PSEACare Dental & Vision Plan Coverage

Quality/Affordable Insurance for Retirees

Program Information:

- PSEA-Retired Members and eligible dependents can enroll in the PSEACare Dental & Vision Insurance.
- Enroll throughout the year into one of six coverage periods. (Jan., Mar., May, July, Sept. or Nov.) Payments accepted within 60 days prior to the start of the coverage period.
- Payments can be made by your choice of monthly ACH withdrawals or yearly by check.

Dental Coverage Overview:

- Dental program is administered by United Concordia utilizing the **Advantage Plus** Network of Dentists. Visit www.ucci.com, click on **Find A Dentist** and select the Advantage Plus network for a list of providers in your area.
- For general questions regarding this program please call the PSEA Health & Welfare Fund @ (800)944-7732, ext. 7024. For claim and network questions please call UCCI @ (800)332-0366, group number 898381001

Vision Coverage Overview:

- Vision program is administered by National Vision Administrators (NVA). For a list of participating providers, visit www.e-nva.com, click on **Find Provider** and enter group/sponsor number 00350124.
- For general questions regarding this program please call the PSEA Health & Welfare Fund @ (800)944-7732, ext. 7024. For claim and network questions please call NVA @ (800)672-7723.

2018/19 Cost of Coverage for PSEACare Dental & Vision Plan:

Individual Coverage Annual Cost = $463 / Individual Coverage Monthly ACH Payment Option = $39

Two-party Coverage Annual Cost = $926 / Two-party Coverage Monthly ACH Payment Option = $78

Family Coverage Annual Cost = $1389 / Family Coverage Monthly ACH Payment Option = $117

Rates shown are guaranteed for the 12 month benefit contract period.

While premiums can change at each annual enrollment period, it is worth noting that PSEACare premiums have not increased since 2009.

Opting out of the program can only occur at each annual enrollment period. For those who pay via ACH, notification to the PSEA Health & Welfare Fund must be made at least 30 days prior to the start of the next contract year.

For additional information please call 1-800-944-7732 Ext. 7024

Details of benefits are listed on the reverse side →

PSEACare Dental & Vision Coverage Summary

Dental Benefit Coverage [1]	In-Network	Out-of-Network Reimbursement
Diagnostic/Preventive Routine Oral Examinations and Cleanings - *Twice during the 12 month contract period* Routine Bitewing X-rays - *Twice during the 12 month contract period* Full Mouth X-rays - *Once every 36 months* Flouride, Sealants, and Space Maintainers	**Covered in Full** (100% of MAC*)	Covered at 100% (100% of MAC*)
Basic Services Basic Restorations - Amalgam or White Resin Restorations - White resin coverage available for all teeth Simple Extractions Endodontics - Pulpal therapy and root canal filling Denture Repair	**Covered at 70%** (70% of MAC*)	Covered at 60% (60% of MAC*)
Major Services Major Restorative - Inlays, onlays, single crowns (caps) Oral Surgery - Extraction and oral surgery procedures Prosthodontics - Construction & repair of dentures, bridges and partials Denture Relining - Relining existing dentures Periodontics - Surgical & non-surgical treatment of gum disease	**Covered at 60%** (60% of MAC*)	Covered at 50% (50% of MAC*)
Program Deductibles & Maximums		
Contract Year Deductible - *Deductible does not apply to Diagnostic & Preventive Procedures*	**$50 Per Person**	
Contract Year Program Maximum Benefit Payments	**$1,600 Per Person**	

**MAC - Maximum Allowable Charge of United Concordia. Out-of-Network Providers may bill above the maximum allowable charge*

Vision Benefit Coverage [1]	In-Network	Out-of-Network Reimbursement
Examination	Covered in Full	$27 Maximum
Tonometry - *One vision examination every 24 months*	Covered in Full	$3 Maximum
Frames - *Frames and one pair of lenses every 24 months*	$100 Retail Allowance	$30 Maximum
Lenses - Single Vision (pair)	Covered in Full	$24 Maximum
Lenses - Bifocal (pair)	Covered in Full	$36 Maximum
Lenses - Trifocal (pair)	Covered in Full	$46 Maximum
Lenses - Aphakic (pair)	Covered in Full	$72 Maximum
Low Vision Aids (*every 24 months, in lieu of exam, lenses and frames*)	Covered in Full up to $250	$250 Maximum
Contacts - Medical necessity (*every 24 months, in lieu of exam, lenses and frames*)	Covered in Full up to $250	$250 Maximum
Contacts - Cosmetic (*every 24 months, in lieu of exam, lenses and frames*)	Covered in Full up to $75	$75 Maximum

Benefits also include In-Network discount prices on lens options such as UV Coating, Scratch resistance, Progressive lenses, etc.

[1] **Subject to limitations and exclusions, see Summary Plan Document for details at www.pseahwf.org/retired_members/**

PSEACare Dental & Vision Enrollment Form

Member's Information:

Name: ________________________________

Address: ________________________________

City: ____________________ *State*: ____ *Zip Code*_________

SSN # ____________________ *Telephone* (   ) ___________

Birthdate: ____ /____ / _______ *Gender:* ___ *Male* ___*Female*

Effective Date for Benefit coverage contract period (please circle one):

July 1, 2018 **September 1, 2018** **November 1, 2018**

January 1, 2019 **March 1, 2019** **May 1, 2019**

Spouse's Information (if enrolling spouse):

Name: ___________________________ *Gender:* __ Male __ Female

Social Security # ___________________ *Birthdate:* ___ /____ / _____

Dependent's Information (if enrolling dependent up to age 26):

Name: ___________________________ *Gender:* __ Male __ Female

Social Security # ___________________ *Birthdate:* ___ /____ / _____

Dependent's Information (if enrolling dependent up to age 26):

Name: ___________________________ *Gender:* __ Male __ Female

Social Security # ___________________ *Birthdate:* ___ /____ / _____

I certify the statement made herein is complete and true to the best of my knowledge and belief.

____

Signature

2018/19 PAYMENT OPTIONS

Monthly Rates:			Annual Rates:		
	Individual	$39		Individual	$463
	Two-Party*	$78		Two-Party*	$926
	Family*	$117		Family*	$1,389

Note: Monthly premium rates include a $5 per participant per year processing charge.

* Includes dependent children up to age 26 or any age with certified disability.

Please Choose Payment Option: (Please check one) Monthly ______ Annual______

If you choose to pay monthly, please complete and sign the ACH Payment Authorization form on the back on this page.

Questions? Please contact us at
1-*800-944-7732*
Ext. 7024

Please send check payable to:
PSEA Health and Welfare Fund
PO Box 1724
Harrisburg PA 17105-1724

HWF Use Only:
*Carrier:*__________
*ACH:*___________

MONTHLY ACH PAYMENT AUTHORIZATION

PSEACare premiums are established each 12-month contract period by the Pennsylvania State Education Association Health & Welfare Fund ("Fund") Trustees and are subject to change at each renewal.

When signing up for the ACH payments, please send a check in the amount of the first month's payment. The submitted check will be used to make the first month's payment and will be the account from which all future payments will be made via ACH. ACH payments will begin in the first month of the benefit period.

Please send completed enrollment form (front side of this page), this ACH Authorization, and check payable to:

PSEA Health and Welfare Fund
P.O. Box 1724
Harrisburg PA 17105-1724

Questions? Contact us at 1-800-944-7732 ext. 7024

2018/19 Check amount for first month's payment: Individual $39 or Two-Party $78 or Family $117

I authorize the PSEA Health & Welfare Fund to make automatic deductions from my checking account for the PSEACare monthly payments. _________ (please initial)

I understand that by initialing above, I am authorizing monthly charges from the checking account provided to the Fund for my PSEACare premium. This charge will be reflected as a debit on the regular account statement for the checking account provided. I further understand that the amount of these premiums may change at the end of each 12-month contract year and that the amount debited from my account for the PSEACare premium may also change to match the premium rate. **Payments will be deducted on or about the 15th of each month.**

I understand that although I am making monthly payments, I am responsible for all twelve (12) months of the PSEACare premium for the coverage I have elected. If I wish to stop participating in PSEACare, I must notify the Fund no less than thirty (30) days before the date of my annual contract renewal. (*For example, assume that your annual contract renewal date is July 1. You must notify the Fund on or before June 1 that you do not wish to continue to participate in PSEACare.*)

I agree to notify the Fund in writing of any changes to my account information at least fifteen (15) days in advance of the scheduled payment date. I understand that if the scheduled payment date falls on a weekend or holiday, the payment may be executed on the next business day. Further, I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the scheduled payment date.

If the ACH transaction is rejected by my bank for non-sufficient funds ("NSF"), I authorize the Fund, at its discretion, to reprocess the charge again no more than thirty (30) days later than the initial charge. In addition, I agree to remit all NSF charges for each attempt that was returned "NSF." The Fund will recoup any bank charges incurred for the "NSF" transaction and its recovery through an electronic charge that is separate from the regular monthly charge for your premium.

I understand that if there are insufficient funds to pay the PSEACare premium and the Fund has attempted to seek electronic payment, the Fund may discontinue my coverage under PSEACare if I fail to make alternative arrangements with the Fund within 15 days of the original ACH charge for the payment of my premium.

I agree not to dispute the premium charge listed above with my bank provided the premium charge is consistent with the information agreed to in this Form. I release the Fund from any claim, demand, or liability relating to the information that I provide. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Signature: ____ **Date:** ___________________

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