PAISBOA
Health Benefit Trust

Philadelphia Area Independent School Business Officers Association Health Benefit Plan

Wrap-Around Plan Document and
Summary Plan Description

Amended and Restated Effective November 1, 2022

This document, together with any applicable benefit description booklets or summaries issued by third-party administrators, and attached hereto, constitutes the Plan Document and Summary Plan Description for the Health Plan offered by Philadelphia Area Independent School Business Officers Association Health Benefit Trust ("PAISBOA HBT"). The booklets and summaries describe situations in which those benefits may be reduced, delayed, forfeited, or denied, as well as your rights and responsibilities and the procedures and deadlines for filing a claim or appeal and taking legal action against the Plan and its fiduciaries. If the booklets or summaries are not attached, then this Plan Document and Summary Plan Description are not complete, and you should contact Human Resources for a complete copy.

If you cannot find answers to your questions in this document or any booklets or summaries you have received or want more information about the Plan, please contact PAISBOA HBT at (484) 580-8844 or the Claims Administrator listed in this document.

TABLE OF CONTENTS

Page

Section One
Introduction

1.1 Introduction

The Philadelphia Area Independent School Business Officers Association Health Benefit Plan (the "Plan" or "Health Plan") is amended and restated effective November 1, 2022. Philadelphia Area Independent School Business Officers Association Health Benefit Trust (hereinafter "PAISBOA HBT") maintains the Plan for the exclusive benefit of the Members of PAISBOA HBT and the Members' Eligible Employees and their eligible Spouses and Dependents, except as provided herein. The Plan has been approved by the Board of Trustees of PAISBOA HBT.

1.2 Applicable Law

The Plan is intended to meet the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), and Sections 105, 106 and 501(c)(9) of the Internal Revenue Code of 1986 ("Code") and the Regulations promulgated thereunder, as amended from time to time.

1.3 Status as Large Group Plan

PAISBOA HBT is a multiple employer welfare arrangement. PAISBOA HBT is designed to be a bona fide association or group of employers under ERISA, and therefore is regulated as a single employee welfare benefit plan on a large group basis.

1.4 Purpose of this Wrap Document

PAISBOA HBT is providing this Wrap-Around Plan Document and Summary Plan Description ("Wrap Document") to give Participants an overview of the Plan, to set forth the relationships between the parties, and to address certain information that may not be addressed in the attached Component Documents.

Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in the Glossary of this Wrap Document.

1.5 Terminology in Component Documents

This Wrap Document supplements the terms of the various Component Documents. The terminology in the Component Documents may have different meanings than the meaning in this Wrap Document. For example, "Member" is defined in the Component Documents as enrolled employees and their dependents, while this Wrap Document uses the term "Participant" to refer to enrolled Eligible Employees and the term "Member" to refer to participating Employers in the PAISBOA HBT. A glossary of the terms and their respective meanings is included in each document.

1.6 Health Plan Component Documents

The Health Plan is available to its Members pursuant to this Wrap Document and the following Component Documents:

Health Plan Options: Self-Funded in the Independence Blue Cross licensed service area with integrated RX program managed by Independence Blue Cross.

- PAISBOA HBT HMO (with Prescription Benefits) (Component Documents 1-3)
- PAISBOA HBT PPO (with Prescription Benefits) (Component Document 4)
- PAISBOA HBT POS (with Prescription Benefits) (Component Document 5)
- PAISBOA HBT HD (with Prescription Benefits) (Component Documents 6-8)

Health Plan Options: Self-Funded in the Highmark Blue Shield licensed service area with integrated RX program managed by Highmark Blue Shield.

- PAISBOA HBT HD (Component Documents 9-10) with Express Scripts integrated RX.

Vision Plan Options: Insured

- Vision Benefits of America, Inc. (Component Document 11).

Dental Plan Options: Self-Funded

- Delta Dental of Pennsylvania (Component Documents 12-13 depending on the Plan option selected). Member schools have the option to select dental benefits through the PAISBOA HBT.

Not All Documents Apply to You. The above list is the full range of benefit options available to Members under the Plan. It is up to Member Schools to elect the options that will be made available to its Eligible Employees. To find out which options are available to you, reference your enrollment material or contact your Human Resources Department.

Read All Documents. You must read this Wrap Document along with the respective Component Documents to understand your benefits!

You must enroll to receive benefits. You must actually enroll to receive benefits under this Plan, as explained in Section Three on Eligibility and Participation. An annual election may be required to enroll in coverage. If so, the details of such annual election are described in the Component Documents or the Member's cafeteria plan.

1.7 Plan Document and SPD

This document and the Component Documents constitute the Plan Document and Summary Plan Description required by ERISA for the Health Plan.

Except for Section Three on Eligibility, if the terms of this Wrap Document conflict with or are less specific than the terms of the Component Documents, then the terms of the Component Documents will control, rather than the terms of this Wrap Document, unless otherwise required by law. The eligibility and participation rules of Section 3 will control over any similar provisions in the Component Documents.

The Health Savings Account (HSA) is an important feature of the High Deductible Health Plan medical option, but the HSA is not sponsored by PAISBOA HBT and is not subject to ERISA. Contact your school's Human Resource Department to determine if your school offers an HSA or Flexible Spending Account (FSA).

Section Two General Plan Identifying Information	
Name of the Plan	Philadelphia Area Independent School Business Officers Association Health Benefit Plan
Type of Plan	Group Health Plan providing medical, prescription drug, dental and vision benefits.
Address of Plan	Philadelphia Area Independent School Business Officers Association Health Benefit Trust 301 Iven Avenue, Suite 315-B Wayne, PA 19087 Tel: (484) 580-8844
Plan Administrator and Agent for Service of Legal Process	Trustees of the Philadelphia Area Independent School Business Officers Association Health Benefit Trust 301 Iven Avenue, Suite 315-B Wayne, PA 19087 Tel: (484) 580-8844 Attention: Heather Gelting
Named Fiduciary	Trustees of the Philadelphia Area Independent School Business Officers Association Health Benefit Trust 301 Iven Avenue, Suite 315-B Wayne, PA 19087 Tel: (484) 580-8844 Chair: Don Kates Vice Chair: Michele Todd Secretary: Hal Davidow Treasurer: Mark Gibbons
Plan Number	501
Plan Sponsor and its IRS Employer Identification Number	Trustees of the Philadelphia Area Independent School Business Officers Association Health Benefit Trust 301 Iven Avenue, Suite 315-B Wayne, PA 19087 Tel: (484) 580-8844 EIN: 46-7526272
Amended and Restated Effective Date	November 1, 2022

Plan Year End	October 31
Health Claims Administrators	Independence Blue Cross Claims Receipt Center P.O. Box 211184 Eagan, MN 55121 Tel: (833) 444-2583 Highmark Blue Shield P.O. Box 1210 Pittsburgh, PA 15230-1210 Tel: (800) 241-5704
Prescription Claims Administrator	IBC Members Independence Blue Cross Claims Receipt Center P.O. Box 211184 Eagan, MN 55121 Tel: (833) 444-2583 Highmark Members Highmark Blue Shield P.O. Box 1210 Pittsburgh, PA 15230-1210 Tel: (800) 241-5704
Dental Claims Administrator	Delta Dental of Pennsylvania P.O. Box 2105 Mechanicsburg, PA 17055-2105 Tel: (800) 932-0783
Vision Claims Administrator	VBA 400 Lydia Street Suite 300 Carnegie, PA 15106 Tel: (800) 432-4966
COBRA Administrator	PlanSource 101 South Garland Avenue Orlando, FL 32801 Tel: (877) 735-0468

Funding Medium and Type of Plan Administration	The Health Plan and Dental Plan are Self-Funded. PAISBOA HBT has entered into contracts with Independence Blue Cross and Highmark Blue Shield (Health and Prescription Drug Plan) and Delta Dental of Pennsylvania (Dental Plan) to provide certain claims administration and other services. Benefits are not guaranteed under those contracts. The Vision Plan is insured. PAISBOA HBT has entered into a contract with Vision Benefits of America and benefits are guaranteed under the contract. PAISBOA HBT is responsible for funding the claim payments and insurance premiums. PAISBOA HBT receives contributions from Members and Participants and holds those assets in trust for the exclusive benefit of Participants and Dependents. Claims are paid out of those assets or under insurance contracts purchased by PAISBOA HBT. To further protect the Health Plan from catastrophic losses, PAISBOA HBT has purchased excess liability insurance in the form of a stop-loss insurance policy.

Section Three
Eligibility and Participation

Section Three of this Wrap Document provides eligibility and participation requirements, and controls over any conflicting or less specific provisions set forth in the various Component Documents.

3.1 Eligible Individuals

The following individuals are eligible for coverage in the Plan:

- An Eligible Employee, as defined in the Glossary of this Wrap Document and as further specified in each Member's Participation Agreement;
- At the option of the Member, an Eligible Retiree, as defined in the Glossary of this Wrap Document; and
- A Dependent, as defined in the Glossary of this Wrap Document.

In order to be a Participant, an Eligible Employee or an Eligible Retiree, as provided above, must:

- Properly enroll in the Plan and properly enroll Dependents in the Plan; and
- Make any required contribution toward the cost of coverage.

In order to be covered as a Dependent, the Spouse, Domestic Partner or Dependent must:

- Properly enroll the individual as a Dependent in the Plan; and
- Make any required contribution toward the cost of coverage.

3.2 Need for Enrollment: Time Limits

New Eligible Employees must enroll in the Plan within 31 days after being hired or after first becoming eligible as described in this document and in the Component Documents.

Thereafter, enrollment is generally limited to the annual enrollment period that occurs before the beginning of each Plan year, unless circumstances give rise to special enrollment rights as described below, or unless other enrollment opportunities are available, such as new elections permitted by a change in status (e.g., switching from full time to part time, going on a leave of absence, a change in cost or coverage related to your benefits, etc.) as described in the Component Documents.

3.3 When Coverage Begins

Coverage is effective as of the date specified by the Member, but in no event shall the effective date be later than the first of the month following 90 days of employment. Coverage for a Participant's Dependent shall be the same day as the Participant's effective date, provided the Participant enrolls a Dependent within 31 days of the date of hire.

3.4 Special Enrollment Rights

In certain circumstances, enrollment may occur outside the open enrollment period, as explained in the Component Documents. The Plan's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you. Contact the Plan Administrator or the Member's Human Resources Department for additional copies.

3.5 Required Contribution Payments

A Participant may be required to contribute to pay for coverage under the Health Plan. The amount of the respective contributions is provided to Participants in notices from the Plan Administrator or Member and may be changed from time to time.

3.6 Termination of Participation

Eligibility for Plan benefits will terminate as provided in the specific Component Document. Generally, this termination will occur either at the end of the month in which the Participant terminates employment with the Member or on the Participant's employment termination date. Other circumstances will also result in the termination of benefits as specified in the Component Documents.

Coverage for the Participant's Spouse and Dependents stops when the Participant's coverage stops and for other reasons specified in the Component Documents (for example, divorce, Dependent's attaining the age limit, and other reasons). Benefits will also cease for the Participant, the Participant's Spouse, Domestic Partner, and Dependents upon termination of the Plan, or the termination of the applicable Plan benefit.

3.7 COBRA Continuation Coverage

If coverage for the Participant, the Participant's eligible Spouse/Domestic Partner, or eligible Dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, or a Child's ceasing to meet the Plan's definition of Dependent) specified in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), then the Participant, the Participant's eligible Spouse/ Domestic Partner, or eligible Dependents may have the right to purchase continuing coverage under the Plan for a limited period of time. In general, COBRA Continuation Coverage is available to "Qualified Beneficiaries," who are Covered Persons whose coverage would otherwise be lost because of a "qualifying event," as described below:

- **Participants.** A Participant may elect COBRA Continuation Coverage, (at the Participant's own expense plus a 2% administration fee) if the Participant's participation under the Plan terminates as a result of Termination of Employment or reduction of hours with a Member.

- **Gross Misconduct.** The Plan Administrator will not offer COBRA Continuation Coverage for the Participant or any of the Participant's Dependents where the Member determines that the Termination of Employment was due to gross misconduct and informs the Plan Administrator of that fact.

- **Dependents.** A Dependent may elect COBRA Continuation Coverage (at the Dependent's own expense plus a 2% administration fee) if the Dependent's participation under the Plan would terminate as a result of one of the following qualifying events:

    - Death of a Participant;

    - A reduction in hours of a Participant;

    - Termination of Employment of a Participant, except for a termination due to gross misconduct;

    - Divorce or legal separation from a Participant;

    - If the Participant cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that coverage was cancelled earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation;

    - A Dependent child ceases to qualify as a Dependent under the Plan; or

    - A Participant becomes entitled to Medicare.

Other individuals who may qualify for COBRA Continuation Coverage:

- **Recipients under Qualified Medical Child Support Orders.** A child of the Participant who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Participant's period of employment with a Member is entitled to the same rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.

- **Children Born To or Placed for Adoption During COBRA Period.** A child born to, adopted by or placed for adoption with a Participant during a period of Continuation Coverage is considered to be a Qualified Beneficiary provided that, the Participant has elected Continuation Coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and lasts for as long as COBRA coverage for other Qualified Beneficiaries of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.

- **Participants and Dependents after FMLA.** If a Participant takes leave under the Family and Medical Leave Act (FMLA) and does not return to work at the end of that leave, the Participant and any Dependents will be entitled to elect COBRA if they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave).

COBRA Continuation Coverage elected in these circumstances will begin on the last day of FMLA leave or the date coverage actually ends, if later.

COBRA Continuation Coverage is the same coverage that the Plan gives to other Participants and their Dependents under the Plan that are not receiving COBRA Continuation Coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Participants or Dependents covered under the Plan, including Open Enrollment and Special Enrollment rights.

Duty to Notify Plan Administrator of Qualifying Events. The Plan Administrator must be timely notified in writing that a qualifying event has occurred to be eligible for COBRA Continuation Coverage.

- Notice must be given by the Employer within **30 days** of the following qualifying events:
  - Termination of Employment of a Participant;
  - Reduction of hours of a Participant;
  - Death of a Participant;
  - Participant becoming entitled to Medicare; or
  - Bankruptcy of Member.
- Notice must be given within **60 days** by the Qualified Beneficiary or its representative, for all other qualifying events not previously mentioned, following either:

- The date of the qualifying event; or
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

- If the Covered Person provides written notice that does not contain all of the information and documentation required on the applicable form (see "Forms" below), such notice will nevertheless be considered timely **if all of the following conditions are met**:
  - Notice is mailed or hand delivered by the deadline;
  - The Plan Administrator is able to determine the identity of the Employer, Participant and Qualified Beneficiaries, and the qualifying event from the Notice; and
  - The Notice is supplemented with the requested additional information and documentation to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator.

If any of the above conditions are not met, the incomplete Notice will be rejected, and COBRA will not be offered.

***Caution*:** If these procedures are not followed or if written notice is not provided to the Plan Administrator within the specified time period, any Participant or Dependent who loses coverage will not be offered the option to elect Continuation Coverage.

***Notice Procedures*:** Any notice must be in writing. Oral notice, or notice by telephone, is not accepted. Participant must mail, e-mail or hand-deliver their notice to the agent of the Plan Administrator at this address:

PlanSource
101 South Garland Avenue
Orlando, FL 32801
Tel: (877) 735-0468

If mailed, the Participant's notice must be postmarked no later than the last day of the specified time period. Any notice provided must state the name of the Plan (Philadelphia Area Independent School Business Officers Association Health Benefit Plan), the name and address of the Participant covered under the Plan, and the name(s) and address(es) of the Dependent(s) who lost

coverage. Participant's notice must also state the qualifying event and the date it happened.

***Forms*:** The Plan's Notice of Qualifying Event Form should be used to notify the agent of the Plan Administrator of a qualifying event. (A copy of this form can be obtained from your Employer or PlanSource.) If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Plan's Notice of a Second Qualifying Event (a copy of the form can be obtained from your Employer or PlanSource) must also state the event and the date it happened. If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Participant's Notice of Disability must also include the name of the disabled qualified Dependent, the date when the Dependent became disabled, the date the Social Security Administration made its determination. Participant's Notice of Disability must include a copy of the Social Security Administration's determination, and a statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled (a copy of this form can be obtained from your Employer or PlanSource).

- **Electing COBRA Continuation Coverage**. The following rules apply to COBRA election:
    - COBRA Continuation Coverage will begin on the date after coverage would have been lost due to the qualifying event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage;
    - Each Qualified Beneficiary has an independent right to elect Continuation Coverage;
    - A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA Election Notice, using the Plan's Election Form and following the procedures specified on the Election Form;
    - Written notice of election must be provided to the Plan Administrator at the address provided on the Plan's Election Form. If mailed, the election must be postmarked no later than the 60th day of the election time period;
    - A Participant or Dependent may change a prior rejection of Continuation Coverage at any time during the specified time period by providing the Notice of Election; provided that continuation coverage will be prospective from the date coverage is elected;

- A Participant or Dependent who fails to elect Continuation Coverage within the specified time period will lose his or her right to elect Continuation Coverage; and

- Unless otherwise indicated, an affirmative election of COBRA Continuation Coverage by a Participant shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.

  The Participant (i.e., the Eligible Employee or former Eligible Employee who is or was covered under the Plan), a Qualified Beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the Notice of Election on behalf of all Qualified Beneficiaries who lost coverage due to the qualifying event described in the Notice.

> ***Note Regarding Failure to Elect***. In considering whether to elect Continuation Coverage, Participant should consider that a failure to continue their group health coverage will affect Participant's future rights under federal law.
>
> The Participant should consider that they have Special Enrollment rights under federal law. The Participant has the right to request Special Enrollment in another group health plan for which the Participant is otherwise eligible (such as a plan sponsored by the Participants spouse's employer) within 30 days after the Participant's group health coverage ends. The Participant will also have the same Special Enrollment rights at the end of Continuation Coverage if the Participant gets Continuation Coverage for the maximum time available to Participant.

- **Length of Continuation Coverage**. COBRA Continuation Coverage is a temporary continuation of coverage. The COBRA Continuation Coverage periods described below are maximum coverage periods.

- **Period of Continuation Coverage for Participants**. A Participant, who qualifies for COBRA Continuation Coverage as the result of Termination of Employment or reduction in hours of employment, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the qualifying event.

  Coverage under this Section may not continue beyond:

  - The date on which the Member ceases to maintain a group health plan;

  - The last day of the month for which the required contributions have been made;

- The date after the COBRA Continuation Coverage election, when the Participant becomes entitled to Medicare; or

- The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by PAISBOA HBT.

- COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Person not receiving COBRA Continuation Coverage (i.e. filing fraudulent claims).

- **Period of COBRA Continuation Coverage for Dependents**. If a Dependent elects COBRA Continuation Coverage under the Plan as the result of the Participant's Termination of Employment or reduction in hours of employment as described above, Continuation Coverage may be continued for up to 18 months measured from the date of the qualifying event. COBRA Continuation Coverage for all other qualifying events may continue for up to 36 months.

  In addition to maximum periods discussed immediately above, Continuation Coverage under this subsection may not continue beyond:

  - The last day of the month for which required contributions have been made;

  - The date after the COBRA Continuation Coverage election, when the Dependent becomes entitled to Medicare;

  - The date which the Member ceases to maintain a group health plan; or

  - The first day after the COBRA Continuation Coverage election, when the Dependent is covered under any other group health plan that is not maintained by the PAISBOA HBT.

  - COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving COBRA Continuation Coverage (i.e., such as fraud).

- **Contribution Requirements for COBRA Continuation Coverage**. Participants and Dependents who elect COBRA Continuation Coverage as the result of one of the qualifying events specified must make Continuation Coverage Payments.

  Participants and Dependents must make the Continuation Coverage Payments monthly prior to the first day of the month in which such coverage will take effect. However, a Participant or Dependent has **45 days** from the date of an affirmative election to pay the Continuation Coverage Payment for the period between the date medical coverage would otherwise have terminated due to the qualifying

event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a **31-day** grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the **31-day** grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which required contributions were made. The **31-day** grace period shall not apply to the **45-day** period for payment of COBRA premiums as set out in this Subsection.

- **Cost of COBRA Continuation Coverage**.

  - **Amount**. Each Qualified Beneficiary may be required to pay the entire cost of Continuation Coverage. The amount a Qualified Beneficiary may be required to pay cannot exceed 102% of the cost to the group health plan (including both Employer and Participant contributions) for coverage of a similarly situated Plan Participant who is not receiving Continuation Coverage (or in the case of an extension of Continuation Coverage due to a Disability, 150%).

  - **Timely Payment of Premiums**. Participants and Dependents who elect COBRA Continuation Coverage as the result of one of the Qualifying Events specified above must make Continuation Coverage Payments.

    Participants and Dependents must make the Continuation Coverage Payment monthly prior to the first day of the month in which such coverage will take effect. However, a Covered Person has 45 days from the date of an affirmative election to pay the Continuation Coverage Payment for the period between the date medical coverage would otherwise have terminated due to the Qualifying Event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a 31-day grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the **31-day** grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which required contributions were made. The **31-day** grace period shall not apply to the initial **45-day** period for payment of COBRA premiums.

- **Limitation on Participant's Rights to COBRA Continuation Coverage**.

  - If a Dependent loses, or will lose medical coverage, under the Plan as the result of a divorce or ceasing to be a Dependent, the Participant or Dependent is responsible for notifying the Plan Administrator within **60**

days of the divorce or loss of Dependent status. Failure to make timely notification will terminate the Dependent's rights to COBRA Continuation Coverage under this Section.

- A Participant or Dependent must complete, sign, and return the required enrollment materials within **60 days** from the later of:
  - Loss of coverage; or
  - The date the Plan Administrator or authorized representative of the Plan sends notice of eligibility for COBRA Continuation Coverage.

    Failure to enroll for COBRA Continuation Coverage during this 60-day period will terminate all rights to COBRA Continuation Coverage under this Plan. An affirmative election of COBRA Continuation Coverage by a Participant or Participant's spouse shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.

- **Second Qualifying Event**. If a second qualifying event occurs during an 18-month extension explained above, coverage may be continued for a maximum of 36 months from the date of the first qualifying event provided that the Qualified Beneficiary notifies the Plan Administrator within **60 days** of the second qualifying event. Such second qualifying events include the death of a Participant, divorce from a Participant, or a Dependent child ceasing to be eligible for coverage as a Dependent under the Plan. Participant must notify the Plan Administrator within **60 days** after the second qualifying event using the Notice Procedures previously stated. (Generally, this second qualifying event extension is not available under the Plan when a Participant becomes entitled to Medicare during the initial 18-month period of Continuation Coverage). **Failure to provide timely notice will result in non-extension of COBRA Continuation Coverage**.

- **Medicare or Other Group Health Coverage**.

  ***Note*:** Participant must notify the agent of the Plan Administrator if any Qualified Beneficiary has become entitled to Medicare and the date of Medicare entitlement.

  Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA Continuation Coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered

under another group health plan (but only after any applicable preexisting condition exclusions of the other plan have been exhausted or satisfied).

- **Extension of COBRA Continuation Period for Disabled Participants**. The period of continuation shall be extended to 29 months (measured from the date of the qualifying event) in the event:

    - The Participant is disabled (as determined by the Social Security laws) within **60 days** after the date of the qualifying event; and

    - The individual provides evidence to the Plan Administrator or authorized representative of such Social Security Administration determination prior to the earlier of 60 days after the date of the Social Security Administration determination, or the expiration of the initial 18 months of COBRA Continuation Coverage.

      In such event, the Plan may charge the individual up to 150% of the amount of the group health plan cost for the COBRA coverage for all months after the 18th month of COBRA coverage, as long as the disabled Participant is in the covered group. The Participant must notify the Plan Administrator if a Participant is deemed no longer disabled, in which case COBRA Continuation Coverage ends as of the first day of the month that is more than 30 days after the Social Security Administration determination.

3.8 USERRA Continuation Coverage

Continuation and reinstatement rights may also be available if a Participant is absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available pursuant to USERRA is included in the Component Documents.

You May Have Rights Under COBRA And USERRA. A Participant's rights under COBRA and USERRA are similar but not identical. Any election that a Participant makes pursuant to COBRA will also be an election under USERRA. COBRA and USERRA may both apply with respect to the continuation coverage elected. If COBRA or USERRA give covered Dependents different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstance.

3.9 Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Participant's non-custodial Child as required by any Qualified Medical Child Support Order (QMCSO) under ERISA §609(a), including a National Medical Support Notice. The Plan has procedures for determining whether an order qualifies as

a QMCSO. A Participant can obtain, without charge, a copy of such procedures from the Plan Administrator or the Member's Human Resources Department.

3.10 Family and Medical Leave

If a Participant is on a Family or Medical Leave of Absence, the Participant may continue coverage in accordance with the Family and Medical Leave Act (FMLA), and the Plan will continue coverage, as if the Participant was Actively at Work if the following conditions are met:

- The required contribution is paid; and
- The Participant has written approval of leave from the Member.

Coverage will be continued for up to the greater of:

- The leave period required by the Family and Medical Leave Act of 1993 and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the Participant returns to Actively at Work status, no new Waiting Period will apply.

3.11 Members

A list of Members (i.e., participating Employers) may be obtained free of charge from PAISBOA HBT. This list is posted at https://phbt.memberclicks.net/member-list

Section Four
Plan Benefits Summary

4.1 Benefits

The Plan provides the Participant and the Participant's Eligible Dependents with benefits as set forth in Section One of this Wrap Document, and as more fully described in the Component Documents.

4.2 Premiums and Contributions

The cost of the benefits provided through the Health Plan will be funded in part by Member contributions and in part by Participant contributions (which may be pre-tax or after-tax). The Plan Administrator or Member will determine and periodically communicate the Participant's share of the cost of the benefits provided through the Health Plan, which may change at any time.

Each Member will pay contributions in an amount that (in PAISBOA HBT's sole discretion) is sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by Participant contributions.

Participant contributions will be used in their entirety prior to using Member contributions to pay for the cost of benefits.

4.3 Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under the Health Plan shall be allocated as determined by the Plan Administrator, in its sole discretion, in a manner that is consistent with applicable fiduciary obligations under ERISA.

4.4 Newborns and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending physician (e.g., a Participant's physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, Plans may not set the level of benefits for out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Section Five
Plan Administration

5.1 Plan Administrator

The Plan Administrator for the Health Plan is identified above in Section Two.

5.2 Power of Plan Administrators

Subject to the limitations of the Plan including any Component Document, the Plan Administrator will from time to time establish rules for the administration of the Health Plan and transaction of its business. The Plan Administrator will rely on the records of the applicable Member with respect to any and all factual matters dealing with the employment and eligibility of an Eligible Employee. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including but not limited to, the sole and absolute discretion to:

- Construe and interpret the various terms of the Plan;
- Decide questions of eligibility to participate in the Plan; and
- Determine the amount, manner, and time of payments of any benefits to any covered person.

The Plan Administrator will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive, and binding.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan at the time it made the decision that is the subject of review.

5.3 Outside Assistance

The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The Health Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Board of Trustees and/or Plan Administrator in the administration of the Plan.

5.4 Delegation of Powers

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable the Plan Administrator to properly carry out such duties. The Plan Administrator as such shall have no

power in any way to modify, alter, add to, or subtract from any provisions of the Plan other than expressly provided in this Wrap Document or the Component Documents.

5.5 Questions

Questions regarding eligibility for benefits or the amount of any benefits payable under the Plan should be directed to the Plan Administrator.

Section Six
Circumstances That May Affect Benefits

6.1 Denial, Recovery or Loss of Benefits

The Participant's benefits (and, except in some cases in the event of the Participant's death, the benefits for the Participant's Eligible Dependents) will cease when participation in the Plan terminates. (See Section Three.) The Participant's benefits will also cease upon termination of the Plan. In addition, there may be a loss of benefits (or benefits may be less than expected) in the following situations: (1) failing to meet precertification or preauthorization requirements, (2) failing to keep the Plan advised of a current address, (3) failing to pay premiums, (4) using out of network providers, (5) application of the Plan's coordination of benefits provisions, and (6) application of the Plan's reimbursement and subrogation provisions.

6.2 Rescission of Coverage

The Plan Administrator reserves the right to rescind coverage under the Plan if an Eligible Employee, Spouse, or Dependent becomes covered under this Plan or receives Plan benefits as a result of an act, practice, or omission that constitutes fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the Eligible Employee, Spouse, or Dependent became covered or received a Plan benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30 days' advance notice to an Eligible Employee, Spouse, or Dependent of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage only has a prospective effect; or
- The cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay premiums (including COBRA premiums) toward the cost of coverage. A rescission is subject to the claims payment and appeal procedures described in Section Nine.

6.3 Reimbursement and Subrogation

In certain circumstances, the Plan may recover overpaid benefits through its rights to subrogation and reimbursement. These Plan rights, if any, are described in detail in the Component Documents.

Section Seven
Amendment or Termination of the Plan

7.1 Right to Amend, Merge or Consolidate

PAISBOA HBT reserves the right to merge or consolidate the Plan and to make any amendment or restatement to the Plan from time to time, including those which are retroactive in effect, subject to requirements under the law. Such amendments may be applicable to any covered person. Terminating a portion of the Plan (including terminating a contract through which a portion of the benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

Any amendment or restatement shall be deemed to be duly executed by PAISBOA HBT when signed by an executive officer of PAISBOA HBT.

7.2 Right to Terminate

The Plan is intended to be permanent, but PAISBOA HBT may at any time and without notice terminate the Plan in whole or in part.

7.3 Effect on Benefits

Except as may otherwise be provided by applicable law or the Component Documents, if the Plan is amended or terminated, covered persons may not receive benefits described in the Plan after the effective date of such amendment or termination. Any such amendment or termination shall not affect a covered person's right to benefits for claims incurred prior to such amendment or termination. If the Plan is amended, covered persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen at any time. If the Plan is terminated, covered persons will not be entitled to any rights under the Plan.

Section Eight
No Contract of Employment

Nothing contained in the Plan shall be construed as a contract of employment with the PAISBOA HBT or any Member, or as a right to be continued in the employment of PAISBOA HBT or any Member, or as a limitation of the right of PAISBOA HBT or any Member to discharge any of the Participants, with or without cause.

Section Nine
Claims and Appeals Procedures

9.1 Claims and Appeals for the Self-Funded Health Plan

For purposes of determining the amount of, and entitlement to, benefits under the Health Plan, the Plan Administrator is the Named Fiduciary (as specified in Section Two). The Named Fiduciary has the full power to make factual determinations and to interpret and apply the terms of the Plan to the benefits provided through the Plan.

To obtain a particular benefit, you must submit to the Claims Administrator for that benefit in accordance with the claims procedures, set forth in the Component Document. The Plan Administrator or Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim.

The Claims Administrator will decide your claim in accordance with reasonable claims procedures set forth in the Component Document, as required by any applicable provisions of ERISA (if ERISA applies) and the ACA. If a claim is denied in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the Claims Administrator for a review of the denied claim. The Claims Administrator will decide the appeal in accordance with reasonable claims procedures, as required by any applicable provisions of ERISA (if ERISA applies) and the ACA. If you do not appeal on time, then you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court, as described below).

See the Component Documents for more information about how to file a claim and for details regarding the claim procedures applicable to a claim.

9.2 Claims Deadline

Unless specifically provided otherwise in a Component Document or pursuant to applicable law, a claim for benefits under this Plan must be made within 12 months after the date of service, except in the absence of legal capacity. It is a Participant's responsibility, or the responsibility of a Participant's designee to make sure this requirement is met.

9.3 Administrative Exhaustion Requirement

All claim review procedures provided in the Plan and the applicable Component Document must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty.

9.4 Limitation on Actions

To the extent not otherwise specified in the applicable Component Document, any legal action for the recovery of any benefits or breach of fiduciary duty must be commenced within one year after the Plan's claim review procedures have been exhausted.

9.5 Failure to File a Request

If a Participant fails to file a request for review in accordance with the claim procedures outlined herein and in the Component Document, a Participant shall have no right of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

9.6 Evidence in Litigation

If the Participant files suit in a state or federal court, only evidence which was previously submitted during the claims and appeals process may be submitted. No new evidence may be submitted in court.

Section Ten
Statement of ERISA Rights

Note: This Statement of ERISA Rights does not apply to any Component Benefit Programs to which ERISA does not apply.

10.1 Participant's Rights

Participants are entitled to certain rights and protections under The Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to the following rights.

10.2 Receive Information about Participant's Plan and Benefits

The Participant may examine without charge at PAISBOA HBT's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

The Participant may obtain, upon written request to PAISBOA HBT, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Wrap Document. The Plan Administrator may make a reasonable charge for the copies.

The Participant may receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case PAISBOA HBT, as Plan Administrator, is required by law to furnish each Participant with a copy of this Summary Annual Report.

COBRA

The Participant may continue health care coverage for themselves, a Spouse/Partner, or Dependents if there is a loss of coverage under the Plan as the result of a qualifying event. The Participant, Spouse, or Dependents may have to pay for such coverage. Review this Wrap Document and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

10.3 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participant and other Plan Participants and beneficiaries. No one, including a Participant's Member Employer or any other person, may fire the Participant or otherwise discriminate against

the Participant in any way to prevent the Participant from obtaining a Plan benefit or exercising his or her rights under ERISA.

10.4 Enforce Your Rights

If the Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that the Participant can take to enforce the above rights. For instance, if a Participant requests a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and does not receive them within 30 days, the Participant may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay the Participant a specified penalty amount per day until the Participant receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If the Participant has a claim for benefits, which is denied or ignored in whole or in part, and if the Participant has exhausted the claims procedures available to the Participant under the Plan, then the Participant may file suit in a state or federal court. In addition, if the Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, then the Participant may file suit in a state or federal court.

If Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees.

10.5 Assistance with Your Questions

If the Participant has any questions about the Plan, the Participant can contact the Plan Administrator at (484) 580-8844 or by mail at PAISBOA HBT, 301 Iven Avenue, Suite 315, Wayne, PA 19087. If the Participant has any questions about this statement or about Participant's rights under ERISA, or if assistance is needed in obtaining documents from the Plan Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Participant may also obtain certain publications about the Participant's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section Eleven
Plan Information

11.1 Health Plan Documents Control

Benefits under the Health Plan are provided solely pursuant to the plan document (which includes this document), and one or more Component Documents. Except for Section Three of this document governing eligibility, if the terms of this Wrap Document conflict with the terms of a Component Document, the terms of the Component Document will control, unless superseded by applicable law. For this purpose, silence in the Wrap Document or a Component Document is not necessarily a conflict or inconsistency.

11.2 Compliance with Federal Mandates

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the Component Document(s), including the following:

- Employee Retirement Income Security Act of 1974 (ERISA);
- Internal Revenue Code of 1986 (Code);
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
- Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
- Women's Health and Cancer Rights Act of 1998 (WHCRA);
- Genetic Information Nondiscrimination Act of 2008 (GINA);
- The Health Information Technology for Economic and Clinical Health Act (HITECH);
- Mental Health Parity and Addiction Equity Act (MHPAEA); and
- Affordable Care Act (ACA).
- Consolidated Appropriations Act (CAA) and Transparency in Coverage Rule (TCR).

11.3 Verification

The Plan Administrators shall be entitled to require reasonable information to verify any claim or the status of any person as an Eligible Employee or Dependent. If the Eligible Employee or Dependent does not supply the requested information within the applicable time limits or

provide a release for such information, such Eligible Employee or Dependent shall not be entitled to benefits under the Plan.

11.4 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against PAISBOA HBT, any of its Members, Eligible Employees, or persons connected therewith, except as provided by law; or

- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provide herein or as provided by law.

11.5 Governing Law

The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the Commonwealth of Pennsylvania, except to the extent such laws are preempted by ERISA or other federal law. Exclusive jurisdiction and venue of all disputes arising out of and relating to the Plan, matters of Plan interpretation or factual determinations made by the Plan Administrator or its delegates is in any court of appropriate jurisdiction in Philadelphia, Pennsylvania.

11.6 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.7 Caption

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

11.8 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the Internal Revenue Service, we inform each Participant that to the extent this communication (including any of the Component Documents) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (a) avoiding any penalties that may be imposed on a Participant or any other person or entity under the Internal Revenue Code or (b) promoting, marketing or recommending to another party any transaction or matter addressed herein. If the Participant is not the original addressee of this communication, the Participant should seek advice from an independent advisor based on the particular circumstances.

11.9 No Assignment of Benefits

Benefits payable under this Plan may not be assigned, transferred or in any way made over to another party by a Participant or Dependent for any reason. The Plan will not recognize any assignment of any rights under this Plan or ERISA, and any attempt to assign such rights shall be void. The payment of benefits directly to a health care or other provider, if any, shall be done as a convenience to the Participant or Dependent and shall not make the provider an assignee. In no event shall any provider of benefits be a "participant" or "beneficiary" under the Plan and no provider shall have standing under ERISA or the claims procedures of this Plan. Neither the Company nor the Plan shall be in any manner liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

11.10 Recoupment

The Plan has the right to recover any mistaken payment, any overpayment, any payment that is made to any individual who was not eligible for that payment or any payment that was required to have been made to the Plan under Section 6.3. The Plan, or its designee, may withhold or offset future benefits payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

11.11 Decisions of Medical Care

The Plan's health care benefits provide solely for the payment of certain health care expenses. All decisions regarding health care will be solely the responsibility of each covered individual in consultation with the personal health care provider selected by the individual. The Plan and any applicable insurance contracts contain rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement. The covered individual in accordance with the Plan's claims procedure may dispute any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and neither the Plan nor the Board of Trustees will have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Plan for the payment of covered expenses.

11.12 Statute of Limitations

A claim or action (i) to recover benefits allegedly due under the Plan or by reason of any law, (ii) to enforce rights under the Plan, (iii) to clarify rights to future benefits under the Plan, or (iv) that relates to the Plan and seeks a remedy, ruling or judgment of any kind against the Plan or a Plan fiduciary or party in interest (collectively, a "Judicial Claim"), may not be commenced in any court or forum until after the claimant has exhausted the Plan's claims and appeals procedures (an "Administrative Claim"). A claimant must raise every argument and/or produce all evidence the claimant believes supports the claim or action in the Administrative Claim and shall be deemed to have waived any argument and/or the right to produce any evidence not submitted to the

Administrator or its delegate as part of the Administrative Claim. Any Judicial Claim must be commenced in the appropriate court or forum no later than 24 months from the earliest of (A) the date the first benefits were paid or allegedly due; (B) the date the Plan Administrator or its delegate first denied the claimant's request; or (C) the first date the claimant knew or should have known the principal facts on which such claim or action is based; provided, however, that, if the claimant commences an Administrative Claim before the expiration of such 24 month period, the period for commencing a Judicial Claim shall expire on the later of the end of the 24 month period and the date that is three months after final denial of the claimant's Administrative Claim, such that the claimant has exhausted the Plan's claims and appeals procedures. Any claim or action that is commenced, filed or raised, whether a Judicial Claim or an Administrative Claim, after expiration of such 24-month period (or, if applicable, expiration of the three-month period following exhaustion of the Plan's claims and appeals procedures) shall be time-barred. Filing or commencing a Judicial Claim before the claimant exhausts the Administrative Claim requirements shall not toll the 24-month limitations period (or, if applicable, the three-month limitations period).

Section Twelve
HIPAA Protected Health Information

12.1 HIPAA Privacy and Protected Health Information

This Section 12 permits the Plan to disclose protected health information ('PHI'), as defined in HIPAA, to the Board, acting solely in its capacity as the sponsor of the Fund and not as the administrator of the Fund, to the extent that such PHI is necessary for the Board to carry out its administrative functions related to the Fund. This Amendment reflects the requirements set forth in 45 C.F.R. §164.504(f) of HIPAA and the related regulations promulgated by the U.S. Department of Health and Human Services (HHS).

12.2 Disclosure To The Trustees

The Plan (or health insurance issuer or HMO with the Plan's permission) may disclose PHI to the Trustees that is necessary for the Trustees to carry out administrative functions related to: eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. All other access to PHI by the Trustees is done in the Board's capacity as the administrator of the Plan and is described in the HIPAA Policies and Procedures for the Plan. The Trustees may use and disclose the PHI provided to it from the Plan (or health insurance issuer or HMO) only for the purposes described in this paragraph.

12.3 Limitations And Requirements Related to The Use and Disclosure of PHI

The Trustees agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:

a) Use and Further Disclosure. The Trustees will not use or further disclose PHI other than as permitted or required by the Plan or as required by all applicable law, including but not limited to HIPAA. When using or disclosing PHI or when requesting PHI from the Plan, the Trustees will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

b) Agents and Subcontractors. The Trustees will require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the Trustees with respect to such information.

c) Employment-Related Actions and Decisions. Except as permitted by HIPAA and other applicable federal and state privacy laws, the Trustees will not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan sponsored by the Trustees.

d) Reporting of Improper Use or Disclosure. The Trustees will promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.

e) Adequate Protection. The Trustees will provide adequate protection of PHI and separation between the Plan and the Trustees by:

(1) ensuring that only the Trustees will have access to the PHI provided by the Fund;

(2) restricting access to and use of PHI to only the individuals identified in 12.3(e)(1) above and only for the functions performed by the Trustees that are described in 12.2 above;

(3) requiring any agents of the Plan who receive PHI to follow the Plan's privacy rules; and

(4) using the following procedure to resolve issues of noncompliance by the individuals identified in 12.3(e)(1) above. Once the Trustees becomes aware of any incident of noncompliance with the HIPAA Privacy Regulations or these policies, the following steps will be taken:

(i) The Plan will be immediately notified, and the Plan and the Trustees will cooperate to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI;

(ii) After an investigation into the alleged incident, those employees who are found to be in violation of these policies or the HIPAA Privacy Regulations will be sanctioned as is deemed appropriate; and

(iii) The Plan and the Trustees will cooperate to create new safeguards and procedures so as to prevent a future incident of noncompliance.

f) Return or Destruction of PHI. If feasible, the Trustees will return or destroy all PHI received from the Plan that the Trustees maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Trustees will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

g) Participant Rights. To the extent required by HIPAA and not already provided by the Board as administrator of the Fund, the Board will provide Fund participants with the following rights:

(1) the right to access to their PHI in accordance with 45 C.F.R. §164.524;

(2) the right to amend their PHI upon request (or the Trustees will explain to the participant in writing why the requested amendment was denied) and incorporate any such amendment into a participant's PHI in accordance with 45 C.F.R. §164.526; and

(3) the right to an accounting of all disclosures of their PHI in accordance with 45 C.F.R. §164.528.

h) Cooperation with HHS. The Trustees will make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Fund's compliance with HIPAA.

12.4 Certification

The Plan will disclose PHI to the Trustees only upon receipt of Certification by the Trustees that the SPD has been amended in accordance with 45 C.F.R. §164.504(f), and that the Trustees will protect the PHI as described in Section 12.3 above.

12.5 Security Standards Requirement

To comply with the applicable Security Standards regulations, the Trustees must:

a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

b) ensure that the adequate separation required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

c) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

d) report to the Plan any security incident of which it becomes aware.

12.6 Amendment

Notwithstanding any other provision of the Fund, this Section 12 may be amended in any way and at any time by the Privacy Officer.

Section Thirteen
Glossary

Capitalized terms used in the Plan have the following meanings:

Code means the Internal Revenue Code of 1986, as amended.

Component Document means the booklet or summary issued by a third-party administrator, a Summary Plan Description, or another governing document prepared by the PAISBOA HBT summarizing the Component Benefit Programs.

Dependent shall mean any person described below:

- **Spouse**. The legally recognized Spouse of a Participant, provided that a Spouse that is legally separated or divorced from the Participant shall not be a Dependent, except for purposes of COBRA Continuation Coverage.
- **Domestic Partner**. In the case where a Member elects to make Domestic Partner coverage available, an Eligible Employee's Domestic Partner that meets the criteria set forth by the Member in the Member's Participation Agreement or other documentation covering eligibility for Domestic Partners.
- **Child**. A Child up to the end of the Plan Year when such Child attains Age 26, who is:
    - A natural Child of a Participant, Spouse or Domestic Partner;
    - A legally adopted Child, which shall be defined as a Child adopted or placed for adoption with the Participant, Spouse or Domestic Partner. The Child's placement for adoption ends upon the termination of the legal obligation;
    - A stepchild;
    - A Child of a Participant required to be covered in accordance with applicable requirements of any Qualified Medical Child Support Order as defined by ERISA Section 609;
    - A Child who is past the limiting age when they:
        - Are a full-time student;
        - Are eligible for coverage under the Plan;
        - Prior to attaining age 26 and while a full-time student were:

- A member of the Pennsylvania National Guard or any reserve component of the U.S. armed forces and were called or ordered to active duty, other than active duty for a training period of 30 or more consecutive days; or

- A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa.C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

  Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

  The Participant will be required to provide proof of eligibility in accordance with the terms listed in the Component Document.

  - A Child with proof of legal guardianship for whom the Participant or the Participant's Spouse is the court-appointed legal guardian.

- **Disabled Child**. A Child, as defined above, regardless of age, who is incapable of self-sustaining employment due to a severe physical or mental condition that is expected to last indefinitely and who is dependent on a Participant or a Participant's Spouse for support and maintenance. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within thirty- one (31) days after the date the Child attains the limiting age under the bullets above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan.

- **Dependent Limitations**. In addition to the above limitations, a Dependent does not include:

  - A Spouse if they are on active duty in the Armed Forces of any country;

  - A grandchild of the Participant or the Participant's Spouse, unless either is named the legal guardian of the Child; or

  - For purposes of coverage under this Plan, if both parents are Participants, a Dependent shall only be covered as a Dependent under this Plan by one parent.

Eligible Employee shall mean:

- An Eligible Employee employed an average of at least 30 hours per week with the Member as determined by the Member based on the rules and regulations for determining full-time Employee status under IRC §4980H.

The term **Eligible Employee** shall not include

- Leased Employees;
- Employees regularly working fewer than 30 hours per week. Members follow the ACA eligibility rules for variable hour employees.
- Collectively bargained employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals;
- Individuals hired through a temporary staffing agency and who are employees of the temporary staffing agency;
- A member of the Member's Board of Trustees, an owner, partner or officer, unless engaged in the conduct of the business on a full time basis;
- An independent contractor or consultant who is paid on other than a regular wage or salary by the Member; or
- A student employee that is not paid or who is not entitled to pay or who is engaged in a federal work study program or similar program of a state or a political subdivision of a state.

Eligible Retiree shall mean a former Eligible Employee of a Member who at the time of retirement, met the Member's age and years of service requirements for coverage under any Component Benefit Program providing retiree coverage. The PAISBOA HBT will no longer permit retirees to be a member of the plan after October 31, 2025.

Employer shall mean a Member of PAISBOA HBT.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Member shall mean a good standing Member of the Philadelphia Area Independent School Business Officers Association, and who is approved for membership, as set forth in the PAISBOA HBT Trust Agreement, Bylaws, and Participation Agreement.

Participant shall mean an Eligible Employee or Eligible Retiree of a Member who meets the eligibility requirements and is covered by the Plan.

Participation Agreement shall mean the agreement signed by the Member and PAISBOA HBT to evidence the Member's participation in the Plan, and the terms and conditions upon which Eligible Employees of the Members will become eligible to participate in the Plan.

Plan shall mean the Philadelphia Area Independent School Business Officers Association Health Benefit Plan.

Plan Administrator shall mean the Executive Director of PAISBOA HBT, as identified in Section Two.

Plan Effective Date shall mean November 1, 2022.

Component Documents

Health Plan: (Self-Funded)

- PAISBOA HBT HMO (Component Documents 1-3)
- PAISBOA HBT POS (Component Document 4)
- PAISBOA HBT PPO (Component Document 5)
- PAISBOA HBT HD (Component Documents 6-8) with Independence Prescription Benefits described at.www.ibx.com
- Highmark BS HDHP (Component Document 9-10)

Vision Plan: (Self-Funded)

- Vision Benefits of America, Inc. (Component Document 11)

Dental Plan: (Self-Funded)

- Delta Dental of Pennsylvania (Component Documents 12-13)