PENN-DELCO School District
2026-2027 Benefit Highlights

ADMINISTRATOR'S EDITION

IT IS TIME FOR YOU TO THINK ABOUT THE BENEFIT OPTIONS YOU AND YOUR FAMILY WILL WANT FOR THE COMING YEAR, WHICH WILL TAKE YOU THROUGH THE PLAN YEAR BEGINNING JULY 1 AND ENDING JUNE 30.

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Your Choice

Administrators Hired BEFORE 7/1/2022

As an eligible employee of Penn-Delco School District, you have benefit options for you and your family to select, which will take you through the 2026-2027 plan year. You have the opportunity to select one of the following medical plan options:

- Personal Choice C2-F1-01 (Core Plan)
- Personal Choice Gold Plan (Optional Plan)
- The Board will contribute 87% of the cost of the C2-F1-01 Plan. You will be responsible for 13% of the cost.
- The Board will contribute 88% of the cost of the Gold Plan. You will be responsible for 12% of the cost.

Administrators Hired AFTER 7/1/2022

As an eligible employee of Penn-Delco School District, you have benefit options for you and your family to select, which will take you through the 2026-2027 plan year. **If you elect medical, you are required to go into the Personal Choice Gold Plan but have the option to buy-up to the Personal Choice C2-F1-01 plan.**

- Personal Choice C2-F1-01 (Core Plan)
- Personal Choice Gold Plan (Optional Plan)
- The Board will contribute 88% of the cost of the Gold Plan. You will be responsible for 12% of the cost for the Personal Choice Gold Plan. If you elect to buy-up, the employee will pay 100% of the difference in premium costs between the optional health plan and core health plan in addition to the employee premium.

Your portion of the cost will be paid through mandatory payroll deductions through a Section 125 Plan. Additionally, you will have the opportunity to select the following health benefits:

- Prescription
- Dental
- Vision
- Penn-Delco School District will also contribute 87% toward your prescription, dental, and vision benefits. You will be responsible for 13% of the costs.

For actual costs, please see the rate sheet available on Employee Navigator.

Medical Plans

	PC GOLD PLAN		PC C2-F1-01	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$0 / $0	$2,500 / $5,000	$0 / $0	$500 / $1,500
Out-of-Pocket Maximum	$3,000 Individual / $6,000 Family	$5,500 Individual / $11,000 Family	$1,000 Individual / $2,000 Family	$3,000 Individual / $9,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Doctor's Office Visits	$35 copay	30% after deductible	$15 copay	30% after deductible
Specialist Visit	$45 copay	30% after deductible	$30 copay	30% after deductible
Preventive Care (includes Pediatric Immunizations, Routine Gynecological Exams)	100%	30%, no deductible	100%	30% no deductible
Maternity First OB Visit Hospital	$35 copay $300 / day; maximum of 5 copayments / admission	30% after deductible	$15 copay 100%	30% after deductible
Inpatient Hospital Services	Unlimited	30% after deductible	Unlimited	30% after deductible
Outpatient Surgery Facility Physician / Surgeon	$250 copay 100%	30% after deductible	100%	30% after deductible
Emergency Room	$250 copay (waived if admitted)	$250 copay (waived if admitted); no deductible	$100 copay not waived if admitted	Covered at In-Network level
Urgent Care Visit	$175 copay	30% after deductible	$70 copay	30% after deductible
Ambulance Emergency Non-emergency	100%	100% no deductible 30% after deductible	100%	100% 30% after deductible
Outpatient Laboratory / Pathology	100%	30% after deductible	100%	30% after deductible
Outpatient X-Ray / Radiology Routine Radiology / Diagnostic MRI / MRA, CT / CTA Scan, PET Scan	$45 copay	30% after deductible	$30 copay $60 copay	30% after deductible
Physical, Speech and Occupational Therapy	1-30 visits: $35 copay 31-60 visits: $45 copay	30% after deductible	$30 copay 30 visits / year	30% after deductible
Restorative Service (including Chiropractic)	$45 copay	30% after deductible	$30 copay 30 visits / year	30% after deductible
Chemo / Radiation / Dialysis	100%	30% after deductible	100%	30% after deductible
Skilled Nursing	100% (120 day / year)	30% after deductible	100% (120 day / year)	30% after deductible
Hospice / Home Health Care	100%	30% after deductible	100%	30% after deductible
Durable Medical Equipment	$45 copay	30% after deductible	30%	50% after deductible
Mental Health Outpatient Inpatient	$45 copay $300 / day; max of 5 copayments / admission	30% after deductible	$30 copay 100%	30% after deductible
Substance Abuse Outpatient Inpatient (Rehab / Detox)	$45 copay $300 / day; max of 5 copayments / admission	30% after deductible	$30 copay 100%	30% after deductible

ASK YOUR ADVOCATE TEAM

PUT OUR TEAM TO WORK TO MAXIMIZE YOUR HEALTHCARE BENEFITS.

Gallagher is ready to help you get the most from your benefit program by providing support from an advocate at no cost to you.

GET ASSISTANCE WITH:

Explanation of benefits

Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?

Prescription challenges

Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization for a medication?

Benefits questions

Are you unsure if the insurance company will pay for a certain procedure?

Difficult situations

Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

Claim issues

Did you receive a bill from a doctor but don't know why?

CONNECT WITH YOUR BENEFIT ADVOCACY CENTER

Email: Bac.penndelcoschooldistrictadvocates@AJG.com

Call Toll Free: 833.380.2604 | M-F 8:30 am - 5:00 pm

Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc. is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Neither Arthur J. Gallagher & Co., nor its affiliates provide accounting, legal or tax advice.
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SECTION 125 PLAN

The Pretax Premium Feature allows you to pay any required healthcare benefit premium payments you must make using "tax-favored" or pretax dollars. If you are required to make contributions for your healthcare benefit options, your contributions will automatically be withheld from your pay on a pretax basis unless you specify otherwise. Your monthly cost for healthcare plan elections will be deducted from your gross pay – before any federal, Social Security, and most state and local taxes are withheld.

Pay-related benefits, such as life insurance and disability income, will not be affected. If your pay after your payroll deductions is less than the Social Security Wage Base, your future Social Security benefits may be slightly reduced because you will be paying less in FICA taxes. If your pay is more than the Social Security Wage Base, your Social Security benefit will not be reduced at all.

CHANGING YOUR ELECTIONS

The benefits you elect during the enrollment period will remain in effect through June 30, 2027. During the year, you can make certain changes only if you have a Qualifying Change in Status or a Special Enrollment Event. If you wish to change your coverage, you must submit the appropriate form. Any benefit changes must be made no later than 30 days after the event and must be consistent with the Qualifying Change in Status or Special Enrollment Event.

A Qualifying Change in Status includes a change in:

- Employee's legal marital status;
- Number of employee's dependents;
- Employment status of employee, employee's spouse or dependent that causes the individual to become or cease to be eligible;
- Judgment, decree or court order for coverage of children;
- Medicare / Medicaid eligibility;
- Residence or worksite of employee, employee's spouse or dependent.

HIPAA SPECIAL ENROLLMENT RIGHTS

Loss of Other Coverage (excluding Medicaid or a State Children's Health Insurance Program).
If you decline enrollment for yourself or for an eligible dependent (including a spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependent's other coverage). ***However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).***

Loss of Coverage for Medicaid or a State Children's Health Insurance Program.
If you decline enrollment for yourself or for an eligible dependent (including a spouse) while Medicaid coverage or coverage in a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. ***However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.***

New Dependent by Marriage, Birth, Adoption or Placement for Adoption.
In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Prescription Drug Program

CVS Caremark

WHAT IS COVERED?

Covered Drugs are those which, under Federal law, are required to bear the legend: "Caution – Federal law prohibits dispensing without prescription," or which require a prescription by state law. Insulin is a covered drug. Benefits are available for up to a 30-day supply at the retail pharmacy and a 90-day supply through mail order.

The following copayment(s) will be made by you for each separate prescription order and refill:

Prescription	Retail Pharmacy (30-day supply)	Mail Order (90-day supply)
Generic	$15 copay	$30 copay
Formulary Brand Name	$35 copay	$70 copay
Non-Formulary Brand Name	$55 copay	$110 copay
Prescription	**1-30 Day Supply**	**31-90 Day Supply**
Specialty Drug	$100 copay	$200 copay
Out-of-Pocket Maximum*	$5,850 Individual / $11,700 Family	

OUT-OF-POCKET MAXIMUM

A specified dollar amount of copayments incurred by a subscriber for prescription medication is an out-of-pocket maximum. The prescription plan will pay for most medications covered at 100%.

BRAND / GENERIC

If you choose a preferred brand or a non-preferred brand when there is a generic available, you will be responsible for the copayment plus the difference between the least costly generic and brand name medication. While you are not required to utilize generic drugs, if you or your doctor prefer the brand name drug, you will have a higher out-of-pocket expense.

PRIOR AUTHORIZATION

Prior authorization promotes clinically appropriate and cost-effective medications. It ensures that prescribed medications are being used for their appropriate indications. Online messaging alerts the pharmacist of the required intervention.

STEP THERAPY

In Step Therapy, the covered drugs you take are organized in a series of "steps," with your doctor approving and writing your prescriptions.

Dental Plan

United Concordia

WHAT IS COVERED?

Participating United Concordia dentists must accept the allowance as payment in full for covered services. Payment for covered services performed by a non-participating dentist will be made directly to you on the basis of a percentage of the Usual, Customary and Reasonable (UCR) allowance as shown or the amount charged, whichever is less.

PARTICIPATING DENTISTS

The Elite Prime Network is licensed dentists who have entered into an agreement with United Concordia to abide by United Concordia's policies regarding services, your portion of the charged fees, and other matters pertinent to United Concordia's obligations to its subscribers. Names of participating dentists can be obtained by calling United Concordia or going to **www.ucci.com**, clicking on Find a Dentist and choosing the Elite Prime Network.

Payment for services performed for you by a non-participating dentist is also calculated by United Concordia on a UCR basis, but United Concordia pays its share to you. You are responsible for payment of the non-participating dentist's total fee, which may include amounts in addition to your share of United Concordia's calculation of UCR and services not covered by the Group Dental Contract.

Your out-of-pocket expenses may be substantially increased by using a non-participating dentist.

PREDETERMINATION OF BENEFITS

If total charges for a treatment plan exceed an amount of $300, you may wish to consider obtaining a predetermination. The predetermination is a condition of approval of the charges for payment. You should ask the attending dentist to submit the claim form in advance of performing services. United Concordia will act promptly in returning a predetermination voucher to you and the attending dentist with verification of your eligibility, scope of benefits and definition of the 60-day period for completion of services.

Plan Maximum: *The Plan provides an annual maximum of $1,800 for all covered services per covered person. The annual maximum begins each January and ends each December. The Plan provides a lifetime maximum for orthodontia at $800 per person.*

United Concordia Flex Elite Prime Network	
DIAGNOSTIC AND PREVENTIVE	
Routine Examinations, Cleanings, Fluoride Treatments and X-rays, Palliative Treatment, Space Maintainers	100%
BASIC	
Basic Restorative (Fillings), Endodontics, Surgical and Non-Surgical Periodontics, Repairs of Bridges, Repairs of Crowns, Inlays, Onlays, Denture Repairs, Complex Oral Surgery, Simple Extractions, General Anesthesia	100%
MAJOR	
Crowns, Inlays, Onlays, Prosthetics (Bridges, Dentures)	100%
ORTHODONTICS	
Diagnostic, Active, Retention Treatment (limited to dependent children under age 19)	50%
DEDUCTIBLES AND MAXIMUMS	
Deductibles	N/A
Calendar Year Maximum	$1,800
Orthodontic Lifetime Maximum	$800

The percentages listed in the coinsurance schedule are payable to participating dentists or subscribers and subject to limitations and exclusions as specified in the Group Dental Contract. This schedule is applied to the payment for services criteria explained elsewhere in this material.

Special Note: Dental benefits may be based on the least costly treatment that conforms to generally accepted dental practice.

Vision Plan

National Vision Administrators

WHAT IS COVERED?

Vision		
Plan Features	**In-Network**	**Out-of-Network[2]**
Exams[1]	100%	100% UCR[3]
Lenses Single, Bifocal, Trifocal and Lenticular	Up to $300 (NVA providers have significant discounts)	Up to $300
Frames	$15	$15
Contact Lenses (in lieu of lenses and frames) **Disposable Contacts** **Specialty Contacts**	 $217 $300	 $217 $300

*[1]**Frequency:** Adults, age 19 and over, are eligible for an examination and one pair of glasses or contacts once every two years during the Plan Year (July – June). Dependents under age 19 are eligible for an examination and lenses once every year during the Plan Year (July – June) and are eligible for frames once every two years during the Plan Year (July – June).*

*[2]**Out-of-Network Benefits:** You must submit your invoice and claim form to NVA directly. Once reimbursed, if you have an outstanding balance, fill out a Vision Reimbursement Form and send it along with your receipt and EOB to Gallagher Benefit Services and you will be reimbursed directly. You may fax to **610.627.0256** or mail to 40 West Front Street, Media, PA 19063.*

*[3]**NVA** will reimburse a set fee of $35 for the examination and the District will self-fund the difference between allowance and the charge for the employee only. Please note dependents under the policy will receive the $35 allowance for non-participating providers.*

HOW YOUR PROGRAM WORKS

Participating Provider: When making your appointment with an NVA participating provider, please notify them that your coverage is administered by NVA and sponsored by Penn-Delco School District.

The provider will telephone NVA to verify your vision care eligibility.

Non-Participating Provider: If you select a non-participating eye care provider, you will be responsible for one hundred percent (100%) of the cost at the time of service. You must submit your invoice and claim form to NVA directly.

Once reimbursed, if you have an outstanding balance, fill out a Vision Reimbursement Form and send it along with your receipt and EOB to Gallagher Benefit Services and you will be reimbursed directly. You may fax to **610.627.0256** or mail to:

40 West Front Street,
Media, PA 19063

For additional information you can access the website at: **www.e-nva.com**. The website allows you to check eligibility, print new cards, review claims, find providers and review benefits.

Flexible Spending Account (FSA)

Benefit Resource, Inc.

HOW DO YOU PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT?

Benefit Resource, Inc. administers and processes your Flexible Spending Account claims. The Benefit Resource, Inc. website and mobile app have everything you need to manage your FSA account(s).

Flexible Spending Accounts are a special tax-saving feature of your District's Flexible Benefits Plan. If you choose to take advantage of this tax-savings feature, you can direct part of your pay to one or both of these accounts. Separate accounts will be set up in your name for each type of account.

A Healthcare Spending Account is for eligible health-related expenses for you or your dependents. You may direct up to a maximum of $3,400 per plan year to a Health Care Spending Account.

A Dependent Care Account is used for daycare expenses that you must pay for eligible dependents while you are working. Please note, a dependent could be a dependent child or a dependent relative. You may direct up to a total maximum amount of $7,500 (per household) per calendar year to a Dependent Care Account.

PLEASE NOTE: The Health Care and Dependent Care Flexible Spending Account elections do NOT roll over from year-to-year; however, up to $680 in unused funds in your Health Care FSA only can roll over into the following plan year. All claims must be submitted to BRI by September 30, 2027.

Contact Information

Benefit Plan	Provider Name	Contact Number	Website
Medical	Independence Blue Cross	215.241.2400	www.ibxpress.com
Dental	United Concordia	800.332.0366	www.ucci.com
Vision	National Vision Administrators	800.672.7723	www.e-nva.com
Prescription Drugs	CVS Caremark	800.875.0867	www.caremark.com
Flexible Spending Account	Benefit Resource, Inc.	800.473.9595	www.benefitresource.com

Legal Notices

AVAILABILITY OF SUMMARY HEALTH INFORMATION

You are offered a series of health plan options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about each health plan option in a standard format, to help you compare plans. You may request paper copies of the SBCs by contacting the plan administrator noted on the first page of this document.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

The provider of our group health plan coverage reports that they have always provided coverage for these services and will continue to do so in consultation with the attending physician and the patient. Any deductibles or coinsurance will apply consistent with other benefits in your plan will apply consistent with other benefits in your plan.

MICHELLE'S LAW

Enacted in 2008, Michelle's Law requires health insurance plans that cover dependent students to continue coverage for up to 12 months if the student takes a medically necessary leave of absence.

- The dependent must have been covered under the plan before taking a leave of absence.
- Applies to employer-sponsored health plans that require dependents to be a student to be eligible for coverage over a certain age.
- Cost of coverage for the employee cannot be changed during this 12-month period.
- Notification requirements and timelines can vary by plan (i.e. The student or representative has 90 days to submit required documentation that establishes eligibility for continued coverage)
- At any point over the 12-month coverage period, if the dependent is no longer considered a student their status on the plan cannot be revoked until after the coverage period.

A plan that considers a dependent ineligible at a certain age is in compliance with Michelle's Law.

NOTICE OF PRIVACY PRACTICES - ISSUED FOR THE GROUP HEALTH PLANS SPONSORED BY THE SCHOOL DISTRICTS AND MUNICIPALITIES THAT PARTICIPATE IN THE DELAWARE COUNTY PUBLIC SCHOOLS HEALTHCARE TRUST

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE AND ISSUE DATE: April 20, 2021

The Delaware County Public Schools Healthcare Trust (the "Trust") is the Plan Administrator of the group health plans sponsored by school districts and municipalities that participate in the Trust. These group health plans are referred to jointly throughout this Notice as the "Plan". This Notice applies to all individuals who participate in the Plan.

Our Responsibilities

The Plan understands that information about you and your health is personal. As a result, this Notice will describe your rights and certain obligations that the Plan has regarding the use and disclosure of your health information. This Notice applies to all records of medical expenses submitted and/or reimbursed under the Plan but this Notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

It is the Plan's responsibility under State and Federal law to maintain the privacy of your health information. The Plan must also give you this Notice of its legal duties and its privacy practices, and it must follow the terms of the Notice that is currently in effect.

The Plan reserves the right to change this Notice and to make the new provisions effective for all health information it maintains, as well as any health information it receives in the future.

If the Notice is changed, a revised version of the Notice will be provided in hard copy to all past and present participants and beneficiaries for whom the Plan still maintains protected health information. You also have a right to request a paper copy of this Notice at any time.

The term "Protected Health Information" ("PHI'') includes all individually identifiable health information (including genetic information) transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

HOW THE PLAN MAY USE OR DISCLOSE YOUR PHI

The Plan is self-insured so the Plan has entered into agreements with third party administrators ("TPAs") to administer the Plan on a day-to-day basis including reviewing and reimbursing any and all claims submitted for reimbursement. As a result of TPAs handling the day-to-day administration of the Plan, the Trust, as the Plan Administrator, receives very little PHI.

The Plan has, however, adopted general policies and procedures that will be followed when the Plan uses and/or discloses PHI. In addition, the Trust (when acting on behalf of the Plan) and the Plan's TPAs are required to follow these general policies and procedures when administering the Plan. Shown below is a summary of these policies and procedures.

Uses and Disclosures that are Required

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it. In addition, the use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy and security regulations.

Uses and Disclosures to Carry Out Payment and Health Care Operations

The Plan and its business associates may use or disclose PHI without your authorization or opportunity to agree or object in order to carry out treatment, payment and health care operations.

Treatment includes but is not limited to determining your eligibility for services requested by your physician. While the Plan generally does not use or disclose PHI for treatment, the Plan is permitted to do so if necessary.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, and plan reimbursement). It includes the act of determining whether particular medical costs are reimbursable under the Plan. The information may identify you, your diagnosis and treatment, and supplies used in the course of treatment.

Health Care Operations include, but are not limited to, general administrative and business functions such as quality assessment and improvement, business planning and cost management purposes.

It also includes arranging for legal services and auditing functions including fraud and abuse compliance programs. This PHI may identify you, your diagnosis and treatment, and supplies used in the course of treatment. Without exception, however, the Plan will never use your genetic information for underwriting purposes.

Uses and Disclosures to the Trust as Plan Administrator and/or to the School District or Municipality as Plan Sponsor

The Plan may disclose PHI to the Trust, as the Plan Administrator, or the school district or municipality for which you work for plan administration functions such as claims processing, auditing or to investigate a potentially fraudulent claim when the Trust and/or the school district or municipality for which you work has amended its Plan documents to protect your PHI as required by federal law. In addition, the Plan may disclose PHI to the Trust and/or the school district or municipality for which you work when authorized by you in writing (see Upon Your Authorization below). This information may identify you, your diagnosis, and treatment or supplies used in the course of treatment. However, at no time will the Plan disclose PHI to the Trust and/or the school district or municipality for which you work for employment-related actions or decisions unless otherwise authorized by you.

In addition, the Plan may use or disclose "summary health information" to the Trust and/or the school district or municipality for which you work for the purpose of making decisions regarding modifying, amending or terminating the Plan. This summary health information may include claims history, claims expenses or type of claims experienced by individuals for whom the Trust and/ or the school district or municipality for which you work has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA This material will be provided in a manner that is consistent with federal law.

Finally, the Plan may disclose to the Trust, or to the school district or municipality for which you work, information on whether you are participating in the Plan.

Uses and Disclosures for which Authorization or the Opportunity to Object is Not Required

Required by Law – The Plan may use and disclose PHI about you as required by law. For example, the Plan may disclose PHI for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority such as a subpoena.
- To report information related to victims of abuse, neglect, or domestic violence where there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence.
- To assist law enforcement officials in their law enforcement duties.

For Public Health – Your PHI may be used or disclosed for public health activities, such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability, or for other health oversight activities.

Upon Your Death - Your PHI may be disclosed to funeral directors or coroners, if permitted by law, to enable them to carry out their lawful duties. Your PHI may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.

For Health and Safety or Government Functions – Your PHI may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Your PHI may be disclosed for specialized government functions, such as protection of public officials or reporting to various branches of the armed services.

Worker's Compensation - Your PHI may be used or disclosed when authorized by and to the extent necessary to comply with Worker's Compensation or other similar programs established by law.

Business Associates - There are some services the Plan provides through contracts with business associates. For example, as explained earlier, the Plan has entered into agreements with TPAs to administer the Plan from day to day. To protect your PHI, the Plan requires its business associates to sign written agreements which state that they will protect the privacy of your PHI. Generally, a business associate may use and disclose PHI for the purposes set forth in this Notice. In addition, the law requires Business Associates to comply with HIPAA.

Upon Your Authorization – In all situations other than those described above, the Plan can ask for your written authorization (on forms provided by the Privacy Officer) before using or disclosing PHI about you, even when you are requesting the disclosure to a third party. For example, if you want an employee of the Trust to act on your behalf to resolve a disputed claim under the Plan, you will need to complete a written authorization stating the Trust's authority to act on your behalf. Further, while the Plan has never sold your PHI or used your PHI for marketing purposes, if it ever wanted to do so, it would need to get your authorization first.

You may always refuse to sign an authorization. Please be aware that once your information has been disclosed, the Plan has no control over any re-disclosure by the recipient. You may always revoke an authorization in writing.

Except to the extent that the information has already been used or disclosed, the Plan will abide by your request to revoke your authorization.

HOW OTHER PERSONS (OTHER THAN THE PLAN) MAY USE OR DISCLOSE YOUR PHI

In addition to those disclosures allowed by the Plan, your PHI may be disclosed by other persons that are subject to the privacy and security rules under federal law. For instance, your PHI may be disclosed to the school district or municipality for which you work by a health care provider if:

- The care is provided to you at the request of the school district or municipality;
- The PHI disclosed is about a work-related illness or injury or a workplace-related medical surveillance;
- The disclosure is required by federal or state law; and
- At the time the care is provided, the provider notifies you in writing that PHI related to medical surveillance and work-related illnesses and injuries are going to be disclosed to the school district or municipality.

MINIMUM NECESSARY STANDARD

Except in those situations set forth below, when using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. The exceptions are:

- Disclosures to a health care provider for treatment;
- Disclosures to you about your PHI;
- Disclosures to the Secretary of the Department of Health and Human Services;
- Disclosures required by HIPAA Privacy Regulations;
- Disclosures which you authorize; or
- Disclosures required by law.

To the extent practicable, this means that the Plan and its Business Associates will only disclose a limited data set. A limited data set is information where individually identifiable information about you is removed except that your age, address (city, state and zip code only) and dates (if reasonably necessary for the purpose of the disclosure) may be retained. The Plan must determine what is reasonably necessary based on the request that it receives.

SECURITY OF EPHI

The Plan and its Business Associates will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of your electronic protected health information ("EPHI") that it creates, receives, maintains or transmits.

YOUR PHI RIGHTS

Right to Request Restrictions and Confidential Communications related to PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. However, the Plan will notify you if it is unable to agree to a requested restriction on how your information is used or disclosed.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Officer at the address set forth at the end of the Notice.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Designated Record Set" includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by, or for, the Plan; or other information used in whole or in part by, or for, the Plan to make decisions about individuals.

Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested PHI will be provided within 30 days if the PHI is maintained on site or within 60 days if the PHI is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

Requests for access to PHI should be made to the Privacy Officer at the address set forth at the end of the Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the Department of Health and Human Services.

You may be charged for the costs of copying, mailing, or other supplies directly associated with your request for your PHI.

Right to Request that Your PHI be Amended

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

This request must be in writing and provide a reason to support the requested amendment.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to act on the amendment within the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the Privacy Officer at the address set forth at the end of the Notice.

You or your personal representative will be required to complete a form to request the amendment of the PHI in your designated record set.

Right to Receive an Accounting of Designated Record Set Disclosures

At your request, the Plan will also provide you with a list of instances in which the Plan disclosed your PHI except for those disclosures exempted by law, for example, those for treatment, payment or healthcare operations purposes, and those authorized by you or your representative. Your request must state a time period which may not be longer than six (6) years (you may request a shorter time period).

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if we give you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Exercising Your Rights Through A Personal Representative

You may exercise your PHI rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or be allowed to take any action for you.

Generally, except where otherwise provided by state law, the Plan will treat the parent or guardian of an unemancipated minor as the minor's personal representative with whom the Plan can share PHI.

The Plan retains discretion to deny access to PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Right to File a Complaint

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the Department of Health and Human Services. Complaints to the Plan can be filed with the Privacy Officer at the address set forth at the end of the Notice. You will not be retaliated against for filing a complaint.

GENERAL OBLIGATIONS OF THE PLAN

The Plan is required to:

- Maintain the privacy of PHI, except as otherwise permitted under this Notice, under law or as authorized by you.
- Provide you with this Notice of the duties and privacy practices with respect to your PHI. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.
- Abide by the general terms of this Notice or such other notice, as amended.
- Notify you if the Plan is unable to agree to:
  - a requested restriction on how your PHI is used or disclosed.
  - grant your request for access to your PHI.
  - grant your request for an amendment to your PHI.
- Account for disclosures of your PHI.
- Accommodate the reasonable requests that you may make to communicate PHI by alternative means or at alternative locations.

NOTICE IN THE EVENT OF A BREACH OF UNSECURED PHI

The Plan goes to great efforts to prevent a breach of your PHI and EPHI. As such, the Plan does not anticipate any such breach. In the unlikely event that PHI or EPHI that has not been rendered unusable, unreadable or indecipherable by technology approved by Health and Human Services (referred to as "unsecured PHI") is accessed, acquired or disclosed as a result of a security breach, the Plan will notify you and, if required by law, the Secretary of the Department of Health and Human Services. An acquisition, access, use or disclosure of PHI in a manner not permitted under HIPAA is presumed to be a breach unless the Plan or Business Associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of various factors. If the breach affects over 500 individuals within a designated State or jurisdiction, notice will be provided to prominent media outlets in that State or jurisdiction.

RIGHT TO AMEND

The Plan reserves the right to amend, modify or alter its information practices and to make the new provisions effective for all PHI it maintains presently and in the future.

STATE LAW

State law may provide for additional protections for your PHI. If the Plan is notified of a state law providing for additional protection for your PHI, you will receive an additional required notice.

CONTACT INFORMATION

If you (i) have any questions or want additional information about this Notice or the policies and procedures described in the Notice, (ii) want to exercise any of the rights described in this Notice, or (iii) want to file a complaint, please contact:

Finance Manager Plan Privacy Officer
Delaware County Public Schools Healthcare Trust
200 Yale Avenue Morton, PA 19070

Please mark all communications (including the envelope and letter) to the Privacy Officer as "Confidential."

NO CHANGE TO PLAN

Except for the privacy rights described in this Notice, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Plan. You should refer to the specific Plan document for complete information regarding any rights or obligations you may have under the specific Plan.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your state for more information on eligibility.

ALABAMA – Medicaid

http://myalhipp.com
855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
http://myakhipp.com/ | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

http://myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.8322 | Fax: 916.440.5676 | Email: hipp@dhcs.ca.gov

COLORADO – Medicaid and CHIP

Health First Colorado (Colorado's Medicaid Program)
https://www.healthfirstcolorado.com
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
https://hcpf.colorado.gov/child-health-plan-plus
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.mycohibi.com/
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid

www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid

GA HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
678.564.1162, Press 1
GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564.1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
https://www.in.gov/medicaid/ | 800.457.4584
Family and Social Services Administration
http://www.in.gov/fssa/dfr/ | 800.403.0864

IOWA – Medicaid and CHIP (Hawki)

Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
800.338.8366
Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
800.257.8563
HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
888.346.9562

KANSAS – Medicaid

https://www.kancare.ks.gov/
800.792.4884 | HIPP Phone: 800.967.4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: https://kynect.ky.gov | 877.524.4718
Medicaid: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Medicaid: www.ldh.la.gov/healthy-louisiana
Customer Service Line: 888.342.6207
Medicaid Email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP):
https://www.ldh.la.gov/lahipp
LaHIPP Phone: 877.697.6703 | LaHIPP Email: La.HIPP@la.gov
LaHIPP Fax: 888.716.9787
LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US
800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium:
https://www.maine.gov/dhhs/ofi/applications-forms
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

https://www.mass.gov/masshealth/pa
800.862.4840 | TTY: 711 | Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

https://mn.gov/dhs/health-care-coverage/
800.657.3672

MISSOURI – Medicaid

http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573.751.2005

MONTANA – Medicaid

http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
800.694.3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid

http://dhcfp.nv.gov
800.992.0900

NEW HAMPSHIRE – Medicaid

https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
800.356.1561
CHIP: http://www.njfamilycare.org/index.html
800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392

NEW YORK – Medicaid

https://www.health.ny.gov/health_care/medicaid/
800.541.2831

NORTH CAROLINA – Medicaid

https://dma.ncdhhs.gov
919.855.4100

NORTH DAKOTA – Medicaid

https://www.hhs.nd.gov/healthcare
844.854.4825

OKLAHOMA – Medicaid and CHIP

http://www.insureoklahoma.org
888.365.3742

OREGON – Medicaid and CHIP

http://healthcare.oregon.gov/Pages/index.aspx
800.699.9075

PENNSYLVANIA – Medicaid and CHIP

https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
800.692.7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

http://www.eohhs.ri.gov
855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

http://www.scdhhs.gov
888.549.0820

SOUTH DAKOTA – Medicaid

http://dss.sd.gov
888.828.0059

TEXAS – Medicaid

https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
800.440.0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542
Adult Expansion: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/
CHIP: https://chip.utah.gov/

VERMONT – Medicaid

https://dvha.vermont.gov/members/medicaid/hipp-program
800.250.8427

VIRGINIA – Medicaid and CHIP

https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid and Chip: 800.432.5924

WASHINGTON – Medicaid

https://www.hca.wa.gov/
800.562.3022

WEST VIRGINIA – Medicaid and CHIP

https://dhhr.wv.gov/bms/ or http://mywvhipp.com/
Medicaid: 304.558.1700
CHIP Toll-free: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP

https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
800.362.3002

WYOMING – Medicaid

https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
800.251.1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 4/30/2026)

Penn-Delco School District
2026-2027 Benefit Highlights
ADMINISTRATOR'S EDITION

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting

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