

**PENNSYLVANIA STATE EDUCATION ASSOCIATION
HEALTH AND WELFARE FUND
FLEXIBLE BENEFITS PROGRAM
SUMMARY PLAN DESCRIPTION**

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**PENNSYLVANIA STATE EDUCATION ASSOCIATION
HEALTH AND WELFARE PLAN
FLEXIBLE BENEFITS PROGRAM
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. The Plan provides a number of different Benefit Programs. This summary provides information about one of the Benefit Programs provided under the Plan: the Flexible Benefits Program. This summary is designed to answer your questions about how the Flexible Benefits Program works. If you have any questions after reading this summary, the Plan Administrator will be available to discuss the Plan with you.

This document is only intended to provide you a brief summary of the Flexible Benefits Program. In order to fully understand the detailed operation of the Flexible Benefits Program, and the Plan as a whole, you would need to review the Plan document (which includes a separate Appendix G covering the Flexible Benefits Program), the Trust Agreement, and any agreements that the Plan maintains with Insurance Carriers or Administrators. 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 the Flexible Benefits Program is only available to eligible employees of employers that have agreed to join the Plan and participate in the Flexible Benefits Program. Also, please be advised that any or all of the Benefit Programs provided under this Plan, including the Flexible Benefits Program, 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.

“**Claims Administrator**” means the Fund’s third-party administrator responsible for administering the Flexible Benefits Program under the Plan.

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

“Dependent” means 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 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.

“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.

“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;
- (b) PSEA and its Affiliates in their capacities as Employers;
- (c) Affiliates that make contributions to the PSEA-HWF on behalf of its members; and
- (d) The Commonwealth of Pennsylvania and/or its political subdivisions, agencies, or instrumentalities.

“Incurred” - An expense is **“incurred”** within the meaning of the Flexible Benefit Program, when you become obligated to pay the expense. Generally, this is when you receive the service or product that gives rise to the expense, not when you are billed or pay for the service or product.

“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.

“Program Year” means, with respect to the Employees of an Employer that has joined the Plan to participate in the Flexible Benefit Program, the twelve-month period designated as the Program Year in the written agreement between the Employer and the Fund that provides for participation in the Flexible Benefits Program.

“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. For purposes of the Plan, the terms Spouse and marriage shall have the meanings given to them under the federal Defense of Marriage Act, Pub. L. 104-99 §1 (Sep. 21, 1996) to the extent it applies.

“You” means an individual who is or may become entitled to elect, or has elected, to participate in the Flexible Benefits Program.

III. ELIGIBILITY

Generally, you are eligible to participate in the Flexible Benefits Program if:

- You are an Employee of a participating Employer that has adopted the Plan and the Flexible Benefits Program; and
- You meet the eligibility criteria established by your Employer in its adoption agreement with the Plan.

Your participating Employer decides whether one or both of the Accounts will be made available to you. Your Employer also determines how long you must work (not more than 12 months) and how old you must be (not older than 21) in order to participate. The Claims Administrator of the Flexible Benefits Program will give you information about the Accounts your Employer has made available to you and the eligibility criteria you must meet in order to participate.

Taxation of Domestic Partner Coverage

Under Federal law, if a Domestic Partner or the child of a Domestic Partner is not a dependent of an Employee participating in the Plan 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 Employee and reported as such on the Employee'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 Flexible Benefits Program allows eligible Employees to pay for certain types of expenses on a pre-tax basis. Participants may contribute, through salary reduction contributions, to one or both of the following Accounts:

- Dependent Care Reimbursement Accounts
- Health Care Reimbursement Accounts

Participants may use the amounts credited to their Accounts to pay for eligible expenses. Participants make contributions to their Accounts by electing to reduce their wages and to have that amount of the reduction credited to their Account(s). The amount by which a Participant's wages are reduced is generally not subject to federal income tax, Social Security (FICA) taxes, and, in most cases, state income taxes.

The participating Employer's agreement with the Plan specifies which of the Accounts will be established under the Flexible Benefits Program for that Employer's Employees. It also specifies how long Employees must work (not more than 12 months) and how old Employees must be (not older than 21) in order to participate.

Dependent Care Reimbursement Account

Amounts credited to your Dependent Care Reimbursement Account may be used to pay eligible dependent care expenses.

The maximum amount that you may elect to contribute for a Program Year to your Dependent Care Reimbursement Account is \$5,000.00 (\$2,500 if you are married and file a separate return for federal income tax purposes). Also, your contributions to a Dependent Care Reimbursement Account may not exceed your or your Spouse's earned income during the Program Year. If your Spouse is a full-time student or is physically or mentally incapable of caring for him/her, your Spouse is deemed to have earned income for this purpose of \$200/month (if you have only one Dependent who is a qualifying individual) or \$400/month (if you have more than one Dependent who is a qualifying individual).

You may use the balance credited to your Dependent Care Reimbursement Account, during the Program Year, to pay for your eligible dependent care expenses. The balance of your Account at any time during a Program Year will be equal to the total of the amounts by which your salary has been reduced, as of that date, less any amounts paid to you or on your behalf for eligible dependent care expenses during the Program Year.

Eligible dependent care expenses are, generally, expenses that you or your Spouse incur, in order to allow you and your Spouse to be gainfully employed, for household expenses and the care of a qualifying individual. A qualifying individual may be either your Dependent (for whom you may claim a deduction on your federal income tax return) who is under age 13, or your Spouse or

another dependent who lives with you, if the Spouse or other dependent is physically or mentally incapable of caring for him/herself. However, you may receive reimbursement only for expenses that qualify to be excluded from your federal income tax as dependent care assistance. The person who provides care for the qualifying individual(s) must be over the age of 18 and may not be your or your Spouse's Dependent.

The rules for making elections to participate, making claims for benefits, and other rules that may affect your Account are described below.

Health Care Reimbursement Account

Amounts credited to your Health Care Reimbursement Account may be used to pay eligible medical expenses.

The maximum amount that a Participant may elect to contribute for a Program Year to a Health Care Reimbursement Account is \$5,000.00; however, your Employer may choose a lower amount as the maximum contribution allowed to be made to a Health Care Reimbursement Account for its Employees.

At the beginning of a Program Year (or the first date of your participation, if later), your Health Care Reimbursement Account will be credited with the full amount you have elected to contribute to it for that Program Year; it will be reduced, during the Program Year, for each payment made to you or on your behalf for eligible medical expenses, at the time such payment is made.

Eligible medical expenses are generally any medical expenses incurred by you, your Spouse, or your Dependents during the Program Year that are not covered by insurance and that you could deduct as medical expenses on your federal tax return. Eligible expenses do not include insurance premiums, long-term care expenses, or expenses reimbursed through any other source.

The rules for making elections to participate, making claims for benefits, and other rules that may affect your Account are described below.

V. PARTICIPATION

The Flexible Benefits Program operates on the basis of a Program Year, which is a 12-consecutive-month period that begins and ends on the dates set by your Employer.

Your Employer establishes the eligibility requirements (how long you must work and how old you must be to become eligible) as described above. After becoming eligible, you must choose whether to participate in the Flexible Benefits Program before the beginning of each Program Year. If you first become eligible to participate during the first year you are hired, you may elect to participate for the remainder of the current Program Year. In order to participate, you must complete an enrollment form and submit it to your Employer in accordance with the Employer's procedures.

Except if you have a “change in circumstances” (explained below), your elections of whether to participate and how much you will contribute to an Account cannot be changed during a Program Year.

If you do not complete an election form to participate for a Program Year and return it to your Employer by its due date, you will be deemed to have elected not to participate in the Flexible Benefits Program for that Program Year.

Change in Circumstances

If you have a change in circumstances, you may change your elections for the rest of that Program Year, but only in a way that is consistent with and due to the change in circumstances. The Claims Administrator has the discretion to determine whether you have had a change in circumstances and what kind of new election is permitted under the Flexible Benefits Program. The following is a list of events that may constitute a change in circumstances for this purpose:

- Change in your marital status (including marriage, death of a Spouse, divorce, legal separation, or annulment);
- Change in the number of an eligible Employee’s Dependents (by reason of birth, death, adoption, or placement for adoption);
- Change in employment status of either the Employee or the Employee’s Spouse;
- Change in a Dependent’s status as a Dependent;
- Change in your place of residence;
- Significant change in the cost or provider of dependent care coverage (e.g., by reason of an increase or decrease in rates charged or a change in the provider of care);
- Becoming entitled to Medicare or Medicaid, or to exercise a special enrollment right under HIPAA, or taking family or medical leave under the Family and Medical Leave Act (FMLA).

You should contact the Claims Administrator for further information on changes in circumstances or if you think you may qualify for changing your elections based on a change in circumstances.

VI. PAYMENT OF ELIGIBLE EXPENSES

You may use your Account balances to pay for eligible expenses incurred during the Program Year and during the Grace Period for the Program Year, which is the 2 1/2 month period following the end of the Program Year. You must submit all of your claims for expenses incurred during a Program Year and the Grace Period for that Program Year no later than 90 days after the end of the Grace Period. For the Flexible Benefits Program, an expense is “incurred” when you become obligated to pay the expense, regardless of when you are actually billed for, or pay, it. Generally, this occurs when you receive the service or product on which the expense is based.

The following is an example of how these rules work. If your Program Year began on January 1, 2008, and ended on December 31, 2008, the Grace Period for the Program Year would run from January 1, 2009, until March 15, 2009 (2 1/2 months after the end of the Program Year), and you could make claims for that Program Year for your eligible expenses incurred from January 1, 2008, until March 15, 2009. The deadline for submitting all claims for that Program Year (including Grace Period claims) would be June 15, 2009, 90 days after the end of the Grace Period.

You may make a claim for an eligible expense at any time during a Program Year by following the claims process established and maintained by the Flexible Benefits Program Claims Administrator. You will be required to submit proof of your eligible expenses. If the Claims Administrator approves a claim, the Claims Administrator will pay the claim by check, or, if you have elected this method with the Claims Administrator, by direct deposit to your selected bank account. Your Employer may also choose to provide you with the option of paying for eligible expenses with an electronic debit card, for which you may be charged a small additional amount per month.

Any balance remaining in your Account after the end of the Program Year, and after payment of all of your claims submitted for that Program Year, will be forfeited.

Your claims for reimbursement will be handled by the Claims Administrator of the Flexible Benefits Program in accordance with the rules applicable to Claims, described below.

VII. TERMINATION OF COVERAGE

Participant Coverage. Your participation in the Flexible Benefits Program will terminate in the following circumstances:

- discontinuance of the Plan as a whole or of the Flexible Benefits Program;
- loss of your eligibility (such as ceasing to be an eligible Employee of a participating Employer) or loss of your Employer's eligibility to participate in the Plan or in the Flexible Benefits Program;

- your failure to make the contributions to PSEA-HWF when due in accordance with your elections for a Program Year; or
- failure of your Employer to make contributions to PSEA-HWF when due (as required under your elections for a Program Year or the agreement between your Employer and PSEA-HWF); or
- your election (or deemed election) not to participate in the Flexible Benefits Program for a Program Year.

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 the Flexible Benefits Program for claims that arose before termination of your participation in the Plan or under the Flexible Benefits Program.

You will have 90 days from the termination of coverage to file claims that were for expenses incurred before termination of your participation in the Plan.

VIII. 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 the Flexible Benefits Program for claims that arose before termination of your participation under the Plan or under the Flexible Benefits Program will not be affected.

IX. CONTINUATION OF COVERAGE FOR CERTAIN HEALTH BENEFITS

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

In General

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice 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 other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when 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 the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your 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 your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or 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.

Your dependent children will become qualified beneficiaries if they lose 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 or 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 child."

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, 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 or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Pennsylvania State Education Association at 400 North Third Street, PO Box 1724, Harrisburg, PA 17105. The telephone number is 717-255-7024.

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.

The COBRA continuation coverage lasts only until the end of the plan year in which the qualifying event occurs. COBRA continuation coverage may only be elected under this plan if, as of the date of the qualifying event, the maximum benefit available under the plan for the remainder of the plan year is more than the maximum amount that the Plan could require as payment to maintain coverage for the remainder of that plan year.

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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA 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 Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Pennsylvania State Education Association
400 North Third Street, PO Box 1724, Harrisburg, PA 17105
717-255-7024

Special Rules - In addition, special rules may apply under the Family and Medical Leave Act (“FMLA”), the Health Insurance Portability and Accountability Act (“HIPAA”), 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. 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. USERRA allows veterans to return to covered status under a group health plan under special timing rules. QMCSOs 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.

X. CONTRIBUTIONS

The Flexible Benefits Program is funded solely through salary-reduction contributions made by Participants. Other Program of the Plan are funded, variously, through 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, 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 as set forth from time to time in elections you make in accordance with the terms of the Flexible Benefits Program. Such contributions will be paid by your Employer to the PSEA Health and Welfare Fund and will be held in trust under the Plan. The Fund is located 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.

XI. SUBROGATION AND REIMBURSEMENT

In certain situations, such as an automobile accident, the Plan may pay benefits for a sickness or injury caused by another person or organization and the party at fault may pay you for those medical and related expenses. You must pay back to the Plan or Insurance Carrier who paid the claim the amount the party at fault paid you or the provider, up to 100% of the benefit the Plan or Insurance Carrier paid. 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.

XII. CLAIMS

Initial Procedures. All claims should be made in accordance with the procedures established by the Claims Administrator of the Flexible Benefits Program. The Claims Administrator, which has discretionary authority over any claim made under the Flexible Benefits Program, is a named plan fiduciary with respect to such claim.

Right to Review of Denied Claims. If a claim for benefits under the Flexible Benefits Program is denied in whole or in part, you are entitled to have your claim initially reviewed by the Claims Administrator. You or your authorized representative will receive from the Claims Administrator, a written notice stating the specific reason(s) for the denial, a specific reference to the provisions in the Flexible Benefits 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 Flexible Benefits Program, which are described as follows.

Appealing an Adverse Benefit Determination. 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.

Notice of Benefit Determination on Appeal.

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.

XIII. 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.

XIV. 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. Although the Plan is administered as one plan, for simplification of the reporting requirements, the Plan has been divided into two components. The following insured benefit Programs are included in Pennsylvania State Education Association Health and Welfare Fund Insured Program Plan Number 501: Basic Income Protection, Voluntary Disability Insurance, Basic Life Insurance, Voluntary Long Term Care, and Travel and Accident. The following self-insured benefit Programs are included in Pennsylvania State Education Association Health and Welfare Fund Self-Insured Program Plan Number 502: Dental, Opti-Vision, Vision, Prescription, PSEACare Dental and Vision, and Flexible Benefits.

Plan Year. September 1 to August 31.

Program Year. With respect to the Employees of an Employer that has joined the Plan to participate in the Flexible Benefit Program, the twelve-month period designated as the Program Year in the written agreement between the Participating Employer and the Fund that provides for participation in the Flexible Benefits Program.

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.

Claims Administrator. Tri-Star Benefit Systems, Inc. is the Claims Administrator of the Flexible Benefits Program. Communications concerning the Flexible Benefits Program should be addressed to Tri-Star Benefit Systems, Inc., 14323 South Outer 40 Road, Suite 200-S, Chesterfield, MO 63017. The telephone number of the Claims Administrator is (800) 727-0182.

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, 2008, the Trustees of the PSEA Health and Welfare Fund are: Fred T. Berestecky, Michael J. Crossey, Donald S. Grenaldo, Jack Kelly, Clair E. Lewis, 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.