



Summary Plan Description

January 1, 2015

**PENNSYLVANIA STATE EDUCATION ASSOCIATION
HEALTH AND WELFARE FUND**

SUMMARY PLAN DESCRIPTION

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**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 in the Commonwealth of Pennsylvania, Employees of the Pennsylvania State Education Association (“PSEA”) or its Affiliates, and PSEA Members. 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 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 and are incorporated by reference.

Please be advised that not all Benefit Programs are available to all Employees or Members, or their family members. 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 may be amended from time to time.

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

Contribution. A payment made or required to be made by an Employer to the Fund pursuant to the terms of a collective bargaining agreement as provided under the Fund’s policies and procedures or by a Participant to self-pay for Benefits as permitted under the Fund. Contributions that are payable but not yet paid are considered “plan assets” of the Fund.

“Dependent”, depending on the definition adopted by the Contributing Employer, shall mean EITHER

(1) the Spouse of a Participant and a Participant’s child, provided any of the following conditions are met with respect to a child in accordance with Section 152 of the Internal Revenue Code:

- (a) The child is the unmarried child of a Participant or his Spouse and (i) is under 19 years of age and (ii) is financially Dependent on the Participant for one-half or more of his support.
- (b) The child is the unmarried child of a Participant or his Spouse and (i) is under the age of 23 (or the age specified in the Employer’s written agreement with the Fund, if different), (ii) is financially Dependent on the Participant for one-half or more of his support, and (iii) is enrolled as a full-time student in an educational institution (accredited university or college or technical or specialized school).
- (c) The child is the unmarried child of a Participant or his Spouse and is physically or mentally unable to be self-supporting, regardless of age, providing the disability occurred prior to age 19.

The term child includes adopted children, stepchildren and foster children who are Dependent on the Participant for principal support and maintenance.

“Dependent” also means, where the Employer elects to extend coverage to Domestic Partners, the child of the Domestic Partner of a Participant whose Employer has elected to provide Benefits to Domestic Partners, provided the child is unmarried and (i) is under 19 years of age, (ii) is under the age of 23 (or the age specified in the Employer’s written agreement with the Fund, if different), and is enrolled as a full-time student in an educational institution (accredited university or college or technical or specialized school), or (iii) is physically or mentally unable to be self-supporting, regardless of age, providing the disability occurred prior to age 19; or

(2) Dependent shall mean:

A. Child may include the following individuals who are under age 26 and are:

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

(b) A stepchild, that is, the child of the Participant's Spouse;

(c) A child placed in the custody or guardianship of a Participant by court order, regardless of whether that order requires the provision of health Benefits; provided, however, that such custody or guardianship shall be of a permanent nature and not subject, in written form or otherwise, to any condition or agreement which would allow a natural parent or other person to acquire or reacquire custody or guardianship in his discretion, even by court order. 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.

(d) A child who has been placed with the Participant for adoption. The term "placed for adoption," means the assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation. The Participant must provide the Fund with written updates about the progress of the adoption process at least once every six (6) months.

(e) 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.

NOTE: Each Contributing Employer shall make the determination about whether to extend coverage to Dependents to age 19 or to age 26 and shall so inform the Fund. The Employer, not the Fund, makes this determination.

“Domestic Partner” Same Sex Domestic Partners who meet the requirements established by the Fund: 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. NOTE: Each Contributing Employer shall make the determination about whether to extend coverage to Domestic Partners and shall so inform the Fund. The Employer, not the Fund, determines whether the Employer shall extend coverage to Domestic Partners.

“Employee” means any person who is employed by an Employer, and includes professional employees, clerical, administrative, and support personnel, supervisors, management level employees, confidential employees of an Employer, and the full-time officers and employees of PSEA and its Affiliates. An Employee does not include any person who is not treated as an Employee by an Employer on its books and records and is subsequently reclassified by any government agency or court of law as an Employee with respect to years before the reclassification. “Employee” also includes an individual who is retired or on leave of absence from employment in education or is otherwise an eligible Member who is temporarily unemployed or qualifies as an employee under the federal or state unemployment law covering his or her employment.

“Employer(s)” means

- (a) A board of school directors or other agency authorized by the laws of Pennsylvania to operate, control, conduct or administer a public school entity, including a school district, vocational school or any public or private elementary, secondary, or post-secondary school, or any junior college, college, or university, or similar educational institution in the Commonwealth of Pennsylvania which has entered into a collective bargaining agreement, participation agreement or other writing pursuant to which Contributions are made to the Fund;
- (b) PSEA and its Affiliates in their capacities as Employers which has entered into a collective bargaining agreement, participation agreement or other writing pursuant to which Contributions are made to the Fund;
- (c) Affiliates that make Contributions to the PSEA-HWF on behalf of its members which has entered into a collective bargaining agreement, participation agreement or other writing pursuant to which Contributions are made to the Fund; and
- (d) The Commonwealth of Pennsylvania and/or its political subdivisions, agencies, or instrumentalities which has entered into a collective bargaining agreement, participation agreement or other writing pursuant to which Contributions are made to the Fund.

“Insurance Carrier” means the insurers providing insured Benefits under the Plan.

“Member” means any member in good standing of PSEA or an Affiliate.

“Participant” means an Employee 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.

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

“**You**” means a Participant, Dependent, or Domestic Partner who is eligible to receive Benefits under the Plan. NOTE: Each Contributing Employer shall make the determination about whether to extend coverage to Domestic Partners and shall so inform the Fund. The Employer, not the Fund, determines whether the Employer shall extend coverage to Domestic Partners. Further, the Employer determines the termination date for Dependent Eligibility for Children.

III. ELIGIBILITY

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

- You are an Employee (or retired Employee) of a participating Employer which makes Contributions to PSEA-HWF on your behalf, pursuant to either a collective bargaining agreement or other agreement with PSEA-HWF permitting such participation;
- You are an Employee of PSEA or a PSEA Affiliate (or a retired Employee of PSEA or a PSEA Affiliate); or
- You are a PSEA Member (or maintain membership in PSEA as a retired Member) and are making self-payment as permitted by the Fund.

Generally, you may be eligible to receive Benefits under one or more Benefit Programs if:

- You are a Participant in the Plan with respect to one or more Benefit Programs;
- You are a Dependent of a Participant who participates in one or more Benefit Program(s) that provides Benefits to Dependents;
- You are the Domestic Partner of a Participant who participates in one or more Benefit Program(s) that provides Benefits to Domestic Partners pursuant to the election of the Participant’s Employer.

PLEASE NOTE: The PSEA Member (or retired Member) or Employee (or retired Employee) must continue to be a PSEA Member (or retired Member) or Employee (or retired Employee) and make any required self-paid Contributions in order for Benefits to continue to be paid under the Plan. Family members of a PSEA Member (or retired Member) or Employee (or retired Employee) may only receive Benefits under the Plan so long as they remain eligible family members of an individual who qualifies for participation in the Plan.

With respect to the Voluntary Long Term Care Program, you are eligible to participate if you are a Spouse of an eligible Member, a parent or grandparent of an eligible Member, or a parent or grandparent of a Spouse of an eligible Member. The Voluntary Long Term Care Program stopped accepting new Participants as of March 31, 1999. If you and your Spouse divorce after that date, your former Spouse and his or her grandparents would no longer be eligible for the Voluntary Long Term Care Program.

IMPORTANT INFORMATION

The participation of otherwise eligible Employees, Members and their family members 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.

Qualified Medical Child Support Orders

A child may become eligible for participation in the Plan pursuant to a qualified medical child support order. A qualified medical child support order ("QMCSO") is an order by a court or administrative agency instructing the Plan to provide medical Benefits to a child. A QMCSO is issued to ensure a child has medical Benefits coverage and is often issued during a divorce proceeding.

The Plan recognizes and administers any QMCSO it receives and approves. Participants and Beneficiaries can obtain, without charge, a copy of Plan procedures governing QMCSO determinations from the Plan Administrator. The Plan may delegate administration of QMCSO to the Insurance Carrier providing Benefits under the Plan.

IV. BENEFITS

The following Benefit Programs are currently offered under the Plan:

- Dental
- Basic Income Protection
- Basic Life Insurance
- Vision
- Prescription
- Voluntary Disability Insurance
- Voluntary Long Term Care
- Opti-Vision
- Travel and Accident
- PSEACare Dental and Vision Program

Below is a brief description of each of the Programs offered under the Plan. Participation in the Programs may be limited. You should review the following Program descriptions and the Program brochures to determine whether you may participate in a particular Program. Although this SPD provides an overview about the Benefit, you must read the Program brochure for a more complete description of the Benefits provided under the Program including Benefits, applicable deductibles, co-payments, limits, exclusions, procedures, coordination of Benefits and effective dates. Please note, in addition, that the exact types and conditions of coverage under these Programs are governed by the terms of the insurance policies or other Program documents, and by any applicable agreement between PSEA-HWF and participating Employers. Additional copies of these brochures are available at no charge upon request to PSEA, c/o Fund Manager, 400 North Third Street, Post Office Box 1724, Harrisburg, Pennsylvania 17105-1724 (717) 255-7024, (800) 944-7732 extension 7024. You may also obtain copies of the underlying Plan or Program documents, at a nominal cost, by submitting a written request for such documents to the Fund Manager at the above address.

Programs Which May Be Available To You:

I. Employees of participating Employers may be able to participate in the following Programs:

- Dental
- Basic Income Protection
- Basic Life Insurance
- Vision
- Prescription

In addition, Employees of PSEA and PSEA Affiliates also may participate in the following Programs:

- Voluntary Disability Insurance
- Voluntary Long Term Care
- Opti-Vision
- Travel and Accident

II. PSEA Members may participate in the following Programs:

- Voluntary Disability Insurance
- Voluntary Long Term Care
- Opti-Vision
- Travel and Accident

III. PSEA-R Members may participate in the following Programs:

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

1. **DENTAL**

The Dental Program provides certain dental coverage Benefits. You should read the Dental 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. Also please note that Benefits under the Dental Program may be coordinated with Benefits payable under other dental coverages you might have. The Dental Program is self-insured by PSEA-HWF, and administered by United Concordia Companies, Inc. (UCCI), P.O. Box 69421, Harrisburg, PA 17106.

2. **BASIC INCOME PROTECTION**

The Basic Income Protection Program provides short and long term income protection in the event of a Participant's disability. You should read the Basic Income Protection Program certificate of insurance for a complete description of the Benefits available under the Program including eligibility, limits, exclusions, procedures, and effective dates. The Basic Income Protection Program is insured by the Trustmark Insurance Company, 400 Field Drive, Lake Forest, IL 60045.

3. BASIC LIFE INSURANCE

The Basic Life Insurance Program provides Benefits to the beneficiary of an insured Employee in the event of the Employee's death. You should read the Basic Life Insurance Program certificate of insurance for a complete description of the Benefits offered under the Program including eligibility, limits, exclusions, procedures, and effective dates. The Basic Life Insurance Program is insured by the Trustmark Insurance Company, 400 Field Drive, Lake Forest, IL 60045.

4. VISION

The Vision Program provides vision Benefits. You should read the Vision Program brochure for a complete description of the Benefits offered under the Program including eligibility, Benefits, applicable deductibles, co-payments, limits, exclusions, procedures, and effective dates. The Vision Program is self-insured by PSEA-HWF and is administered by National Vision Administrators, P.O. Box 2187, Clifton, NJ 07015.

5. PRESCRIPTION

The Prescription Program provides prescription Benefits. You should read the Prescription Program brochure for a complete description of the Benefits offered under the Program including eligibility, Benefits, applicable deductibles, co-payments, limits, exclusions, procedures, and effective dates. The Prescription Program is self-insured by PSEA-HWF and is administered by Express Scripts, Inc., P.O. Box 66586, St. Louis, MO 63166.

6. VOLUNTARY DISABILITY INSURANCE

The Voluntary Disability Insurance Program provides short and long term income protection payments in the event of a Participant's disability. Optional cost-of-living adjustments, in-hospital, and accident expense riders are also available. You should read the Voluntary Disability Insurance 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 Disability Insurance Program is insured by the New York Life Insurance Company in the City of New York, 51 Madison Avenue, New York, NY 10010 and administered by USI Affinity Insurance Service, 1 International Plaza, 4th Floor, Philadelphia, PA 19113.

7. 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 UNUMProvident Corporation, 2211 Congress Street, Portland, ME 04122 and administered by USI Colburn Insurance Service, 1 International Plaza, 4th Floor, Philadelphia, PA 19113

8. OPTI-VISION

The Opti-Vision Program provides certain discounts for vision examinations, lenses, and frames from participating vision providers. 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.

9. TRAVEL AND ACCIDENT

The Travel and Accident Program provides certain travel and accident Benefits to Employees of PSEA and PSEA Members while on business travel on behalf of PSEA, PSEA Health and Welfare Fund, or for any local Affiliate. You should read the Travel and Accident Program brochure for a complete description of the Benefits offered under the Program including eligibility, limits, exclusions, procedures, and effective dates. The Travel and Accident Program is insured by National Union Fire Insurance Company of Pittsburgh, PA, 70 Pine Street, New York, NY 10270.

10. PSEACARE DENTAL AND VISION PROGRAM

The PSEACare Dental and Vision Program provides certain 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. The Program is operated on a July 1 to June 30 or January 1 to December 31 contract year. Individuals eligible to participate cannot join or 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.

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 no longer working in a position represented by the PSEA, ceasing to participate in any category of PSEA membership) or loss of your Employer's eligibility to participate in the Plan or a specific Program;
- your failure to make Contributions to PSEA-HWF when due (if you are required to make Contributions); or
- failure of your Employer to make Contributions to PSEA-HWF when due (if required under a collective bargaining agreement or other agreement between your Employer and PSEA-HWF).

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. You should read the PSEACare Dental and Vision Program brochure for more information on when your participation under the PSEACare Dental and Vision Program may be terminated.

Family Coverage. Your family's coverage generally terminates when your coverage terminates. However, special Continuation Coverage rules for certain health Benefits may apply to you or your family members. Section VII of this Summary Plan Description provides more information about the Continuation Coverage rules.

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

<p>BOTH YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS NOTICE</p>

Continuation Coverage – If you are an Employee of a participating Employer covered by the PSEA Health and Welfare Plan, you have the right to choose Continuation Coverage for yourself and/or your family, 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.**

Please note that even if you elect continuation coverage from the Fund, you will need to elect medical coverage separately. Electing continuation coverage through the Fund will **not** provide you with continuing medical coverage.

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 other members of your family 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.

If you lose coverage for health Benefits under this Plan, you may be Eligible to continue your health Benefits coverage by purchasing "COBRA" continuation coverage. This coverage is described in detail below. You may also be able to purchase coverage that includes medical, prescription, and also dental and vision coverage alternatives through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

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.” You, your Spouse, and your Dependent children 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 an **Employee** of a participating Employer covered by the PSEA Health and Welfare Plan, you will become a qualified beneficiary if you lose health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

If you are the **Spouse** 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:

- Your Spouse dies;
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his/her gross misconduct;
- Your Spouse becomes entitled to Medicare Benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Dependent children of an Employee covered by the PSEA Health and Welfare Plan will become qualified beneficiaries if they lose health coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee’s hours of employment are reduced;
- The parent-Employee’s employment ends for any reason other than his/her gross misconduct;
- The parent-Employee becomes entitled to Medicare Benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “Dependent.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee’s Spouse, surviving Spouse, and Dependent children will also become qualified beneficiaries if the bankruptcy results in their loss of health coverage under the Plan.

<p>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.</p>
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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 end of employment or reduction of hours of employment, death of the Employee, the commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee's becoming entitled to Medicare Benefits (under Part A, Part B, or both), 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 Dependent child's losing eligibility for coverage as a Dependent, 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, your Employer's 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. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

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), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent, 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 and children 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 anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family 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 your family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family 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 Spouse and any Dependent children 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, or if the Dependent child stops being eligible under the Plan as a Dependent, but only if the event would have caused the Spouse or Dependent child 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.

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 Employer ceases to provide any group health plan for its employees.

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 and Dependent child(ren) losing eligibility for coverage as a Dependent.

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 Family and Medical Leave Act ("FMLA") and the Uniformed Services Employment and Reemployment Rights Act ("USERRA") and for qualified medical child support orders ("QMCSOs"). These special rules may only apply if you receive Benefits from the Fund as an Employee of a participating employer (or as a family member of such Employee). Briefly, FMLA may entitle you to elect to continue or discontinue your group health plan participation while you are on an FMLA leave of absence, and, if you suspend your coverage, you will be reinstated immediately upon your return to active employment.

USERRA allows veterans to return to covered status under a group health plan under special timing rules. QMSCOs generally require a parent's group health plan to cover a child where the parents are divorced. Furthermore, state laws may provide additional continuation coverage or other protection of Benefit rules that may apply to you. See your Employer 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" or "Dependent children," 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.

VIII. CONTRIBUTIONS

The Plan is funded by Contributions from Employers, Contributions from Participants, insurance contracts, and assets of the Trust. Contributions for Employers and 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.. 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 exclusively 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 by check or money order 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.

IX. SUBROGATION AND REIMBURSEMENT

If you or a Dependent who is covered under this Fund become ill or injured as a result of a third party's actions, the Plan is given the broadest rights to recover any 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, subject to any equitable principles or defenses that you raise and are cognizable under applicable federal law. Where this section refers to "you," it means both the Participant and the Dependent, regardless of whether the Participant is a party to any action against the third party. The Plan's rights of subrogation and reimbursement are detailed in Article VII of the Plan document. You should contact the Plan Administrator if you have any questions or would like a copy of the Plan document.

X. CLAIMS

Claims for Benefits Under an Insured Program

Initial Procedures. All claims should be made in accordance with the terms of the particular Benefit Program in which you participate. The entity which has discretionary authority over any claim made under the Plan is a named plan fiduciary with respect to such claim.

Right to Review of Denied Claims. If a claim for Benefits for an insured Program is denied in whole or in part, you are entitled to have your claim initially reviewed by the Insurance Carrier. You or your authorized representative will receive from the Insurance Carrier, a written notice stating the specific reason(s) for the denial, a specific reference to the provisions in the policy, the Program, or the Plan upon which the denial of your claim is based, and a description of any additional information or material necessary for you to perfect your claim, accompanied by an explanation of why such material or information is necessary. You will also receive an explanation of the applicable claims review procedure. You will then be entitled to a reconsideration of the denial of your claim in accordance with the terms of the policy or program description relating to the particular Program in which you participate.

If the Insurance Carrier does not establish a procedure for reconsideration of a denied claim, or if the Insurance Carrier denies the claim after reconsideration, you may seek arbitration of the claim as described below and in accordance with the Plan provisions governing this issue, in which case:

- I. PSEA-HWF waives its right to assert that you failed to exhaust administrative remedies because you did not submit the Benefit dispute to arbitration under the Plan;
- II. PSEA-HWF agrees that any statute of limitations or other defense based on timeliness is tolled during the time that arbitration is pending;
- III. You may submit a Benefit dispute to arbitration only after exhausting the appeals permitted by the Insurance Carrier.
- IV. PSEA-HWF will provide you, upon request, sufficient information relating to the arbitration to enable you to make an informed judgment about whether to submit a Benefit dispute to arbitration, including a statement that your decision as to whether or not to submit a Benefit dispute to arbitration will not affect your right to any other Benefits under the Plan, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process.
- V. No fees or costs will be imposed on you in connection with the arbitration.

A request for arbitration as described above must be filed with PSEA-HWF by written notice within 60 days after your receipt of the notice of denial.

Upon receipt of a request for arbitration PSEA-HWF will promptly seek arbitration of the dispute in accordance with the Dispute Resolution Program for Insurance Claims of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

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 you 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 a your 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;
- (iv) 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;
- (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 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.

XI. 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 5500 Series) 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 Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents 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.

XII. 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 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. 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.

Collective Bargaining Agreements. The Plan is maintained in part pursuant to one or more collective bargaining agreements. Certain Participants and beneficiaries who participate in the Plan pursuant to the terms of a collective bargaining agreement may receive a copy of the applicable collective bargaining agreement upon written request to the Plan Administrator. Collective bargaining agreements may be available for examination by Participants and beneficiaries at the office of the applicable Employer.

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, 2012, the Trustees of the PSEA Health and Welfare Fund are: Arthur Aloise, Frederick T. Berestecky, Donald S. Grenaldo, Jack Kelly, Dolores McCracken,

Melvin S. Riddick, and W. Gerard Oleksiak. 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.



400 North Third Street
PO Box 1724
Harrisburg, PA 17105-1724
(717) 255-7024 • (800) 944-7732

