PSEACare

An Explanation of your Dental and Vision Program

Offered by:

PSEA Health and Welfare Fund
400 North Third Street
P.O. Box 1724
Harrisburg, PA 17105-1724

(800) 944-7732, ext. 7024
(717) 255-7024

PSEA HEALTH AND WELFARE FUND

PSEACARE FOR RETIREES AND ELIGIBLE DEPENDENTS.

BENEFITS UNDER THIS PROGRAM ARE AVAILABLE TO:

- Members of PSEA-Retired
- Spouses and Domestic Partners of PSEA-Retired members
- Dependent children of PSEA-Retired members * up to age 26 or any age with certified disability

IMPORTANT

While this booklet describes the principal features of the PSEACare Dental and Vision Programs, it is not to be considered the contract of benefits and provisions. The PSEA Health and Welfare Plan, Trust, Dental Program, and Vision Program are the controlling documents. The benefit explanations contained herein are subject to all provisions of the controlling documents, and do not modify such documents in any way nor shall the subscriber accrue any rights because of any statement in or omission from this Explanation. This Explanation is for informational use only.

DENTAL PROGRAM DESIGN

Your dental program is designed to help meet the cost of dental care. Payment is made on the basis of United Concordia's Maximum Allowable Charge (MAC) for the procedure(s) performed. Dental benefits are divided into ten categories. They are:

DIAGNOSTIC	Procedures to assist dentists to evaluate existing conditions and dental care required – to include exams, diagnosis, and x-rays (twice during contract period); full mouth x-rays (every thirty-six months).
PREVENTIVE	Prophylaxis, including cleaning, scaling and polishing (twice during contract period).
BASIC RESTORATIVE	Amalgam and Resin Restorations (white fillings) covered.
MAJOR RESTORATIVE	Inlays, onlays, single crowns are benefited where basic restorative services are not adequate.
ORAL SURGERY	Extraction and oral surgery procedures, including pre-and post-operative care. General anesthesia is covered when used in conjunction with covered oral surgical procedures.
ENDODONTIC	Procedure for pulpal therapy and root canal filling.
PERIODONTIC	Surgical and Non-Surgical procedures for treatment of gums and supporting structures of teeth.
PROSTHODONTICS	Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures.
DENTURE REPAIR	Repair of broken dentures.
DENTURE RELINING	Relining or rebasing of dentures more than six months old, and not more than once in any 36 consecutive months.
IMPLANTS	Implant placement, Surgical services, Supporting structures, Implant/Abutment supported prosthetics, Other Implant related services.

Dental Benefit Coverage [1]	In-Network	Out-of-Network Reimbursement
<u>Class 1 - Diagnostic/Preventive</u> 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 at 100% (100% of MAC*)	Covered at 100% (100% of MAC*)
<u>Class 2 – Basic Services</u> Basic Restorations – Amalgam or White Resin - White resin coverage available for all teeth Simple Extractions Endodontics – Pulpal therapy and root canal filling Denture Repair	Covered at 70% (70% MAC*)	Covered at 60% (60% MAC*)
<u>Class 3 – Major Services</u> Major Restorative – Inlays, onlays, single crowns (caps) Oral Surgery – Extraction and oral surgery procedures Prosthodontics – Construction/Repair of dentures, bridges etc Periodontics – Surgical and non-surgical treatment of gum disease	Covered at 60% (60% MAC*)	Covered at 50% (50% MAC*)
Implants (Implant coverage is available after being enrolled in the plan for at least 12 months)	Covered at 50% (50% MAC*)	Covered at 50% (50% MAC*)
<u>Program Deductibles and Maximums</u> Contract Year Deductible (Deductible does not apply to Class 1 Services) Contract Year Program Maximum Benefit Payments - Program Maximum Benefit Excludes Class 1 Claims	$50 per person $2,250 Per Person	

Rider to Schedule of Benefits and Schedule of Exclusions and Limitations

Implantology Rider

This Rider is effective on the date issued to the Policyholder and is attached to and made a part of the Certificate of Insurance.

Except where specifically changed by this Rider, all of the terms and conditions of Your Plan's Certificate of Insurance, Schedule of Benefits and Schedule of Exclusions and Limitations also apply to this Rider. In the event of a conflict between the provisions in this Rider and the Certificate of Insurance, Schedule of Benefits or Schedule of Exclusions and Limitations, this Rider shall control.

SCHEDULE OF BENEFITS

The Company will pay implantology benefits for eligible Members for the following Covered Services equal to 50% of the Maximum Allowable Charge.

Implantology Services

Implant Placement
- Endosteal
- Eposteal
- Transosteal
- Mini

Surgical Services
- Second stage implant surgery
- Implant removal
- Debridement of periimplant defects
- Debridement and osseous contouring of periimplant defect
- Bone graft at time of implant placement

Supporting Structures
- Connecting bar
- Prefabricated abutment
- Custom fabricated abutment

Implant/Abutment Supported Prosthetics
- Removable Dentures
- Fixed Dentures (Hybrid Prosthesis)
- Single Crowns
- Fixed Partial Dentures

Other Implant Related Procedures
- Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla
- Sinus augmentation, lateral open approach
- Sinus augmentation, vertical approach
- Bone replacement graft for ridge preservation
- Cone beam diagnostic imaging (for capture and interpretation only)

Deductible(s)

The annual Deductibles indicated on the Schedule of Benefits will be applied to implantology services.

Maximum(s)

The annual Maximum indicated on the Schedule of Benefits will be applied to implantology services.

Waiting Period(s)

This plan has a Waiting Period for Implantology dental services which must be satisfied. The Waiting Period is 12 months which means that the waiting period will not be satisfied until 12 months of the policy have expired.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

The Schedule of Exclusions and Limitations is amended as follows:

Exclusions

Any exclusions relating to implantology services are deleted.

Limitations

The following limitation does not apply to the above listed implantology procedures:

> An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist.

The following limitations are added to the Schedule of Exclusions and Limitations:

All implantology services are limited to Member's age eighteen (18) and older.

All implantology services (not inclusive of prosthetics) are limited to one (1) per tooth per lifetime.

Implant prosthetics limited to one (1) per five (5) year(s).

Mini implants limited to one (1) per tooth per lifetime and a maximum of four (4) per arch per lifetime, in support of a complete removable denture.

Cone beam diagnostic imaging limited to one (1) digital image per lifetime.

Cone beam imaging capture and interpretation for TMJ series are excluded.

Cone beam imaging for post processing are excluded.

Preventive Incentive Rider

This Rider is effective on the date issued to the Policyholder and is attached to and made a part of the Certificate of Insurance.

Maximums

The Maximums listed on the Schedule of Benefits do not apply to the following Covered Service(s):

- Exams for all Members;
- Prophylaxis (cleanings) for all Members;
- All X-rays for all Members;
- Fluoride treatments for all Members;
- Sealants for all Members;
- Palliative treatment (emergency treatment of dental pain) for all Members.

About Your Administrator

United Concordia Companies, Inc. (UCCI) is the administrator of your plan. Its staff is composed of qualified professional administrative personnel who are available to assist you if needed. Their toll-free number is **(800) 332-0366,** and their website is **www.ucci.com.** To find Concordia Advantage Plus Network participating providers, please call the toll-free number or visit their website.

Identification Cards

An identification card is provided to individuals enrolled in the PSEACare Dental Program. This card will contain all information necessary to complete the member portion of the dental claim form. The identification card is **NOT** an eligibility card; it is for information only. Identification cards are available by accessing www.ucci.com and logging in to My Dental Benefits.

Using Your Dental Plan

By using a participating provider, you will have direct access to your benefits. To find a participating provider, visit "Find A Dentist" on the United Concordia website at *www.unitedconcordia.com*. The dental office will either ask you for your carrier identification card or the member identification assigned by the carrier. This will allow the dental office to file claims on your behalf for services rendered. You will be responsible for any co-insurance/deductible payments to the dental provider. In most instances, a non-participating dental office will also file claims on your behalf. If they do not, ask for a completed A.D.A. approved claim form and mail to:

United Concordia Companies Inc.
P.O.Box 69421
Harrisburg, Pa. 17106-9421

Please note that benefits under your Dental Plan may be coordinated with any other dental benefits you may have available under another group health plan. UCCI is responsible for the coordination of benefits. The rules that UCCI uses to coordinate benefits are outlined at section 11below. In addition, if your dental claims are caused because of the actions of a third party, UCCI or the Fund may take action to recover these monies from the third party. This is called "subrogation". The subrogation rules are described below.

Payment for Services

Payment is made on the following basis:

- Participating Dentists: Services performed by Participating Dentists are paid on the Maximum Allowable Charge (MAC) as determined by UCCI. Payment for services is made to participating dentists for contractual benefits covered. The administrator will advise patients/members of any charges not payable by the Fund, and therefore, these charges are the responsibility of the patient/member. Those are generally co-payments, deductibles, charges after annual maximums have been exceeded, or charges for services not covered by the contract.

- Non-Participating Dentists: For services performed by non-participating dentists, payment is made according to the MAC level. Payment is sent by UCCI to the member. The member is also advised of his/her responsibility for co-payments, deductibles, or charges above the maximum, in accordance with the terms of the group Master Contract. The patient is responsible for making payment directly to the dentist.

Maximum Allowable Charge

The PSEA Health and Welfare Fund's PSEACare dental program provides benefits based on the Maximum Allowable Charge (MAC) of UCCI.

The maximum allowable charges are based on:

Data received from two national resources;

UCCI's own experience; and

Competitive information.

Predetermination

Predeterminations are used to determine member eligibility and to review the treatment plan for the extent of coverage. This process allows both the member and the dentist to know in advance if the procedure will be covered and what the allowance will be. As a result, the member knows ahead of time what his/her out-of-pocket expense will be. Predetermination is recommended for extensive treatment plans, such as crowns, inlays, prosthodontics and periodontics.

Predetermination also allows the administrator to review the proposed services for propriety and quality. Frequently there may be alternate methods for treating a dental condition. For example, a tooth can be restored with a filling or a crown. If an alternate (and perhaps less expensive) course of treatment which meets accepted dental standards is available, the administrator may recommend it. The member is not required to accept the less expensive procedure, but he or she will be responsible for any additional charges if the more expensive treatment is chosen.

Predetermination decisions **do not** guarantee payment. Payment also depends on patient eligibility and coverage at the time service is rendered and must be verified at such time by the administrator.

Claims and Appeal Procedures

UCCI attempts to process all claims within a reasonable processing time. If a claim will be delayed more than thirty (30) days, the administrator will notify the subscriber in writing stating the reason for delay.

Routine claims questions can be sent to UCCI, P.O. Box 69421, Harrisburg, PA 17106-9421, or call direct **(800) 332-0366**.

If a claim for benefits is denied, either in part or in whole, you will receive a written notice explaining the reason or reasons for the denial of benefits. If the information received with the claim is incomplete, the notice will tell you what additional facts or materials are needed and why.

You may appeal a denial of benefits for any claim by sending a letter to the PSEA Health and Welfare Fund, 400 North Third St. P.O. Box 1724, Harrisburg, Pa. 17105-1724, stating why you think your claim should not have been denied, along with any additional information, documents, data or comments you think have a bearing on your claim. Your appeal must be made within one hundred twenty (120) days after you have been notified of the denial of benefits. In preparing your appeal, you or your representative will have the right to examine documents pertinent to your appeal.

The PSEA Health and Welfare Fund trustees will review all the facts on which the original decision was based and any additional information you have provided in your appeal. You will receive a final decision in writing within sixty (60) days of the date your appeal is received. Where there are special circumstances requiring, for example, extensive review by medical specialists of technical records, a final decision may take longer than sixty (60) days. In that case, you will be informed promptly of the need for additional information and further review time.

For a full description of claim appeal procedures, including claims for on-going and urgent care treatment, please see Section X below.

Exclusions

No payments shall be made for the following:

- Services or supplies which are provided to a patient by any federal or state government agency or by any municipality, county, or other political subdivision.
- Charges for which benefits or services are provided the patient by any hospital, medical or dental service corporation, any group insurance, franchise or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions, unless the coordination of benefit provisions provide otherwise.
- That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Plan's benefits would be in excess to the third-party benefits and therefore, the plan would have right of recovery for any benefits paid in excess.
- For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered.
- For treatment of fractures and dislocations of the jaw.
- For treatment of malignancies or neoplasms.
- For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
- For treatment and appliances for bruxism (night grinding of the teeth).
- Preventative restorations.
- Incomplete treatment (for example, but not limited to, patient does not return to complete treatment) and temporary services (for example, but not limited to, temporary restorations).
- Specialized procedures and techniques (for example, but not limited to, precision attachments, copings, and intentional too canal treatment).
- Procedures that are:
    - Part of a service but are reported as separate services; or
    - Reported in a treatment sequence that is not appropriate; or
    - Misreported or that represent a proecure other than the one reported.
- Services or supplies with respect to congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
- Services or devices when teeth are present that increase the vertical dimension of an occlusion to normal or otherwise.
- Services or supplies for cosmetic purposes, including, but not limited to, charges for personalization or characterization of dentures.

- General anesthesia and analgesia, except when administered with oral surgical procedures.
- Services or supplies for which the Covered Person would have no legal obligation to pay in the absence of this or any other similar coverage.
- Services rendered or supplies furnished or devices started prior to the effective eligibility date of a patient.
- Services rendered or supplies furnished or devices finished after the termination date of a patient's eligibility for benefits under the plan.
- Claims submitted to the insurance carrier for services rendered in excess of one year old.
- Preventive plaque control programs, including oral hygiene instructions.
- Periodontal splinting, equilibration and gnathological recordings.
- Myofunctional therapy.
- Temporal mandibular joint dysfunction.
- Prescription drugs incident to covered dental services.
- Charges for hospitalization, including hospital visits.
- Replacing tooth structure lost by attrition.
- Services, supplies or charges that are not prescribed by or performed by or under the direct supervision of a dentist.
- Services, supplies or charges that are submitted by a dentist and another professional provider which are the same services performed on the same date for the same patient.
- Services, supplies or charges that are not medically or dentally necessary as determined by the Fund.
- Services, supplies or charges that are experimental or investigative in nature.
- Services, supplies or charges that are not necessary according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist.
- Services, supplies or charges that do not meet accepted standards of dental practice.
- Services, supplies or charges that are for unusual procedures and techniques.
- Services, supplies or charges that are not billed by the dentist or for which the patient incurs no charge.
- Services, supplies or charges that are performed by a dentist or other professional provider who in any case is compensated by the facility for similar covered services performed for patients.
- Telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form.
- Duplicate and temporary devices, appliances and services.
- Loss or theft replacements.

- Services for which the cost has been or is later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law.

- Local anesthesia when billed for separately by a dentist.

- Routine post-operative visits.

- Any denture or bridge replacement made necessary by reason of loss or theft or participant alteration of a denture or bridge.

- Services of assistant surgeons except that the patient, when an inpatient, will be entitled to the services of a dentist who actively assists the dentist in charge of the case in the performance of covered surgical services when the dental condition of the patient or the type of surgical service requires the assistance and when the hospital does not employ surgical interns, residents or house staff who are utilized for such assistance. The assistant surgeon will be paid at the co-insurance level of the covered surgical procedure.

- Services and charges necessitated by lack of the patient's cooperation with the Dentist or non-compliance with prescribed dental care that result in additional liability.

- Charges for services to the extent that such charges exceed the charge that would have been made and actually collected if no coverage existed.

- Orthodontics and charges for the replacement and/or repair of any orthodontic appliance furnished under the treatment plan or for any duplicate orthodontic device or appliance.

- Gold foil restorations.

- Local infiltration or block anesthetic.

- Any other dental service or treatment except as provided in the Dental Program Document.

Limitations

Payment for services will be limited as follows:

- Routine oral examinations
    - Comprehensive and periodic – two (2) of these services per contract year. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patien is absent from the office for three (3) or more year (s).
    - Limited problem focused and consulations – one (1) of these services per dentist per patient per 12 months.

- Bitewing x-rays – twice during contract period

- Full mouth x-rays and panorex x-rays – once in a 36-month period.

- Intraoral Films:
    - Occlusal – two (2) per 24 months under age eight (8).

- Prophylaxis (cleaning, scaling and polishing of teeth) – twice during contract period. One (1) additional for members under the care of a medical professional during pregnancy

- Flouride Treatments: Topical application of Flouride is covered for dependent children under age 14 – one in a six consecutive month period.

- Sealants: Sealant benefits are available to dependent children under age 16 on permanent first and second molars. Benefit – One application per tooth in any three-year period beginning from the initial application.

- Space Maintainers: Space maintainers are available for dependent children under age 14 on primary molars and permanent first molars. Recement space maintainers are eligible once in a three-year period and ineligible within 6 months of insertion of the space maintainer by the same provider.

- Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age 14.

- Periodontal Services:

  - Full mouth debridement – one (1) per 24 months
  - Periodontal maintenance following active periodontal therapy – two (2) per calendar year in addition to routine prophylaxis.
  - Periodontal scaling and root planning – one (1) per 24 months per area of mouth.
  - Surgical periodontal procedures – one (1) per 24 months per area of mouth.

- Consultations – limited to one consultation per consultant per period of hospitalization, when the patient's dental condition requires such consultation.

- Replacement of restorative services only when they are not, and cannot be made, serviceable:

  - Basic restorations – not within 12 months of previous placement of any basic restoration
  - Single crowns, inlays, onlays – not within 4 years of previous placement of any of the procedures in this category.
  - Buildups and post and cores – not within 4 years of previous placement of any of the procedures in this category.

- If more than one dentist provides one dental procedure, the Fund shall be liable for not more than the amount it would have been liable for had but one dentist performed the dental service.

- Pulpal therapy – one (1) per primary tooth per lifetime.

- Root canal treatment – one (1) per tooth per lifetime.

- Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion of any preventative, restorative, or prosthodontics service by the same dentist is included in the preventative, restorative, or prosthodontics service benefit.

- General anesthesia and IV sedation; a total of sixty (60) minutes per session.

- If the patient does not cooperate with the dentist and, as a result, additional treatment is required, any additional liability would be the participant's responsibility.

- Alternate treatment – In all cases in which there are optional plans of treatment, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner.

- Replacement of an existing denture or bridgework will be covered only if at least five (5) years have elapsed since the date of the insertion of the denture or bridgework and only if the existing denture or bridgework is unserviceable and cannot be made serviceable. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist.

- No payment will be made for precious metal dentures. Payment of the applicable percentage of the MAC allowance for a non-precious metal denture will be made toward the charge of the precious metal denture selected by the patient and Dentist.

- Implantology services are limited to covered services as defined above under the Implant category

VISION PROGRAM DESIGN

This program is designed to help meet the cost of eye care. The vision care benefit will include the services of ophthalmologists, optometrists and opticians. The services and materials provided by the participating provider under the plan will be at no cost to the member, or eligible dependents, as long as the patient stays within the plan guidelines.

About Your Administrator

National Vision Administrators (NVA) is the Administrator for the vision plan. NVA has a network of participating Ophthalmologists, Optometrists, and Opticians to serve you. Participating providers can be found at their website, www.e-nva.com, or by calling (800)672-7723. Benefits are also available from non-participating providers.

The PSEA Health And Welfare Fund (PSEA-HWF) Vision Plan Will Only Provide Benefits if Services are Provided by Appropriately Licensed and Credentialed Professionals.

A Provider, who is a licensed doctor of medicine or osteopathy, including a specialist in ophthalmology (Ophthalmologist) or a licensed doctor of optometry (Optometrist) is eligible to provide eye examinations, refractive, and post-refractive services.

A Dispensing Optician, who is a person who makes, fits, supplies, and adjusts eyeglasses in accordance with a prescription written by a Provider to correct a patient's vision deficiencies, is eligible to provide post-refractive services consisting of lenses and frames and associated services.

How To Use Your Vision Program

Participating Providers: When making your appointment with a NVA Participating Provider, please provide them with your name, the name of the patient, your social security number or identification number and your group number. The provider will contact NVA to verify your vision care eligibility.

At the time of your first appointment, present your NVA Vision Identification Card – you do not need to obtain a vision claim form. The Participating Provider will inform you of your eligibility status prior to rendering services. To verify benefit eligibility yourself prior to scheduling your eye care appointment, you may wish to contact NVA's Customer Service Department at **(800) 672-7723**.

When the services have been completed, the Participating provider will have you sign a claim form and he/she will then send it to NVA for processing and payment. You do not pay anything unless you select something other than what the plan allows or a more expensive frame than that which is covered under your program. NVA will pay the provider directly for all plan benefits.

Non-Participating Providers: If you select a non-participating provider, you must pay the provider and reimbursement will be made directly to you from NVA. You must submit an itemized receipt from the doctor and/or optician—including a copy of the doctor's prescription, along with your name, social security number or identification number, patient's name, patient's date of birth, and your group number or a photocopy of your NVA Vision Identification Card to the following address: National Vision Administrators, P.O. Box 2187, Clifton, NJ 07015. Payment will be made according to the non-participating provider reimbursement schedule.

How Much Do Eligible Members Have To Pay For These Services?

If a participating doctor is used, the examination will be provided at no cost. Lenses and frames will also be provided free of charge as long as the patient stays within the plan guidelines. The cosmetic contact lenses benefit is provided in lieu of exam, lenses, and frames. The cosmetic contact lenses allowance is $75, allocated as $45 for contact lenses and $30 for exam.

While the plan is comprehensive, it will not pay for everything (see exclusions and limitations). Patients sometimes select lenses or lens characteristics that are not necessary for their visual welfare,

but are desired for cosmetic reasons. In such cases, the patient will pay according to the lens option schedule in effect at the time of purchase of lenses. There is an additional 15% off balance for conventional/daily contacts and 10% discount off balance for disposable contacts.

The plan provides a wide selection of quality frames. Because of the cosmetic nature of frames and rapidly changing styles, we place a limit on the cost of frames provided under the plan. Patients who select frames that exceed the limit will pay the actual difference between the retail cost of the frame and the plan allowance. There is an additional 20% discount between the frame allowance and retail price when using participating providers.

What Happens If I Go To A Non-Participating Doctor?

If the doctor you select is a non-participating optometrist or ophthalmologist, you must pay the doctor and/or the optician directly and reimbursement will then be made to you by NVA. In this instance, you must mail to NVA itemized receipts from the doctor and/or optician with a copy of the doctor's prescription and your name, social security number or identification number, patient's name, patient's date of birth, and your group number or a photocopy of your NVA Vision Identification Card. The Fund will pay only such usual and customary fees of that doctor for the vision analysis and the allowances for the glasses up to the amounts stated in the schedule of benefits.

Who Do I Call If I Have Problems, Concerns or Questions?

To check on eligibility, payment of claim or a participating provider in your area, call NVA at **(800) 672-7723**. If you feel you have been improperly charged for materials or if you have any questions regarding your vision care plan, please call the PSEA Health and Welfare Fund toll-free at (800) 944-7732, extension 7024.

Covered Benefits

Eye Examination and refractive services which include:

- Case history, testing visual acuity
- External and internal examination of the eyes
- Determination of binocular measurement
- Medication for dilating the pupils and desensitizing the eyes for tonometry
- Tonometry, if indicated
- Summary and finding
- Prescribing of corrective lenses

Post-refractive services which include:

- Facial measurement and other specifications needed for ordering lenses
- Lenses – to correct vision problems – lenses may be plastic.
- Frames – of your choice, in varied styles and colors, will be available.
- Contact Lenses – certified by your doctor as medically necessary. Contact lenses shall be considered medically required only after cataract surgery or other conditions such as, but not limited to, anisometropia or keratoconus, if indicated, or when visual acuity is not correctable to 20/70 with spectacle lenses in a frame, but can be improved to 20/70 or better by the use of contact lenses. Cosmetic contact lenses – In cases involving services in which the provider or patient elect to utilize contact lenses, although the patient does not qualify under the criteria of medical necessity, although benefits are available for cosmetic contact lenses, provided they are received in lieu of conventional lenses, frames and exams.
- Low Vision Aids – certified by your doctor as medically necessary.

Vision Benefit Coverage	**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
Contact-medical necessity (*every 24 months, in lieu of exam, lenses and frames*)	Covered in Full up to $250	$250 Maximum
Contacts-cosmetic (*in lieu of exam, lenses and frames*)	Covered in Full up to $75 (allocated $45 contacts and $30 exam)	$75 Maximum (allocated $45 contacts and $30 exam)

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

Participating Provider Lens Options

<table>
<tr><td colspan="2">If you select materials that are not covered under your program, the participating provider may charge the following:</td></tr>
<tr><th>LENS OPTION</th><th>*Participant Cost</th></tr>
<tr><td>UV COATINGS</td><td>$12.00</td></tr>
<tr><td>AR COATINGS STANDARD</td><td>$40.00</td></tr>
<tr><td>POLYCARBONATE SV</td><td>$25.00</td></tr>
<tr><td>POLYCARBONATE BI/TRI</td><td>$30.00</td></tr>
<tr><td>SOLID TINTS SV/BI/TRI</td><td>$10.00</td></tr>
<tr><td>GLASS PHOTOGREY SV</td><td>$20.00</td></tr>
<tr><td>GLASS PHOTOGREY BI/TRI</td><td>$30.00</td></tr>
<tr><td>TRANSITIONS STANDARD SV</td><td>$65.00</td></tr>
<tr><td>TRANSITIONS STANDARD BI/TRI</td><td>$70.00</td></tr>
<tr><td>SCRATCH COATING</td><td>$10.00</td></tr>
<tr><td>BLENDED SEGMENT</td><td>$30.00</td></tr>
<tr><td>FASHION GRADIENT TINTS</td><td>$12.00</td></tr>
<tr><td>POLAROID</td><td>$75.00</td></tr>
<tr><td>HIGH INDEX</td><td>$55.00</td></tr>
<tr><td>PROGRESSIVE STANDARD</td><td>$50.00</td></tr>
<tr><td>PROGRESSIVE PREMIUM</td><td>Wholesale+25%</td></tr>
<tr><td colspan="2">UV - ultra violet; AR - anti-reflective; SV - single vision; BI - bifocal; TRI - trifocal</td></tr>
<tr><th colspan="2">FRAMES OPTION</th></tr>
<tr><td colspan="2">There is an additional 20% discount on the difference between the frame allowance and retail price when using participating providers.</td></tr>
<tr><th colspan="2">CONTACT LENS DISCOUNT</th></tr>
<tr><td colspan="2">Additional 15% off balance for conventional/daily contacts and 10% discount off balance for disposable contacts.</td></tr>
</table>

*subject to change

Limitations

The benefits payable are subject to the following limitations:

- Examination/tonometry – every 24 months
- Lenses – every 24 months
- Frames – every 24 months
- Payment will not be made for both contact lenses and frames or eye glass lenses within a 24-month period.
- Benefits for photochromic grey and brown lenses, fashion color or coated lenses shall be limited to the allowances made for clear lenses. Any extra charge shall be billed to the patient.
- Benefits for progressive no-line multifocal lenses shall be limited to the Allowances made for lined multifocal lenses. Any extra charge shall be billed to the patient.
- Benefits for prescription sunglasses shall be limited to the Allowance made for prescription glasses. Any extra charge shall be billed to the patient.
- Benefits for industrial safety lenses requiring a prescription shall be limited to the Allowance made for prescription glasses. Any extra charge shall be billed to the patient.

Exclusions

No payment will be made for the following services and materials:

- Medical or surgical treatment of the eyes.
- Drugs or other medication.
- Any lenses which do not require a prescription, such as non-prescription sunglasses.
- Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames.
- Services or materials covered by Workers' Compensation laws.
- Vision services or materials provided by federal, state, or local government.
- Examinations or materials not listed as a covered service.
- Parts or repair of frames.

Claims and Appeal Procedures

NVA attempts to process all claims within a reasonable processing time. If a claim will be delayed more than thirty (30) days, the administrator will notify the subscriber in writing stating the reason for delay.

Routine claims questions can be sent to NVA at P.O. Box 2187, Clifton, NJ 07015 or call direct (800) 672-7723 toll-free.

If a claim for benefits is denied, either in part or in whole, you will receive a written notice explaining the reason or reasons for the denial of benefits. Please see below at Section X for a complete explanation of the claim appeal process. If the information received with the claim is incomplete, the notice will tell you what additional facts or materials are needed and why.

You may appeal a denial of benefits for any claim by sending a letter to the PSEA Health and Welfare Fund, 400 North Third St. P.O. Box 1724 Harrisburg, Pa. 17105-1724 stating why you think your claim should not have been denied, along with any additional information, documents, data or comments you think have a bearing on your claim. Your appeal must be made within one hundred twenty (120) days after you have been notified of the denial of benefits. In preparing your appeal, you or your representative will have the right to examine documents pertinent to your appeal. However, medical information cannot be released to you unless your physician authorized its release in writing.

The PSEA Health and Welfare Fund trustees will review all the facts on which the original decision was based and any additional information you have provided in your appeal. You will receive a final decision in writing within sixty (60) days of the date your appeal is received. Where there are special circumstances requiring extensive review by medical specialists of technical records, a final decision may take longer than sixty (60) days. In that case, you will be informed promptly of the need for additional information and further review time.

PENNSYLVANIA STATE EDUCATION ASSOCIATION HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

I. INTRODUCTION

The Pennsylvania State Education Association Health and Welfare Plan (the "Plan") has been established to provide health and welfare benefits to certain school employees, including Retirees, in the Commonwealth of Pennsylvania, Employees of the Pennsylvania State Education Association ("PSEA") or its Affiliates, and PSEA Members, including Retirees. This summary of the Plan, along with the brochures describing the Programs, is designed to answer your questions about how the Plan works. If you have any questions after reading this summary, the Plan Administrator will be available to discuss the Plan with you.

This document, along with its attachments, is only intended to provide you a brief summary of the Plan. In order to fully understand the detailed operation of the Plan, you would need to review the Plan document, the Trust Agreement, and any agreements that the Plan maintains with Insurance Carriers. To the extent that this summary, along with its attachments, is inconsistent with any of those underlying documents, those underlying documents control.

Please be advised that not all Benefit Programs are available to all Retirees and their Dependents. Please review the Benefit Program descriptions for the terms and conditions of each Program. Also, please be advised that the Benefit Programs provided under this Plan and the Plan itself may be modified or terminated at any time by the Pennsylvania State Education Association.

II. TERMS YOU SHOULD KNOW

The following terms used in this Summary Plan Description are defined below. Capitalized terms used in this Summary Plan Description and not otherwise defined have the meaning set forth in the Plan or other Program documents.

"**Administrator**" means the Fund's third-party administrator or Insurance Carrier responsible for administering a Benefit Program under the Plan.

"**Affiliate**" means any local education association which is chartered by or affiliated with PSEA.

"**Beneficiary**" means the person, designated by the Participant or by the terms of an Insurance Contract, who is or may become entitled to receive benefits under the Plan.

"**Benefit Program(s)**" or "**Program(s)**" means the plan of benefits described in the Program brochures, as amended from time to time.

"**Continuation Coverage**" means the extended health coverage provided under the Plan in accordance with Section VII.

"Dependents" - May include the following:

"**Spouse**" means the person to whom the Participant is legally married.

"**Domestic Partner**" means a same or opposite gender unmarried partner who shares an exclusive mutual commitment with a Participant whose Employer has elected to provide benefits to Domestic Partners. Both partners agree to be financially responsible for each other's common

welfare, living expenses, and financial obligations, including the care of each other's minor dependents. The individuals must be at least 18 years of age and be each other's sole domestic partner and intend to remain so indefinitely. Neither party is married to another person and neither is related to the other by adoption or blood to a degree that would bar marriage in the Commonwealth of Pennsylvania. The partners must currently be residing together and have resided together for at least six (6) consecutive months.

"Child" means the following individuals who are under age 26 and are:

(1) A natural or adopted child of a Participant;

(2) A stepchild, that is, the child of the Participant's Spouse or Domestic Partner;

(3) A grandchild of a participant with legal guardianship.

(4) A disabled child of a participant. For purposes of this Plan, a Disabled Child is a Child who has been determined to be disabled by the Social Security Administration; who is not able to earn a living because of the disability, whose disability began prior to the date on which the Child would have lost Benefit Coverage because of age (age 26); and who is financially Dependent on the Participant for support and maintenance as evidenced by, inter alia, documentation showing that the Participant claims the Disabled Child as a Dependent for federal income tax purposes.

The Fund may rely on documentary evidence to determine for purposes of this Plan that the Participant has custody of, guardianship of, or is otherwise legally responsible for, the child, including evidence that the Participant claims the child as a Dependent for federal income tax purposes.

"Eligible" means that a Retiree or Dependent(s) may obtain coverage for the dental, vision and other benefits available under this Retiree plan because he or she is a member (or eligible dependent of a member) in good standing in the PSEA and has paid the required premium for the benefits sought.

"**Insurance Carrier**" means the insurers providing insured benefits under the Plan.

"**Member**" means any member in good standing of PSEA or an Affiliate.

"**Participant**" for the purpose of this retiree program means a Retiree or a Member who is eligible to receive benefits under one or more Programs under the Plan.

"**Plan**" means the Pennsylvania State Education Association Health and Welfare Plan.

"**Plan Administrator**" means the Pennsylvania State Education Association.

"**PSEA**" means the Pennsylvania State Education Association.

"**PSEA-HWF**" or "**Fund**" or "**Trust**" means the trust called the Pennsylvania State Education Association Health and Welfare Fund.

"Retiree" means a retired PSEA member who has maintained membership in the PSEA.

"**You**" means a Participant, Spouse, Domestic Partner, or dependent child who is eligible to receive benefits under the Plan.

III. ELIGIBILITY

Generally, you are eligible to participate in the Plan if:

- You are a Retiree and maintain PSEA membership.

IMPORTANT INFORMATION

The participation of otherwise eligible Retirees, and their eligible Dependents, may be limited or proscribed by the specific terms and conditions contained in the insurance policy or policies or Program description which provide benefits under a particular Program or by any applicable agreement between PSEA-HWF and the Employer. You must check the terms and conditions of each Program, which will be provided to any Participant or Beneficiary without cost, to determine your eligibility.

Taxation of Domestic Partner Coverage

Under Federal law, if a Domestic Partner or the child of a Domestic Partner is not a dependent of the Participant under Section 152 of the Internal Revenue Code, the fair market value of the benefits provided to the Domestic Partner or the child of a Domestic Partner must be treated as taxable income to the Participant and reported as such on the Participant's Wage and Tax Statement (W-2). Generally, for your Domestic Partner or the child of your Domestic Partner to receive benefits on a non-taxable basis, you must claim your Domestic Partner and/or the child of your Domestic Partner as a dependent on your federal income tax return. You should contact your Employer for more information about the taxability of benefits provided to Domestic Partners or children of Domestic Partners.

PSEA-R Members may participate in the following Programs:

- PSEACare Dental and Vision Program
- Voluntary Long-Term Care
- Opti-Vision
- Travel and Accident

VOLUNTARY LONG TERM CARE

The Voluntary Long-Term Care Program stopped accepting new Participants after March 31, 1999. The Voluntary Long-Term Care Program provides base nursing home, base nursing home plus professional home care, or base nursing home plus total home care coverage. Individuals participating in this Program before April 1, 1999 may continue their

coverage. You should read the Voluntary Long-Term Care Program certificate of insurance for a complete description of the benefits offered under the Program including eligibility, limits, exclusions, procedures, and effective dates. The Voluntary Long-Term Care Program is insured by UNUM Provident Corporation, 2211 Congress Street, Portland, ME 04122 and administered by USI Colburn Insurance Service, 1 International Plaza, 4th Floor, Philadelphia, PA 19113

OPTI-VISION

The Opti-Vision Program provides certain discounts for vision examinations, lenses, and frames from participating vision providers. Opti-Vision can be used as a stand-alone program or in conjunction with your NVA program. You should read the Opti-Vision Program brochure for a complete description of the benefits offered under the Program including eligibility, enrollment, administration, program discounts, procedures, effective dates, and a listing of participating providers. The Opti-Vision Program is self-insured by PSEA-HWF and is administered by National Vision Administrators, P.O. Box 2187, Clifton, NJ 07015.

PSEACARE DENTAL AND VISION PROGRAM

The PSEACare Dental and Vision Program, described in detail above, provides dental and vision benefits at a fixed annual cost. You should read the PSEACare Dental and Vision Program brochure for a complete description of the benefits available under the Program including eligibility, benefits, applicable deductibles, co-payments, limits, exclusions, procedures, and effective dates.

Retirees, and eligible Dependents, cannot terminate participation once a contract year has begun. Failure to renew participation in the Program disqualifies the Participant from all future enrollment in the Program. The dental portion of the Program is self-insured by PSEA-HWF and administered by United Concordia Companies, Inc., P.O. Box 69421, Harrisburg, PA 17106. The vision portion of the Program is self-insured by PSEA-HWF and administered by National Vision Administrators, P.O. Box 2187, Clifton, NJ 07015.

Coordination of Benefits:

If you or your dependents are covered by any other dental benefits plan and receive a service covered by this Plan and the other, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the other plan. The secondary plan’s benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

   A) **Allowable Amount** is the Plan’s allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.

   B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.

   C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** shall be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured.

D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.

F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

2. The fair value of services provided by the Claims Administrator shall be considered to be the amount of benefits paid by the Claims Administrator. The Claims Administrator will be fully discharged from liability to the extent of such payment under this provision.

3. In order to determine which plan is primary, the Plan will use the following rules.

   A) The other plan does not have a provision similar to this one, then that plan shall be primary.

   B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.

   C) Active/Inactive Member.

   D) For actively employed Members and their dependents over the age of 65 who are covered by Medicare, the plan shall be primary.

   E) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest

   time is primary. If another contract does not have this rule, then this rule will be ignored.

   F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time shall be primary.

   G) The plan covering an individual as a COBRA continue will be secondary to a plan covering that individual as a Member or a Dependent.

4. Right to Receive and Release Needed Information – Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.

5. Facility of Payment – A payment made under another plan may include an amount which should have been paid under This Plan. If it does, the Claims Administrator may pay the amount to the organization which made that payment. That amount will then be treated as

though it were a benefit paid under This Plan, and the Claims Administrator will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Claims Administrator.

6. Right of Recovery − If the payment made by the Claims Administrator is more than it should have paid under this COB provision, the Claims Administrator may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Claims Administrator to implement this section.

Subrogation and Reimbursement

If your dental claims are the result of a third party's actions, the Plan is given the broadest rights to recover any medical expenses paid on your behalf, including, but not limited to reimbursement, subrogation, constructive trust and any other federal or state causes of action that may provide legal and/or equitable relief to the Plan. Generally, the Plan treats the third party as primarily liable for your medical expenses. However, the Plan will pay Benefits to you with the understanding that payment of these Benefits is expressly and automatically conditioned on the Plan being reimbursed for these Benefits if there is any recovery from that third party (including any recovery from the other insurance carrier). You and your attorney agree and are required, as a condition of the Fund providing any Benefits for you under this Plan, to hold all money you receive in constructive trust for the Fund, regardless of whether you execute a subrogation agreement. This means that you must treat all dollars you receive from the third party as if you are holding them to repay the Fund before you pay anyone else. Your attorney must place these funds in a restricted account and make payment first to the Fund before taking fees himself or providing payment to you. Any reimbursement amounts which the Plan receives from a third party shall not be reduced by any attorney fees greater than 20%, unless the Plan has consented to a higher attorney fee in writing. You must not do anything that could interfere with the Plan's right to reimbursement from the third party. The Plan may ask you to assign to it your rights against that third party, or your recovery from that third party, to the extent of Benefits paid by the Plan. You must also contact the Plan before you settle the case without the prior written consent of the Plan. The Plan may request that you authorize the Plan to sue on your behalf.

V. TERMINATION OF COVERAGE

Participant Coverage. Your coverage under a Program will terminate in the following circumstances:

- discontinuance of the Plan as a whole or the particular Program in which you participate;
- loss of your eligibility (such as ceasing to participate in any category of PSEA membership); your failure to make contributions to PSEA-HWF when due (if you are required to make contributions)

There are special participation rules for the PSEACare Dental and Vision Program. Failure to renew participation in the PSEACare Dental and Vision Program disqualifies the Participant from all future enrollment in the PSEACare Dental and Vision Program. Annual renewal letters will be sent to plan participants prior to the contract renewal date. Annual renewal notices will be sent to plan participants prior to the expiration of the contract year.

Termination of coverage in any of the circumstances described above will not affect you or your Beneficiary's right to receive benefits under a Program for claims that arose before termination of your participation in the Plan or under a Program.

VI. AMENDMENT AND TERMINATION OF PLAN

The Plan or any or all Programs may be amended or terminated at any time by the Plan Sponsor, PSEA. In the event that the Plan or any or all of the Programs is terminated, your benefits will cease, but your right to receive benefits under a Program for claims that arose before termination of your participation under the Plan or under a Program will not be affected.

VII. CONTINUATION OF COVERAGE FOR CERTAIN HEALTH BENEFITS

BOTH YOU AND YOUR DEPENDENTS SHOULD TAKE THE TIME TO READ THIS NOTICE

Continuation Coverage – If you are a "Covered Employee", including a Retiree and covered by the PSEA Health and Welfare Plan, your dependents have the right to choose Continuation Coverage, at your own expense, if your Dental, Vision, and/or Prescription Benefit Program coverage would otherwise end due to a "qualifying event." This notice contains important information about your right to COBRA Continuation Coverage, which is a temporary extension of health coverage under the Plan. **This Section of the SPD serves as your general notice about COBRA Continuation Coverage. It generally explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to your Dependents who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the rest of this Summary Plan Description or contact the Plan Administrator for more information, including a copy of the Plan document.

What is COBRA Continuation Coverage?

COBRA Continuation Coverage is a continuation of Plan health coverage when that coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." Your Dependents could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

If you are the **Dependent** of an Employee covered by the PSEA Health and Welfare Plan, you will become a qualified beneficiary if you lose your health coverage under the Plan because any of the following qualified events happens:

- The Retired Member dies;
- You are the spouse and become divorced or legally separated from the Retired Member.
- You reach the maximum age as a dependent child under the plan's eligibility guidelines

PLEASE NOTE: For information regarding the continuation of certain health benefit coverage for Domestic Partners and their children, see the paragraph entitled "Continuation of Coverage of Certain Health Benefits for Domestic Partners and Their Children" at the end of this Section VII. In addition, if your same sex marriage was celebrated in a state that recognizes such marriages, your Spouse is entitled to elect COBRA coverage.

When is COBRA Coverage Available?

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the Employee, the Employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events.

For the other qualifying events (divorce or legal separation of the Employee and Spouse, a second qualifying event, or a disability extension or cessation of disability), you must notify the Plan Administrator.

Notice Procedures.

When you must give notice of a qualifying event to the Plan Administrator, you must follow the following procedures or you will not be eligible for COBRA Continuation Coverage:

You must notify the Plan Administrator within 60 days after the qualifying event occurs (or, with respect to a disability extension, after the receipt of the disability determination, if later, but within 18 months of the qualifying event).

You must notify the Plan Administrator in writing.

Your notice must include the following information: your name the type of qualifying event, the date of the qualifying event, and the names of the individuals who you believe are qualified beneficiaries with respect to the qualifying event.

You must provide this notice to: COBRA Administration, PSEA Health and Welfare Fund, Post Office Box 1724, Harrisburg, PA 17105-1724.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage.

COBRA Continuation Coverage is a temporary continuation of health coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or your divorce or legal separation, COBRA Continuation Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage of qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his spouse can last

up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended:

Disability extension of 18-month period of continuation coverage – If you or your Dependents are determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your Dependents may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of Continuation Coverage. In order to extend COBRA Continuation Coverage, you or a qualified beneficiary must provide a copy of the Social Security Administration disability determination letter to the Plan Administrator before the end of the first 18 months of COBRA Continuation Coverage and within 60 days after the date of the qualifying event or the date of receiving the disability determination from the Social Security Administration, if later. This information must be provided to COBRA Administration, PSEA Health and Welfare Fund, Post Office Box 1724, Harrisburg, PA 17105-1724.

Second qualifying event extension of 18-month period of continuation coverage – If you or your Dependents experience another qualifying event while receiving 18 months of COBRA Continuation Coverage, the dependent(s) can get up to 18 additional months of COBRA

Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan Administrator in accordance with the Notice procedures described above. This extension may be available to the dependent(s) receiving Continuation Coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, but only if the event would have caused the dependent(s) to lose coverage under the Plan had the first qualifying event not occurred.

How can you elect COBRA continuation coverage?

To elect COBRA Continuation Coverage, you must complete an election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA continuation coverage. You will have 60 days from the date of the election form in which to elect COBRA Continuation Coverage.

In considering whether to elect COBRA Continuation Coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA

Continuation Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you get COBRA Continuation Coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA Continuation Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA Continuation Coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage for a similarly situated plan participant or beneficiary who is not receiving COBRA Continuation Coverage.

When and how must payment for COBRA Continuation Coverage be made?

First payment for COBRA continuation coverage – If you elect COBRA Continuation Coverage, you must make your first payment for COBRA continuation coverage not later than 45 days after the date you make your election. If you do not make your first payment for COBRA Continuation Coverage in full not later than 45 days after the date you make your election (meaning the date your election is postmarked), you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Periodic payments for COBRA Continuation Coverage – After you make your first payment for COBRA Continuation Coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA Continuation Coverage is due on the 20th day of the month preceding the month for which coverage is to be continued. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan does not send monthly notices of payments due.

Grace periods for periodic payments – Although periodic payments are due on the 20th day of the month preceding the month for which coverage is to be continued, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan.

Termination of COBRA Continuation Coverage Before the End of the Maximum Period

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage;
- A disabled qualified beneficiary is determined to no longer be disabled; or
- The Fund ceases to provide this coverage under a group health.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud). See also Section V of this Summary Plan Description.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights you may have under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep Your Plan Informed of Changes

In order to protect your family's rights, you should keep your Employer and the Plan Administrator informed of any changes in the addresses of family members and changes such as divorce or legal separation.

Plan Contact Information

COBRA Administration
PSEA Health and Welfare Fund
400 North Third Street, P.O. Box 1724
Harrisburg, PA 17105-1724
717/255-7024 ■ 800/944-7732, extension 7024

Special Rules - In addition, special rules may apply under the Health Insurance Portability and Accountability Act ("HIPAA") HIPAA may require that you receive a certificate of creditable coverage when your group health plan coverage terminates. HIPAA may also limit pre-existing condition exclusions and require group health plans to comply with certain nondiscrimination and special enrollment period rules. Please contact the Fund for additional information about these special rules.

Continuation of Coverage of Certain Health Benefits for Domestic Partners and Their Children - If you are a Domestic Partner of an Employee covered by the PSEA Health and Welfare Plan whose Employer has elected to provide coverage to Domestic Partners, or the child of such a

Domestic Partner, and you lose your health coverage under the Plan because of the occurrence of any of the qualified events listed in the above notice for "Spouses" as applicable, including the dissolution of the partnership with the Employee, you may be entitled to the continuation of your health coverage under terms and conditions similar to those described in the above notice.

VII. CONTRIBUTIONS

Contributions for Participants are set forth from time to time and may be changed from time to time by the trustees of the PSEA-HWF.

Some or all of the benefits provided under the Plan may, at the discretion of the Plan Sponsor, be provided by the purchase of insurance contracts issued by one or more insurance companies, or health care service contracts issued by or provided through a health care service provider, qualified health maintenance organization, or preferred provider organization. Any dividends, retroactive rates, proceeds from demutualization, or other refund that may become payable under any insurance or health care service contracts or Program due to actuarial error in rate calculation shall

be the property of and retained by the PSEA-HWF. PSEA-HWF also will retain any and all provider discounts available under any Program offered under the Plan. Any amounts received under the circumstances described above will be used for the PSEA-HWF's tax exempt purposes.

Participant Contributions

Your contributions, if any, are set forth from time to time by the trustees of the PSEA-HWF and must be paid via authorized ACH transaction or by check or money order payable to the PSEA Health and Welfare Fund at the following address:

PSEA Health and Welfare Fund
c/o Fund Manager
400 North Third Street, P.O. Box 1724
Harrisburg, PA 17105-1724

If you or your family member is receiving coverage under the Continuation Coverage rules, payment for the amount due from the date of termination of coverage to the date an individual elects to continue coverage is due no later than 45 days after the date Continuation Coverage is elected. Thereafter, payment by individuals for continuation coverage is due on the 20th day of the month preceding the month of coverage. Failure to make payment by the 30th day after the first day of the month for which coverage would otherwise be provided will result in loss of coverage effective as of the first day of the month. For example, if you are receiving continuation coverage, your premium for the month of October will be due by September 20. If it is not received by October 31, your coverage will be cancelled effective October 1. Section VII of this Summary Plan Description provides more information about the Continuation Coverage rules.

VIII. CLAIMS

Claims for Benefits Under a Self-Insured Program

Parties Permitted to File Claims for Benefits. You or an authorized representative acting on your behalf is entitled to pursue a benefit claim or the appeal of an adverse benefit determination under the Plan.

Filing a Claim for Benefits. You should make a claim for benefits under the Plan by filing a written claim with the Administrator as soon as possible after you have incurred expenses covered under the Plan. The manner in which the Administrator processes a claim for group health benefits will be determined by the classification of the claim. All group health benefit claims will be classified as one of the following:

- Pre-Service Claim. A Pre-Service Claim is a claim for a benefit, the receipt of which is conditioned, in whole or in part, on approval of the benefit in advance of obtaining the medical care.

- Post-Service Claim. A Post-Service Claim is any claim that is not classified as a Pre-Service Claim. A Post-Service Claim generally involves only the payment or reimbursement of costs for medical care that has already been provided.

- Urgent Care Claim. An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations:

  (i) Could seriously jeopardize your life, health, or your ability to regain maximum function; or

  (ii) Would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any determination regarding the severity of your pain must be made by a physician with knowledge of your medical condition.

  If a physician with knowledge of your medical condition determines that a claim is an Urgent Care Claim, the Administrator will treat the claim as such.

Failure to Follow Claim Procedures. If you fail to follow the proper procedures for filing a Pre-Service or Urgent Care Claim, the Administrator will notify you of the failure and provide you with the proper procedures to be followed in filing a claim for benefits. The Administrator will provide such notice to you as soon as possible, but not later than:

(i) 5 days following your failure to follow the proper procedures for filing a Pre-Service Claim; or

(ii) 24 hours after your failure to follow the proper procedures for filing an Urgent Care Claim.

Notice under the preceding paragraph may be provided orally unless you request written notification.

Notice to You of Determination of Claim.

(i) Urgent Care Claims. The Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account medical exigencies, but not later than 72 hours after the Administrator's receipt of an Urgent Care Claim.

   I. If you fail to provide the Administrator with information sufficient to enable the Plan to make a determination on an Urgent Care Claim, the Administrator will notify you of the specific information necessary to complete the claim.

   II. The Administrator will provide such notice to you as soon as possible, but not later than 24 hours after receipt of information insufficient to make a determination on an Urgent Care Claim. The Plan will give you a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. In such case, the Administrator will notify you of its benefit determination as soon as possible, but not later than 48 hours after the earlier of receipt of the specified information, or the end of the period given to you to provide the specified additional information.

(ii) Pre-Service Claims. The Administrator will notify you of its benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of a Pre-Service Claim.

I. The Administrator reserves the right to extend this 15-day period a single time for up to an additional 15 days if it determines that the extension is necessary due to matters beyond its control, and notifies you prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of the time and date by which the Administrator expects to render a decision.

II. If the extension described in the preceding paragraph is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You will be given at least 45 days from receipt of the notice within which to provide the specified information.

(iii) Post-Service Claims. The Administrator will notify you of its adverse benefit determination on a Post-Service Claim within a reasonable period of time, but not later than 30 days after receipt of the claim.

I. The Administrator reserves the right to extend this 30-day period a single time for up to an additional 15 days if the Administrator determines that the extension is necessary due to matters beyond its control, and notifies you prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of the time and date by which the Administrator expects to render a decision.

II. If the extension described in the preceding paragraph is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You will be given at least 45 days from receipt of the notice within which to provide the specified information.

(iv) Concurrent Care Decisions. If the Administrator has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, its reduction or termination of the course of treatment (other than by amendment or Plan termination) is an adverse benefit determination.

I. The Administrator will notify you of such determination at a time sufficiently in advance of the reduction or termination

to allow you to appeal and obtain a determination on appeal of such adverse benefit determination before the benefit is reduced or terminated.

II. If you request extension of your course of treatment beyond the period of time or number of treatments and such request is a claim involving urgent care, the request will be decided as soon as possible, taking into account the medical exigencies. The Administrator will notify you of the benefit determination (whether adverse or not) not later than 24 hours after the Plan's receipt of the claim. The claim must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(v) Other Claims. The Administrator will notify you of its adverse benefit determination within a reasonable period of time but not later than 90 days after receipt of the claim.

The Administrator reserves the right to extend this 90-day period for up to 90 additional days if it determines that the extension is necessary due to special circumstances and notifies you prior to the expiration of the initial 90-day period, of the special circumstances requiring the extension of time and the date by which the Administrator expects to render a decision.

Notice of Adverse Benefit Determination. If the Administrator denies a claim to any extent under the preceding sections, it will give you with a written notice setting forth (in a manner calculated to be understood by you):

(i) The specific reason or reasons for the adverse determination;

(ii) Specific reference to the Plan provisions on which the denial is based;

(iii) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the Plan's review of procedures and the time limits applicable to such procedures, including a statement of the rights you may have to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

(v) A copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, or a statement that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

(vi) An explanation of the scientific or clinical judgment for a determination that is based on medical necessity or experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(vii) In the case of an Urgent Care Claim, a description of the expedited review processes applicable to such claims.

In the case of an Urgent Care Claim, the information above may be provided to your orally. In such case, the Administrator must provide to you a written or electronic notice containing such information not later than 3 days after your receipt of the oral notice.

Appealing an Adverse Benefit Determination: Self-Funded Benefit Program. If you have a claim denied, you may appeal such denial. You must file a written appeal within 180 days of receipt of the notice of denial.

Review of Appeal. Upon receipt of an appeal, the PSEA-HWF will promptly take action to give due consideration to the appeal. Review of your appeal will be conducted as follows.

(i) You may submit written comments, documents, records, and other information relating to the claim for benefits.

(ii) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relating to the claim for benefits.

(iii) Review of you appeal will not afford deference to the initial adverse benefit determination and will be conducted by a named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(iv) In its review, the named fiduciary will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(v) When deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(vi) You will be provided the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(vii) Review of the appeal of an Urgent Care Claim will be conducted in an expedited manner, pursuant to which:

I. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you; and

II. All necessary information, including PSEA-HWF's decision on appeal, will be transmitted by telephone, facsimile, or other available similarly expeditious method.

Notice of Benefit Determination on Appeal.

(i) Urgent Care Claims. PSEA-HWF will notify you of its determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your appeal.

(ii) Pre-Service Claims. PSEA-HWF will notify you of its determination within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your appeal.

(iii) Post-Service Claims. PSEA-HWF will notify you of its determination within a reasonable period of time, but not later than 60 days after receipt of your appeal.

(iv) Other Claims. PSEA-HWF will notify you of its determination within a reasonable period of time, but not later than 60 days after receipt of your appeal (120 days if special circumstances require an extension of time). If special circumstances require an extension of time, written notice of the extension will be furnished to you prior to commencement of the extension.

Notice of Adverse Benefit Determination on Appeal. If PSEA-HWF denies an appeal to any extent, it will furnish you with a written notice setting forth (in a manner calculated to be understood by you):

(i) The specific reason or reasons for the adverse determination;

(ii) Specific reference to the Plan provisions on which the denial is based;

(iii) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(iii) A statement describing any voluntary appeal procedures offered by PSEA-HWF and your right to obtain information about such procedures and a statement that you may have a right to bring an action under Section 502(a) of ERISA;

(iv) A copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, or a statement that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

(vi) An explanation of the scientific or clinical judgment for any determination based on a medical necessity or experimental treatment or similar exclusion, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request;

(vii) A statement explaining that you and PSEA-HWF may have other voluntary alternative dispute resolution options such as mediation, and that you should contact the U.S. Department of Labor and your State Insurance regulatory agency to find out what alternatives may be available.

IX. YOUR RIGHTS UNDER THE PLAN

As a Participant in the Plan, you may be entitled to certain rights and protections, as follows:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), an updated summary plan description, and any applicable collective bargaining agreement. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator may be required by law to furnish you with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue group health coverage for yourself and your Dependent(s) if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent(s) would have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in

any way to prevent you from obtaining a welfare benefit under the Plan or from exercising your rights.

Enforce Your Rights

If your claim for welfare benefits is denied or ignored, in whole or in part, you have 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.

There are steps you may be able to take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may be able to file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may be able to file suit in a state or Federal court after you have exhausted your rights for review and appeal under the Plan. In addition, if you disagree with the Plan’s decision or lack thereof

concerning the qualified status of a medical child support order, you may be able to file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may be able to seek assistance from the U.S. Department of Labor, or you may be able to file suit in a Federal court. The court will decide who should pay court costs and fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights, or if you need assistance in obtaining documents from the Plan Administrator, you may contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 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 and the Employee Benefits Security Administration may assist you. You may also obtain certain publications about your rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

X. GENERAL INFORMATION

Plan Name. Pennsylvania State Education Association Health and Welfare Plan.

Trust Name. Pennsylvania State Education Association Health and Welfare Fund ("PSEA-HWF").

Plan Sponsor. Pennsylvania State Education Association
400 North Third Street, P.O. Box 1724
Harrisburg, Pennsylvania 17105-1724

Identification Numbers. PSEA's federal tax identification number is 23-0961125.
PSEA-HWF's federal tax identification number is 23-2121745.

Plan Numbers. The following benefit programs are included in Pennsylvania State Education Association Health and Welfare Fund Program Plan Number 502: Basic Income Protection, Voluntary Disability Insurance, Basic Life Insurance, Voluntary Long Term Care, Travel and Accident, Dental, Opti-Vision, Vision, and PSEACare Dental and Vision.

Plan Year. September 1 to August 31.

Type of Plan. The Plan is an employee welfare benefit plan providing health, life, disability, and other welfare benefits to Participants.

Plan Administrator. PSEA is the administrator of the Plan. Communications concerning any aspect of the Plan should be addressed to PSEA, c/o Fund Manager, 400 North Third Street, P.O. Box 1724, Harrisburg, Pennsylvania 17105. The telephone number of the Fund Manager is (717) 255-7024 or (800) 944-7732, ext. 7024. The Plan Administrator is a named fiduciary of the Plan.

Type of Plan Administration. Certain benefits under the Plan that are provided under insurance contracts are administered by the Insurance Carrier. The remaining benefits under the Plan are

administered by the Plan Administrator or, with respect to certain benefits, by a third-party administrator.

Funding. The Plan is funded by Employer contributions, Participant contributions, insurance contracts, and Trust investment earnings.

Service of Process. Legal process may be served upon the Plan Administrator. The designated agent for service of legal process is PSEA, c/o Fund Manager, 400 North Third Street, Harrisburg, Pennsylvania 17101.

Trustees. As of September 1, 2020, the Trustees of the PSEA Health and Welfare Fund are: Arthur Aloise, Aaron Chapin, Jack Kelly, Shawn Kerbein, Jeffrey Ney, Melvin S. Riddick, and Kimberly Topper. The Trustees' business address is PSEA-HWF, 400 North Third Street, P.O. Box 1724, Harrisburg, Pennsylvania 17105-1724. The Trustees are named fiduciaries of the Plan.

NOTICE OF PRIVACY PRACTICES

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

THE PLAN'S COMMITMENT TO PRIVACY

The PENNSYLVANIA STATE EDUCATION ASSOCIATION HEALTH AND WELFARE PLAN (the "Plan") is committed to protecting the privacy of the information it maintains that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you ("health information"). In accordance with applicable law, you have certain rights, as described in this Notice, related to your health information.

This Notice informs you of the Plan's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing the Plan's legal duties and privacy practices with respect to your health information; and
- to follow the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refers to participants and Dependents who are eligible for benefits under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

The Plan collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health

information from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff, and from reports and data provided to the Plan by health care service providers. This is the information that is subject to the privacy practices described in this Notice. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information.

We are providing this Notice from the PSEA Health & Welfare Fund (referred to in this Notice as the "Fund") in order to inform you about the way that your health information may be used by the Fund. A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides your health information with important protection.

The Fund is required by federal law to maintain the privacy of your protected health information ("PHI"). The Fund is also required by federal law to provide you with this description of the privacy policies and practices adopted by the Fund. The Fund must follow these policies and

practices, but as permitted by law, the Fund reserves the right to amend or modify these privacy policies and practices.

Changes in our policies and practices may be required by changes in federal and state laws and regulations. Regardless of the reason for the change, we will provide you with notice of any material changes within sixty (60) days of the date the change is adopted. The effective date of this notice is June 30, 2021.

Under HIPAA, how can the Fund use my protected health information ("PHI")? The Fund can use your PHI to facilitate your treatment, to make or obtain payment for your treatment and for health plan operations, including administration, oversight, and other legal purposes.

How may the Fund use my protected health information ("PHI") with respect to payment for my treatment? The Fund may use your PHI for the broad range of actions needed to make

sure that the Fund can make payment for the services you and your family receive. The Fund may use your PHI for making payment to providers for services or treatment you received, for making arrangements for payment through one of the networks of providers through which the Fund provides benefits to you, as well as for coordinating payment to providers though other health plans under the Fund's coordination of benefits rule. For example, the Fund provides participants with access to a network of providers outside this immediate geographic area. The Fund may provide your PHI to the network and directly to the provider in order to ensure that the provider receives the appropriate payment for the services that have been provided to you.

How does HIPAA permit the Fund to use my protected health information ("PHI") with respect to "health care operations?" The Fund may use your PHI for a broad range of actions required to assess the quality of the Fund's plan of benefits as well as for its administration and operations. These activities include, but are not limited to, ensuring that participants or their beneficiaries are eligible for benefits prior to making payment; taking corrective action to recoup overpayments and assessing health plan performance; reviewing the Fund's plan of benefits and determining whether a reduction in costs is possible; continuing case management and coordination of care; commissioning and reviewing actuarial studies relating to the cost of benefits and management studies relating to the operation and administration of the plan; resolving internal grievances; and undertaking medical review, legal, and auditing functions. For example, the Fund

may use PHI to determine the most cost-effective manner of providing vision benefits to its participants and beneficiaries.

May the Fund use my protected health information ("PHI") for purposes besides payment and health care operations? Yes. HIPAA permits the Fund to use your PHI for a number of other purposes, including informing you of treatment alternatives or other health–related benefits that may be of interest to you.

Does HIPAA permit the Fund to disclose my protected health information ("PHI") to my employer or insurer? Under HIPAA, the Fund generally cannot disclose your PHI to your employer without your written authorization. It is important to note, however, that HIPAA does permit the Fund to disclose your PHI without your authorization to workers' compensation insurers, state administrators, or others involved in the workers' compensation systems to the extent the disclosure is required by state or other law.

May the Fund release my protected health information ("PHI") to the Fund's plan sponsor? HIPAA does permit the Fund to disclose information to the "plan sponsor" for administrative functions. Here, the "plan sponsor" is the Fund's Board of Trustees. The Fund may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids or modify, amend, or terminate the plan.

May the Fund release my protected health information ("PHI") to law enforcement or other governmental entities? Your PHI may be disclosed to law enforcement agencies, without your authorization or permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting. Note, however, that the Fund may not disclose your PHI if you are the subject of an investigation that does not arise out of or is directly related to your receipt of health care or public benefits. In addition, the Fund may disclose your PHI in the course of a judicial or administrative proceeding if the Fund receives a court order, subpoena, discovery request or other lawful process. Before releasing this information, the Fund will make reasonable efforts either to notify you or to obtain an order protecting your PHI.

Would the Fund release my protected health information ("PHI") if my health or safety or public health or safety would be jeopardized if it did not? If the Fund has a good faith belief that your health or safety or public health or safety would be jeopardized if it did not disclose the information, the Fund will do so, after consideration of appropriate legal and ethical standards.

Must the Fund have an authorization to release my protected health information ("PHI")? Yes. For example, the following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of PHI; and
- Most uses and disclosures of psychotherapy notes (if the Fund maintains any psychotherapy notes).

Any other disclosure or use of your PHI for any other purpose not described in this notice requires your written authorization. This means that if you want your friend, relative, or union representative to check on the status of a claim you submitted or to advise when or if payment will be made, you must sign an authorization form and submit it to the Fund Office. If you change your

mind after authorizing a use or disclosure of your PHI, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to the Fund of your decision to revoke the authorization.

May the Fund use or disclose my genetic information for underwriting purposes? No. The Fund is prohibited from using or disclosing genetic information for underwriting purposes.

Do I have any rights to information under the federal privacy standards? Your rights to information under HIPAA include:

- the right to request restrictions on the use and disclosure of your PHI. The Fund will carefully consider, although is not required to honor, your request for restrictions;
- the right to restrict confidential communications concerning your medical conditions or treatment if you believe that disclosure of this information could endanger you (this means, for example, that you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential). The Fund will attempt to honor reasonable requests;
- the right to opt out of receiving fundraising communications prepared the Fund;
- the right to inspect and copy your PHI. The Fund may charge a reasonable fee for copying, assembling and postage;
- the right to an electronic copy of electronic medical records. The Fund will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format;
- the right to get notice of a breach of any of your unsecured PHI;
- the right to amend or submit corrections to your PHI. If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, for example, you do not include the reason you wish to correct your records or if the records were not created by the Fund;
- the right to receive an accounting of how and to whom your PHI has been disclosed if it was disclosed for reasons other than payment or health care operations. Your written request for information must be submitted to the Fund and should state the period of time for which you are requesting an accounting;
- the right to file a complaint, that your privacy rights have been violated, with the Fund and the Secretary of U.S. Department of Health & Human Services. NOTE: you will not be penalized or otherwise retaliated against for filing a complaint.

Complaints? Comments? Requests? The Fund has designated Elizabeth C. Krause as the Privacy Officer. If you wish to request information which you have a right to receive, want to file a Complaint with the Fund or if you have any comments or questions regarding this notice, please contact Elizabeth C. Krause, Privacy Officer at 800-944-7732 ext.7140. Please note that the Fund can assess reasonable charges for copying and assembling documents you request as well as for postage.

Revised 06/25/2021

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