

Summary of the Lock Haven (City of) Group Health Plan

Introduction

This Summary is dated January 1, 2014.

The purpose of this Summary is to explain the provisions of the Lock Haven (City of) (the "Employer") Group Health Plan (the "Plan").

The terms and conditions under which an employee may be eligible for and receive the benefits are set forth in the terms of a certificate issued by First Priority Life (the "Certificate"), which administers the claims under the plan. A copy of this Certificate has been provided to each participating employee (referred to as a "Participant"). Additional copies are available upon request.

For any questions about the benefits under the Plan, please contact the Employer.

The Certificate for this Plan is incorporated into this Summary by reference. This Certificate, along with any amendments or attachments, contains the following information:

- 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 contributions; if any, to the premium payment will be provided by the Employer as a separate document;
- A description of any annual or lifetime caps or other limits on benefits;
- 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 Certificate will contain a general description of the provider network and Participants will receive a list of providers in the network from the claims administrator. A list of network providers can also be found on the claims administrator's website at www.bcnepa.com.
- 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;
- Provisions relating to termination of coverage;
- A summary of the claim procedures;
- Provisions describing the coordination of benefits under this Plan with the benefits provided under another similar plan in which the Participant or his/her spouse are enrolled;
- Any subrogation or reimbursement rights that prevent duplicate payments for health care; and
- Any other benefit limitations and exclusions.

Continued Coverage under the FMLA and USERRA - The references in this provision to FMLA apply only for plan years during which the Employer is subject to FMLA. In addition, FMLA benefits are not available to all employees and are subject to other restrictions and conditions. See the Employer's FMLA Policy to determine eligibility for FMLA benefits.

Notwithstanding any other provision to the contrary, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA") or the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"), medical benefits will continue to the extent required by the provisions of these laws. Participants will be required to continue to pay their portion of the premium for continued coverage as required by the FMLA and USERRA.

Except as otherwise provided in the FMLA, participation may be terminated by the Plan Administrator when notified that the Participant does not intend to return to work after the FMLA leave or at the end of the leave if the Participant does not return to work. However, coverage may be continued to comply with the Employer's leave of absence policies or if required by the American's with Disabilities Act.

Coverage will be reinstated following a military leave as required by USERRA.

COBRA Continuation – This section applies only for calendar years during which the Employer is subject to the provisions of COBRA.

If a Participant's medical coverage (and/or the coverage of any dependent) terminates because of a life event known as a "qualifying event," then the Participant and eligible family members may have the right to purchase continued coverage for a temporary period of time. Qualifying events include termination of employment (other than for gross misconduct), reduction in hours, divorce, death, a child ceasing to meet the definition of dependent, or the Participant's or spouse's eligibility for Medicare (Part A, Part B or both).

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has received timely notification that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the Participant in Medicare, the Employer must notify the Plan Administrator of the qualifying event within 30 days after the qualifying event or the loss of coverage. For other qualifying events, such as divorce or legal separation, or the dependent child's loss of eligibility for coverage as a dependent, the Participant or dependent must notify the Plan Administrator in writing within 60 days after the later of the qualifying event or the loss of coverage. Notice must be provided as required by the initial COBRA notice which has been delivered by the Employer or the Employer's COBRA Administrator. If these procedures are not followed or if the notice is not provided within the 60-day notice period, any spouse or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage by the specified deadline, coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, enrollment of the Participant in Medicare (Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation lasts for up to 36 months. When the qualifying event is the end of employment or reduction in the Participant's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period can be extended: (1) if the Participant or dependent covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and the Plan Administrator is notified in a timely fashion, the Participant and covered dependents can receive up to an additional 11 months of coverage for a total of 29 months. The Participant must notify the Plan Administrator within 60 days after the date of the determination, but before the end of the 18-month continuation period. (2) if any covered dependent experiences another qualifying event while receiving COBRA continuation coverage (such as death of the Participant or divorce), the spouse and dependent children can get additional months of COBRA continuation coverage, up to a maximum of 36 months. (3) If a qualifying event that is termination of employment or reduction of hours occurs within 18 months after the Participant becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the Participant became entitled to Medicare (but the Participant's maximum coverage period will be 18 months).

For additional information about COBRA continuation rights and for any questions about COBRA, please read the initial COBRA notice, a copy of which has been provided to each Participant and his/her covered spouse. Participants can contact the Plan Administrator for another copy.

Election Changes –

An Employee or Participant may change his/her election during a Plan Year only if one of the following events occurs and only to the extent that the election change is consistent with the event:

- (1) the Employee/Participant experiences a Change in Status; Change in Status means (1) a change in the Employee's legal marital status, including marriage, divorce, death of spouse, legal separation or annulment; (2) change in the number of dependents, including birth, adoption, placement for adoption, and death; (3) change in employment status, including any employment status change affecting benefit eligibility of the employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, and a change in worksite (but only if the benefit eligibility is lost or gained as a result of the event); (4) a dependent satisfies or ceases to satisfy any dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and (5) residence change of employee, spouse or dependent affecting an employee's, spouse's or dependent's eligibility for coverage.
- (2) An event occurs that triggers one of the HIPAA Special Enrollment Rights including the employee or his or her Spouse or Dependent previously declining coverage and a new dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; or because he or she had coverage and eligibility for such coverage is subsequently lost because it was exhausted (COBRA) or terminated due to loss of eligibility or loss of employer contributions;
- (3) The Employee, spouse or a Dependent becomes entitled to coverage under Medicare;

- (4) the Employee, spouse or a Dependent loses coverage under a Medicaid Plan under Title XIX of the Social Security Act;
- (5) the Employee, spouse or a Dependent loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act;
- (6) the Employee, spouse, or a Dependent is determined to be eligible for group health plan premium assistance under Medicaid or SCHIP plan;
- (7) the Employee takes an FMLA leave of absence;
- (8) the Employee receives a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order) requiring the Employee to provide coverage for a dependent or requiring another person to provide such coverage;
- (9) There is a significant change in cost (whether an increase or decrease) in one of the Component Benefits. The Employers, in their sole discretion and on a uniform and consistent basis will determine whether the cost increase or decrease is significant or insignificant. For an insignificant increase or decrease, the change in election will be made automatically on a prospective basis;
- (10) There is a significant curtailment of coverage or an addition or significant improvement in a Component Benefits. The Employers in their sole discretion and applied on a consistent basis will determine whether there has been a significant curtailment (with or without loss of coverage) or an addition or significant improvement in a Component Benefit that entitles a Participant to make a corresponding election change. In the case of curtailment that results in a loss of coverage under any Component Benefit, the Employers may permit the Participant to withdraw from the Plan;
- (11) There is a change made under another employer plan and the other plan allows an election change or the other employer plan has a different period of coverage.

An Employee/Participant may make a new election within 30 or 60 days of the occurrence of an event described in this section, as applicable (election changes for events listed under 4, 5, and 6 must be requested within 60 days and all others 30), but only if the election is made on account of and is consistent with the event and if the election is made within the specified time period.

Plan Notices

Special Enrollment Rights

If an Employee declines enrollment for him/herself or his/her dependents (including spouse) because of other health insurance coverage, the Employee may in the future be able to enroll and enroll his/her dependents in this plan, provided that enrollment is requested within 30 days after the other coverage ends. In addition, if a Participant has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the Participant may be able to enroll and enroll his/her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

Additional Information

ConnectCare3

Plan participants are encouraged to utilize the services of ConnectCare3. ConnectCare3 is a free, voluntary, confidential Patient Advocacy, Nurse Navigation and Claims Management program designed to help you and your family get the best medical care. ConnectCare3 can coordinate care between multiple physicians and medical treatment facilities, plus determine the interaction with your health insurance coverage. For more information go to www.ConnectCare3.com.

Claims Procedures

The claims administrator will decide claims and make claim payments in accordance with its reasonable claims procedures, as required by federal and any applicable state laws. A complete description of the claims administrator's claims procedures can be found in the Certificate or can be obtained from First Priority Life.

Amendment and Termination of the Plan

The Employer, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The insurance companies that provide benefits under the Plan may make changes to the Plan either as required by law, as requested by the Employer, or in their own discretion. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits.

No Contract of Employment

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

Privacy and Security

The Plan will use a Participant's or Dependent's 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 required disclosures or for purposes related to treatment, Payment for healthcare, and 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 Employer will:

- Not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer 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 Employer 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 Employer 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 which 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 Employer will, if PHI is or has been stored on the Employer'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 business associate to whom the Plan Sponsor 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 business associate or should reasonably have been known to the agent or business associate;
- Report to the Plan any security incident of which the Employer becomes aware; and
- Use methods to encrypt ePHI that are approved by the Department of Health and Human Services.

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

Definitions.

"Breach" means the unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by HIPAA privacy rules that compromises the security or privacy of the PHI.

"DHHS" means the federal Department of Health and Human Services.

"Electronic PHI" is health information about a plan participant that is in an electronic format. Health information includes information about the individual's past, present, or future physical or mental condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual.

"Health Care Operations" means activities of the Plan related to its health care functions, including quality assessment, claims management, patient advocacy, nurse navigation, care coordination, reviewing competence of health care professionals, evaluating provider performance, health plan performance, cost management, resolution of grievances, or any other related activities.

"Payment" includes all activities regarding the provision of benefits under the Plan.

"Protected Health Information" or "PHI" shall mean any individually identifiable health information in electronic, oral or written form that pertains to the past, present or future mental or physical condition of an individual. Protected Health Information is limited to the information created or received by the Covered Entity or its business associate on behalf of the Health Plans. Protected Health Information also includes information for which there is a reasonable basis to believe that it can be used to identify an individual.

"Unsecured PHI" means PHI that is not secured through the use of a technology or methodology described in regulations to the HITECH Act or otherwise approved by the Secretary of the DHHS.

This Plan is hereby amended and restated as of January 1, 2014.

Lock Haven (City of) (the "Employer")

Richard W. Marcinkavage FOR CITY OF LOCK HAVEN

By (written name): RICHARD W. MARCINKAVAGE

Title: CITY MANAGER