvision.com
1-800-999-5431

GENERAL PLAN INFORMATION

Plan Name	Greencastle-Antrim School District Employee Healthcare Benefit Plan
Plan Type	Self-funded employee welfare benefit plans including: Medical, Prescription Drug, Dental and Vision plans.
Employer Identification Number	23-6005775
Plan Number	501
Plan Dates	Medical/Prescription Drug - October 1st through September 30th Dental and Vision – January 1st through December 31st
Plan Sponsor **We/Us**	Greencastle-Antrim School District 500 East Leitersburg Street Greencastle, PA 17225-1116
Plan Administrator	Lincoln Benefit Trust 65 Billerbeck Street New Oxford, Pennsylvania 17350
Named Fiduciary	Trust Manager Lincoln Benefit Trust 65 Billerbeck Street New Oxford, Pennsylvania 17350
Agent for Service of Legal Process	If, for any reason, you want to seek legal action against the Plan, you can serve legal process on the Plan Administrator for the Plan.

Claims Administrators

Medical and Prescription Drug
Highmark Blue Shield
P.O. Box 890173
Camp Hill, PA 17089-0173

Dental
Delta Dental
One Delta Drive
Mechanicsburg, PA 17055-6999

Vision
DavisVision
175 East Houston Street
San Antonio, TX 78205