Staff Education Association Retiree VEBA

Summary Plan Description
And
Plan of Benefits

Effective July 1, 2010, as Amended

June 13, 2011, November 22, 2011, December 12, 2011 & January, 19, 2012

Staff Education Association Retiree VEBA
Three Gateway Center
Suite 1625
Pittsburgh, PA 15222

Visit Us at

www.searveba.com

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Letter from the Board of Trustees

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SEARV Benefit & Coverage Summaries

EXHIBIT A: RETIREE MEDICAL: Transamerica Premier Life Insurance Company

EXHIBIT B: PRESCRIPTION DRUG: United Healthcare

Staff Education Association Retirees VEBA

Three Gateway Center, Suite 1625, Pittsburgh, PA 15222
Phone – (412) 325-2805, Toll Free – (866) 520-9174, Facsimile – (412) 325-2801

To All Staff Education Association Retiree VEBA Eligible Participants:

The Board of Trustees is pleased to furnish you with this Summary Plan Description ("SPD") describing the benefits available to eligible Participants under the Staff Education Association Retiree VEBA ("Plan"). The VEBA was established as a result of a Settlement Agreement reached with the Ohio Education Association (OEA) in 2010. The Plan became effective on July 1, 2010.

"VEBA" stands for voluntary employees' beneficiary association. VEBAs are a type of trust instrument used to hold plan assets for the purpose of providing employee benefits. VEBAs are authorized by Internal Revenue Code § 501(c)(9).

This Summary Plan Description contains information that you need to know about the Plan and how best to take advantage of it, including:

- Description and Overview of the Plan
- Eligibility and Enrollment Provisions
- Medical and Prescription Drug Coverage Summaries
- SEARV Administration
- Your Rights under ERISA
- Privacy Practices of the Plan

The VEBA offers coverage through a Supplemental Medicare (Medical) Benefit Plan along with a Medicare Part D Prescription Drug (PDP) Benefit Plan. A brief description of benefits provided and any required monthly self-contributions are described in this Summary Plan Description. Additionally, the Benefit Packets and Coverage Certificates of the Plan's two insurance companies provide essential information on the coverage provided through each individual insurance company. The insurance company information is incorporated by reference as an integral part of this SPD. Please note that Benefits, Self-Contributions and Insurance Companies are subject to change at any time.

If you have any questions regarding the Plan's administration, eligibility & enrollment provisions, Plan of Benefits or the amount of Self-Contributions toward your coverage, we encourage you to contact the SEARV Administrative Office at the address and telephone number shown at the top of this page as well as shown throughout this Summary Plan Description. For additional important information, please visit the SEARV web site at: **www.searveba.com.** The web site is updated as changes occur within the Plan.

Sincerely,

The Board of Trustees
Staff Education Association Retiree VEBA

The Staff Education Association Retiree VEBA (SEARV) Summary Plan Description (SPD) and Plan of Benefits is not intended to be all inclusive, but rather summarize the main features of the Plan. If there are any conflicts between the information presented in this SPD and the legal Plan documents that govern the Plan, the legal Plan documents will govern. SEARV reserves the right to change or terminate any or all benefits plans at its discretion and in accordance with governing Plan Documents.

CONTACT INFORMATION & REFERENCE CHART

INFORMATION ON THE PLAN	CONTACT
Plan Administrative Operations: Questions and Information on: • Eligibility • Benefits • Monthly Self-Contributions • Plan Documents **Board of Trustees:** John A. Wardell, Chairman Robert Hockenberger, Co-Chairman Garrett Harbron, Secretary to the Board Paul Gonzalez Priscilla Roberge	**SEARV** Three Gateway Center, Suite 1625 Pittsburgh, PA 15222 1-866-520-9174 (toll-free) (412) 325-2801 facsimile **WEB SITE** www.searveba.com **Third Party Administrator** CW Breitsman Associates, LLC
Supplemental Medicare Coverage: (Retiree Medical)	**Transamerica Premier Life** www.mymedsuppinfo.com 1-800-854-0186
Prescription Drug Coverage: (Medicare Type PDP Plan)	**United HealthCare** 1-888-556-6648 www.UHCRetiree.com
Medicare Information:	www.medicare.gov 1-800-MEDICARE (1-800-633-4227)

SECTION I: AUTHORITY AND DUTIES OF THE BOARD OF TRUSTEES

The Board of Trustees and/or its duly authorized designee(s) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this Summary Plan Description, the Trust Agreement and any other plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or Trust. Without limiting the generality of the statement of right, authority, power and discretion, the Board of Trustees and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan.

- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Summary Plan Description and Trust Documents.

- Answer questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan.

- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plans, including this booklet, the Trust Agreement or other plan documents.

- Determine the standard of proof required in any case. All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all Participants, beneficiaries and any other individuals claiming benefits under the Plans. The Board of Trustees may delegate any other such duties or powers as it deems necessary to carry out the administration of the Plans.

- The Board of Trustees also reserves the right in its sole and absolute discretion to amend or terminate the Plan as provided for in the Agreement and Declaration of Trust (effective March 1, 2010) and Settlement Agreement (dated February 2, 2010). While continuation of benefits is expected, it is not guaranteed. Neither you, your beneficiaries nor any other person has or will have a vested or non-forfeitable interest in the Plan, unless specifically indicated. In the event of the Plan's termination (which might occur if the Plan Assets are insufficient to allow the Plan to continue), the Board of Trustees will apply the monies in the funds to provide benefits or otherwise carry out the purpose of the Plan in an equitable manner until the Plan assets have been disbursed. In no event, will any part of the Plan's assets revert to OEA.

SECTION II: ESTABLISHMENT OF THE PLAN

This Summary Plan Description ("SPD") and Plan of Benefits has been prepared to give you a general understanding of the terms of the Staff Education Association Retiree VEBA (the "Plan").

On February 2, 2010, a Settlement Agreement was reached and approved by the United States District Court for the Southern District of Ohio, Eastern Division between the Ohio Education Association (OEA) and the Class Representatives on behalf of the Settlement Class. The Settlement Agreement provided, in summary, among other things:

- Compensatory Damages. OEA provided an initial single payment to the Plan to be used for the reimbursement of Class Member healthcare expenses incurred from 2004 through December 1, 2009.

- Initial Funding. OEA contributed to the Plan a calculated amount of funds to cover healthcare expenses and other administrative operating expenses for the initial year of operation. This amount was set forth in the Settlement Agreement.

- Subsequent Funding. OEA contributed a calculated amount, as set forth in the Settlement Agreement, each December to fund the health care expenses and other administrative expenses for subsequent Plan Years, and made what was believed to be the final contributions in December 2014 and January 2015.

SECTION III: DEFINITIONS

Administrator
The person or persons delegated the authority to administer the Plan.

OEA
The Ohio Education Association, the Defendant in the matter of *Prater, et al v. The Ohio Education Association*, Case 2:04-CV-1077 in the United States District Court for the Southern District of Ohio.

Board of Trustees
The body that is the Plan Sponsor and Named Fiduciary of the Trust Fund whose authority and duties are set forth in the Agreement and Declaration of Trust Establishing the Staff Education Association Retirees' VEBA Trust or one of its amendments and whose members are individual Trustees. The Board of Trustees is comprised of three (3) Class Members and two (2) Public Members.

Class Member
Each individual who qualifies to be included in the Court-Certified Class the Litigation, the matter of *Prater, et al v. The Ohio Education Association*, Case 2:04-CV-1077 in the United States District Court for the Southern District of Ohio.

Class Members, Dependents, and Contingent Beneficiaries if they are eligible for benefits under this plan and are within the defined group of Covered Persons in the Agreement and Declaration of Trust Establishing the Staff Education Association Retirees' VEBA Trust or one of its amendments.

Dependent
An eligible spouse, child, or surviving spouse of a Class Member.

ERISA
The Employee Retirement Income Security Act of 1974, any amendments as may from time to time be made and any regulations promulgated pursuant to the provisions of ERISA.

STAFF RETIREES' VEBA OR SEARV
The short name and abbreviation for the Staff Education Association Retirees' VEBA Trust Fund.

The Class
Any person who (a) is a retired employee of OEA who was a member of OASU at the time of his or her retirement and who retired on or before August 31, 2006, or is a dependent or surviving spouse of such a person; or (b) is a retired employee of OEA who was a member of PSU at the time of his or her retirement and who retired on or before February 8, 2010, or is a dependent or surviving spouse of such a person; or (c) is currently employed by OEA and is a member of PSU who was hired on or before August 31, 2000, and who, subsequent to the court granting preliminary approval to the proposed settlement, retires from the OEA while still a member of PSU, or is a spouse of such a person on February 8, 2010, and any dependent of such a person.

Litigation
The matter of *Prater, et al v. The Ohio Education Association*, Case 2:04-CV-1077 in the United States District Court for the Southern District of Ohio.

Named Fiduciary
The Board of Trustees, each member of which is designated or appointed pursuant to the terms of this SEARV Trust Agreement in accordance with the requirements of ERISA.

Plan of Benefits (or Plan)
The program of health and welfare benefits established and funded or insured pursuant to the Trust and as may be modified and amended pursuant to the terms of the SEARV Trust Agreement.

Plan Sponsor
The Board of Trustees, each member of which is designated or appointed pursuant to the terms of the Trust Agreement.

Public Member
An individual who has experience or expertise, through education, training or employment, in the area of employee benefits for retirees, and who is not a Class Member or an employee or officer of the OEA, the PSU, the OASU or any affiliate or successor to any of the foregoing.

Protected Health Information (or "PHI")
The term as defined in Section 164.501 of the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rules") issued by the Department of Health and Human Services ("HHS") *(see* 45 CFR §§ 160 through 164) and promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1171, *et seq.*

Settlement Agreement
The agreement titled "Stipulation of Settlement" resolving all claims raised by Plaintiffs in the Litigation against OEA which was reached between Class Representatives and OEA and approved by the Court in the Litigation.

Trust, Trust Fund or Fund
The Fund established pursuant to the Agreement and Declaration of Trust Establishing the Staff Education Association Retirees' VEBA Trust to hold the assets that will be used to fund or insure the Plan of Benefits.

Trust Agreement
The Agreement and Declaration of Trust establishing the Staff Education Association Retirees' VEBA Trust including any amendments, supplements or modifications.

Trustees
The individuals designated and appointed in accordance with the terms of the Trust Agreement who have discretionary authority to hold, manage and control the assets of this Trust and who are collectively referred to as the "Board of Trustees."

SECTION IV: BASIC PLAN INFORMATION

Name of Plan: Staff Education Association Retirees VEBA (SEARV)

Type of Plan: A Welfare Plan providing Supplemental Medicare and Medicare Part D Prescription Drug benefits to retired eligible individuals as defined as Class Members in the February 2, 2010 Settlement Agreement, retirees specified in Board of Trustees approved OEA Manager Settlement Agreement(s), and others who participate pursuant to the terms of the Trust Agreement and Plan Documents.

Plan Identification Number: 001

Employer Identification Number: 37-6532569

Plan Sponsor: The Plan Sponsor is the Staff Education Association Retirees VEBA Board of Trustees. The Plan Sponsor's contact information and address are:

Staff Education Association Retirees VEBA
Three Gateway Center, Suite 1625
401 Liberty Avenue
Pittsburgh, PA 15222

Telephone Numbers: 1-412-325-2805 (local PA)

1-866-520-9174 (toll free)

1-412-325-2801 (fax)

Web Site: **www.searveba.com**

Trust: The official name of the Plan is the Staff Education Association Retirees' VEBA Trust. This is the vehicle used to receive and hold the money and other assets that will be used to fund the Plan of Benefits, pay fees and other expenses of the Plan.

Plan Administrator and Agent for Service of Legal Process: The Board of Trustees is the Plan Administrator and Agent for Service of Legal Process of the Plan. The Board of Trustees is currently comprised of Class Members John L. Wardell, Pricilla Roberge and Robert Hockenberger, Public Members Paul Gonzalez and Garrett Harbron. Their principal place of business is listed under the Plan Sponsor section above.

Plan Administrator and Named Fiduciary: The Board of Trustees is the Plan Administrator and the Named Fiduciary of the Plan.

Third Party Administrator: The Plan is administered on a day-to-day basis by a Third Party Administrator, who acts on behalf of the Plan Administrator but has no discretionary authority or control over the Plan.

Third Party Administrator

CW Breitsman Associates, LLC
Three Gateway Center, Suite 1625
401 Liberty Avenue
Pittsburgh, PA 15222

Telephone Numbers: 1-866-520-9174 (toll free)
(412) 325-2108 (fax)
(412) 325-2805 (western PA-local)

SEARV Administrative Contacts:

Charles W. Breitsman & Michele Gentile

Email addresses: charlie@cwb-a.com
michele@cwb-a.com

Plan Year: The 12-month period beginning on January 1 of each year and ending on the following December 31.

SECTION V: OVERVIEW OF THE PLAN

In General

As a Retiree (Class Member), spouse of a Retiree, surviving Spouse of a Retiree, an eligible dependent or retirees specified in a Board of Trustees approved OEA Manager Settlement Agreement(s), you may be eligible to participate in the benefits provided through the SEARV Supplemental Medicare and Prescription Drug Benefit Plans once you become Medicare Eligible.

Medicare Enrollment Coordination

If you are close to age 65 and have not applied for Social Security benefits, you must file a Medicare application with the Social Security Administration during your seven month Medicare Initial Enrollment Period. This period begins with the three-month period immediately preceding the month in which you turn age 65 and ends three months after the month you turn age 65. Your start date for Medicare Part B will be delayed if you wait until you are 65 or sign up during the last three months of your Medicare Initial Enrollment Period.

If you are eligible for Medicare coverage and wish to enroll in this Plan, you must also enroll in Medicare Parts A and B; otherwise, you cannot receive benefits under this Plan.

The Plan's SEARV Administrative Office will attempt to notify you regarding the Plan's enrollment requirements prior to the month in which you turn 65 and become eligible for Medicare. Such notice is made at least 60 days prior to the month in which you will turn 65. If you become eligible for Medicare before you turn 65 (e.g., if you become eligible for Medicare because you are receiving disability benefits from Social Security), you should notify the SEARV Administrative Office for possible special enrollment circumstances.

Initial Enrollment Period

The Initial Enrollment Period is the period prior to you becoming Medicare eligible. The effective date of your initial coverage in this Plan is the 1st of the month in which you become Medicare eligible, have enrolled in Medicare Parts A & B, and you fulfill all of the requirements for enrolling in the Plan.

Open Enrollment Period

There is also a SEARV Open Enrollment Period during the fall of each year, generally, from October through December for Medicare eligible Retirees, their eligible Dependents and retirees specified in a Board of Trustees approved OEA Manager Settlement Agreement(s), who initially waived enrollment in this Plan. This Open Enrollment Period is typically for those who had other qualified coverage (as described further below) and elected to waive Initial Enrollment and are now electing to enroll in this Plan.

Special Circumstances, Life Event Enrollment Period

A Medicare eligible Retiree, Spouse, Surviving Spouse, eligible Dependent or retirees specified in a Board of Trustees approved OEA Manager Settlement Agreement(s), who had waived Initial Enrollment under this Plan, because he or she had other Qualifying Health Care Coverage and Creditable Prescription Drug Coverage (as described below) as of the Initial Enrollment Period, can

elect to enroll in the Plan outside the Open Enrollment Period if they incurred a Life Event circumstance, such as loss of qualified coverage.

The following types of coverage will be considered other Qualifying Health Care Coverage:

- Coverage under a group health plan.

- Health insurance coverage, whether the coverage is offered in the group market, the individual market, or otherwise. For this purpose, health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any policy, certificate, or contract offered by an insurance company, insurance service, insurance organization, or HMO that is licensed to engage in the business of insurance in a state and subject to state law that regulates insurance.

- Credible Prescription Drug Coverage that is at least equal to a qualifying Medicare Part D plan.

Self-Contributions

To receive benefits under the Plan, you must make a Self-Contribution payment each month to the SEARV Administrative Office. The Self-Contribution payment is a nominal amount to cover certain base expenses of the Plan. The amount of the Self-Contribution is determined on an annual basis by the Board of Trustees and is subject to change. The Plan allows Participants to have the Self-Contribution payments made either by check or through a personal bank account direct withdrawal transaction each month. The SEARV Administrative Office will assist you in handling those details.

Termination of Coverage

Your coverage will terminate on the last day of the month during which the earliest of the following events occurs (except as otherwise indicated):

- you fail to make a timely Self-Contribution to the Plan, in which case, coverage will terminate on the last day of the month for which a timely contribution was received (a 30-day grace period will apply);
- you die;
- the Plan is terminated for any reason.

The Board of Trustees is mindful that unusual circumstances occur from time to time and reinstatement of coverage may be considered on a case by case basis.

SECTION VI: SEARV PLAN OF BENEFITS

As briefly described in the pages that follow, Participants who are eligible for Medicare and are properly enrolled in the Plan are provided benefit coverage through a **Supplemental Medicare** and a **Prescription Drug Program**. These Plans provide medical benefits that supplement your Medicare Parts A & B benefits along with prescription drug benefits under a Medicare Part D type plan.

SEARV Supplemental Medicare Plan

The Supplemental Medicare Plan is offered through Transamerica Premier Life Insurance Company and helps cover the cost of medical expenses in conjunction with Medicare Part A and Part B coverage. Medicare generally pays 80% for covered services and the Medicare Supplemental Plan generally pays 20% of the Medicare-approved amount. (The Supplemental Medicare Plan pays only for expenses approved by Medicare, regardless of whether Medicare continues to pay, or if Medicare benefits have been exhausted.)

A Summary of Benefits under the Supplemental Medicare Plan describing what Medicare pays, what the Plan pays and any costs that you may be responsible for can be found under **Exhibit A** in the back of this Summary Plan Description. For additional information on the Medicare Supplemental Plan, please refer to the Benefit information packet which is provided to you by Transamerica Premier Life Insurance Company.

SEARV Prescription Drug Plan

The Prescription Drug Plan is offered through UnitedHealthcare Insurance Company, a Medicare Prescription Drug Plan (PDP) that contracts with the Federal government. Plans are insured or covered by UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor.

A Summary of Benefits and Coverage under the Prescription Drug Plan can be found under **Exhibit B** in the back of this Summary Plan Description. The Summary of Benefits explains some features of the Prescription Drug Plan. It doesn't list every drug covered, every limitation, or every exclusion. To get a complete list of your benefits, please call UnitedHealthcare MedicareRx for Groups and ask for the "Evidence of Coverage." For additional information, please visit the SEARV web site at:

www.searveba.com

SEARV has also elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see your Additional Drug Coverage list for more information.

For additional information, please visit the SEARV web site at: **www.searveba.com**

Q & A provided by UnitedHealthcare

Where is UnitedHealthcare MedicareRx for Groups Plan available?

The service area for this plan includes the 50 United States, the District of Columbia, and the territories. You must live in the service area to join this Plan.

Does my plan cover Medicare Part B or Part D drugs?

UnitedHealthcare MedicareRx for Groups does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies associated with the delivery of insulin that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

Where can I get my prescriptions?

UnitedHealthcare MedicareRx for Groups has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current pharmacy directory or visit us at:

www.UHCMedicareRxforGroups.com

The Customer Service number is listed at the end of this introduction.

What if my doctor prescribes less than a month's supply?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying co-insurance (a percentage of the cost of the drug) or a co-pay (a flat dollar amount for the drug). If you are responsible for co-insurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a co-pay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

What is a prescription drug formulary?

UnitedHealthcare MedicareRx for Groups uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a Part D Abridged Formulary to you.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I get extra help with my prescription drug plan costs or get extra help with other Medicare costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.

- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or

- Your State Medicaid Office.

What are my protections in this plan?

All Medicare Prescription Drug Plans agree to stay in the program for a full plan year at a time. Plan benefits and cost-sharing may change from plan year to plan year. Each year, plans can decide whether to continue to participate with the Medicare Prescription Drug Program. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Prescription Drug Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area and your plan sponsor will notify you of their options for your coverage.

As a member of UnitedHealthcare MedicareRx for Groups, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered.
An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact UnitedHealthcare MedicareRx for Groups for more details.

Please call UnitedHealthcare for more information about UnitedHealthcare ® MedicareRx for Groups (PDP). Visit us at www.UHCMedicareRxforGroups.com or, call us at:

1-888-556-6648 (toll free TTY/TDD 711), 8 a.m. - 8 p.m., local time, Monday through Friday

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

For additional information, call Customer Service at the phone number listed above.

SECTION VII: APPEALS

Appeal of a Benefit Decision

This section describes how you appeal a provider's benefits decision. You must follow the appeals process, including any time limits, described for each provider if you wish to appeal a claim which has been denied in full or in part. If, after the first and second appeal, you or your dependent is not satisfied with the decisions regarding benefits, you have a right to make a final appeal to the SEARV Board of Trustees.

These procedures include any applicable time limits within which your claims must be filed.

If you still have questions, you may call the SEARV Administrative Office at (866) 520-9174.

Appeal Procedure for Decisions Concerning Eligibility or Other Plan Rules

While initial decisions and appeals regarding benefits are made by the entity which administers the benefits (Transamerica Premier Life for Supplemental Medicare coordinated claims; UnitedHealthcare for drug benefit claims), decisions and appeals regarding eligibility to participate in the Plan or the application of Plan rules are made under the direction of the Board of Trustees. The initial decision concerning eligibility to participate in the Plan or application of Plan rules is made by the SEARV Administrative Office. Generally, this initial decision happens when you or a dependent is denied participation in the Plan or is denied coverage (in whole or in part) for a service because of eligibility or coordination of benefits issue or other Plan rule. If you have a question about why your claim was denied for one of these reasons, you should contact the SEARV Administrative Office at (866) 520-9174. If you feel the initial decision was in error, you have the right to request that this decision be reviewed, and this request must be made within 180 days of your notification of the initial decision. This review by the SEARV Administrative Office is a Level 1 review. One appeal from the Level 1 review is allowed.

Level 1 Appeal

The SEARV Administrative Office will review the materials supplied to it and provide a written response not later than 20 business days after your appeal request, and all documents in support of that appeal, are received. If your appeal is denied in whole or in part, the written response will state the specific reason or reasons for the adverse determination; reference the specific Plan provision, rule or guideline on which the determination is based; provide a description of any additional material or information necessary for you to perfect the claim and an explanation of why such information is necessary; and provide a description of how you can appeal the determination. You also will be provided a copy of any rule or guideline upon which the determination is based.

Level 2 Appeal

If you are dissatisfied with the Level 1 Appeal decision, you may request a Level 2 Appeal within 90 days of your notification of the Level 1 Appeal decision. At Level 2, the appeal is reviewed by the SEARV Board of Trustees. Level 2 Appeals will be resolved by the Board of Trustees no later than 90 days from the date that your Level 2 Appeal was received by the SEARV Administrative Office. You will receive a written response to your Level 2 Appeal. If your appeal is denied in whole or in part, the written response will state the specific reason or reasons for the adverse determination and will

reference the specific Plan provision, rule, or guideline on which the determination is based. If you have not already been provided a copy of any rule or guideline upon which the determination is based, you be will provided one.

Expedited Appeals

If your physician believes that the standard appeal time frames could seriously jeopardize your health or could subject you to severe pain that cannot be adequately managed, your appeal will be expedited. The SEARV Administrative Office, by applying a prudent layperson standard, may also determine when an appeal may be expedited.

The SEARV Administrative Office will complete expedited review of a Level 1 appeal as soon as possible considering the medical urgency of the situation, but no later than seventy-two (72) hours after it receives the Level 1 appeal request and will communicate the Plan's decision by telephone to your attending physician or the ordering provider. The SEARV Administrative Office also will provide written notice of the Plan's determination to you, your attending physician or ordering provider, and the facility rendering the service. If a Level 2 Appeal is necessary, the SEARV Administrative Office will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and circumstances permit. The Plan's decision will be communicated by telephone to your attending physician or the ordering provider The SEARV Administrative Office will also provide a written notice of the Plan's determination to you, your attending physician or ordering provider, and to the facility rendering the service.

The SEARV Board of Trustees has full discretionary authority to make final determinations regarding any application for benefits and the interpretation of the Plan and any other regulations, procedures, or administrative rules adopted by the SEARV VEBA. Decisions of the SEARV Board of Trustees (or, where appropriate, decisions of the SEARV Administrative Office) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the SEARV Board of Trustees or a subcommittee is challenged in court, it is the intention of the SEARV Board of Trustees that such decision is to be upheld unless it is determined to be arbitrary or capricious.

SECTION VIII: PLAN AMENDMENTS AND TERMINATION

The SEARV Board of Trustees, subject to certain restrictions contained in the Settlement Agreement and the Agreement and Declaration of Trust, has the power and authority to amend or terminate the Plan at any time and in such manner as it may deem advisable, including but not limited to the authority to increase, decrease, change, amend, or terminate benefits, eligibility rules, or other provisions of the Plan.

Plan Subrogation

If the Plan pays benefits for a Plan Participant who later recaptures the value of those benefits as compensatory damages in litigation, or in settlement of litigation or threatened litigation, the Plan has an immediate right to be reimbursed all benefits paid by the Plan, and the recovered funds constitute plan assets.

SECTION IX: PRIVACY NOTICE OF YOUR HEALTH PLAN

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

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of your Health Plan to protect the privacy of your medical information. The Plan may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accounting Act of 1996 (HIPAA), for purposes of making or obtaining payment for your care, facilitating your treatment by health care providers and conducting health care operations. This Plan has established a Privacy Policy to establish the rules of the use and disclosure of protected health information ("medical information") by the Plan and to guard against unlawful or unnecessary disclosure of your medical information. The Plan is required by law to maintain the privacy of your medical information maintained by the Plan and to provide you with notice of its legal duties and privacy practices with respect to this information.

THE INITIAL EFFECTIVE DATE OF THIS NOTICE IS MAY 14, 2010. The Plan is required to follow the terms of this notice until it is replaced. The Plan reserves the right to change the terms of this notice at any time. If the Plan makes any material changes to this notice, the Plan will revise it and send a new notice to all Participants within 60 days. The Plan reserves the right to make the new changes apply to all your medical information maintained by the Plan before and after the effective date of the new notice.

Purposes for which the Plan May Use or Disclose Your Medical Information Without Your Consent or Authorization.

The Plan may use and disclose your medical information for the following purposes:

- *Health Care Providers' Treatment Purposes*. For example, the Plan may disclose your medical information to your doctor, at the doctor's request, for your treatment by him.

- *Payment*. For example, the Plan may use or disclose your medical information to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.

- *Health Care Operations*. For example, the Plan may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) to authorize Business Associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage, Plan or develop the Plan's business.

- *Health Services*. The Plan may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your medical information to its Business Associates to assist the Plan in these activities.

- *As required by law*. For example, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose your medical information as authorized

by and to the extent necessary to comply with workers' compensation or other similar laws.

- *To Business Associates*. The Plan may disclose your medical information to Business Associates the Plan hires to assist the Plan. Each Business Associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.

- *To Plan Sponsor*. The Plan may disclose your medical information to the Plan Sponsor to carry out Plan administration functions performed by the Plan Sponsor. Where feasible, the information provided to the Plan Sponsor will be in summary form or with identifying information such as names, addresses and other similar information deleted. The Plan may also disclose to the Plan Sponsor the fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your medical information to the Plan Sponsor only to the extent permitted by the Plan documents and Plan Privacy Policy and only if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

The Plan may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes such as complying with a subpoena.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To assist law enforcement officials in identifying a suspect, fugitive, material witness or missing person.
- To law enforcement officials if they believe your death was the result of a crime.
- To correctional facilities where you are being held.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To the appropriate governmental authority to protect a victim of abuse, neglect or domestic violence.
- To a governmental agency authorized to oversee the health care system or government programs.
- To Federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes such as reporting disease, injury, births or deaths; notifying a person at risk of contracting or spreading a disease; ensuring qualify or safety of an FDA-regulated product; participating in public health investigations; or reporting about a work-related illness or injury to permit an Employer to comply with OSHA or similar Federal or State laws.
- To the extent necessary to comply with workers' compensation laws and similar programs.
- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosures with Your Permission

The Plan will not use or disclose your medical information for any other purposes nor will it provide it to another person, even a family member (unless you are a minor and not permitted to act on your own behalf under law in which case it may be disclosed to a parent), unless you give the Plan your written authorization to do so. If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has taken action in reliance on your authorization. You may also be required to file a written request form if you are seeking medical information about yourself. Authorization, revocation and request forms are available from the SEARV Administrative Office.

Personal Representative

You have the right to designate a Personal Representative (such as an Attorney or other representative) to act on your behalf and have access to your medical information as authorized by you. You must submit a written authorization to the Plan designating your Personal Representative and the information to which the representative may have access.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information that the Plan maintains:

- To put additional restrictions on the Plan's use and disclosure of your medical information. The Plan does not have to agree to your request.
- To communicate with you in confidence about your medical information by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence. Even though you requested that we communicate with you in confidence, the Plan may give subscribers cost information.
- To see and get copies of your medical information. In limited cases, the Plan does not have to agree to your request.
- To correct your medical information. In some cases, the Plan does not have to agree to your request.
- To receive a list of disclosures, not authorized by the Privacy Rule, of your medical information that the Plan and its Business Associates made for certain purposes for the last 6 years (but not for disclosures before May 14, 2010).
- To send you a paper copy of this notice upon request or to provide you with a copy of the Plan's Privacy Policy.

If you want to exercise any of these rights described in this notice, please contact the Privacy Officer at the SEARV Administrative Office. The SEARV Administrative Office will give you the necessary information and forms for you to complete and return to the SEARV Administrative. In some cases, the Plan may charge you a nominal, cost-based fee to carry out your request.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan at the SEARV Administrative Office (below). You will not be retaliated against if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services. You may also file a complaint with the Secretary of The U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Contact the SEARV Administrative Office

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact the SEARV Administrative Office:

Mr. Robert Hockenberger, Privacy Officer
SEARV Administrative Office
Three Gateway Center, Suite 1625
Pittsburgh, PA 15222

SECTION X: STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

What are my rights under ERISA? As a participant in the SEARV, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, also known as ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of a plan. The people who operate your 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If you have a claim for a benefit that is denied or goes undecided, 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.

Under ERISA, there are steps you can 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 file suit in a 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 administrator. If you have a claim for benefits which is denied or goes undecided, in whole or in part, you may file suit in a state or federal court after exhausting all levels of review with the Plan Administrator or its designee. If you disagree with the decision or lack thereof, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you

may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal 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. However, no legal action may be commenced or maintained against the Plan prior to your exhaustion of the Plan's claims procedures described in this SPD.

Receive Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator or the Third Party Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should 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.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration's publications hotline at 1-866-444-3272.

SEARV Benefit Summaries

EXHIBIT A: RETIREE MEDICAL

Transamerica Premier Life Insurance Company

EXHIBIT B: PRESCRIPTION DRUG

United HealthCare

Important Note: The following Exhibit A & B display the essential benefit summaries of the Plan. Terms, conditions and covered services are subject to change on an annual basis. Also, please refer to the insurance company certificates of insurance and accompanying documents for additional information. Should SEARV receives a notice of any changes, you will be notified in a reasonable timeframe. Please keep all information regarding changes to the Plan along with this Summary Plan Description in a safe place.

You can also visit the SEARV web site for information on any changes to the Plan.

www.searveba.com

EXHIBIT A

SEARV Retiree Medical Plan – 2017 Summary

Underwritten by Transamerica Premier Life Insurance Company, Cedar Rapids, IA

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD*

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,316	$1,316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	0%	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	0%	3 pints	$0
Additional amounts	100%	0%	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	0%	Balance

Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified. For complete details please see the Master Policy. This policy is renewable at the option of the insurer. This policy's renewability, cancellability and termination provisions are at the option of the group policy holder except in cases of non-payment of premium.

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – In or Out of the Hospital and Outpatient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $183 of Medicare Approved Amounts*	0%	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	20%	$0
Part B Excess charges (Above Medicare Approved Amounts)	0%	100%	$0
BLOOD			
First 3 pints	0%	All costs	$0
Next $183 of Medicare Approved Amounts*	0%	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES:			
Medically necessary skilled care services and medical supplies	100%	0%	$0
Durable medical equipment:			
First $183 of Medicare Approved Amounts*	0%	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	0%	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

EXHIBIT B
SEARV Retiree Prescription Drug – 2017 Summary
United Healthcare

This is a highlight of benefits only and is NOT all inclusive of the Plan's benefits, services, limitations or exclusions		
BENEFITS AND COVERAGE	**In-Network Services**	**Out-of-Network Services**
Part D Outpatient Prescription Drugs		
Part D Gap Coverage	**Full Coverage**	
Initial Coverage Limit	**$3,700**	
True Out of Pocket Threshold	**$4,950**	
Catastrophic Coverage Benefits Amounts	**Greater of 5% Coinsurance or $3.30 for generic drugs and $8.25 for all other drugs**	
Formulary	**16PDP G Full Edit**	
Standard Formulary Edits	**On**	
Bonus Drug List	**List U**	
Rx Deductible		
Part D Retail Copay (up to a 30-day supply)		
Tier 1 Drugs	**$5.00**	
Tier 2 Drugs	**$15.00**	
Tier 3 Drugs	**$30.00**	
Tier 4 Drugs	**$30.00**	
Part D Preferred Mail Order Copay (up to a 90-day supply)		
Tier 1 Drugs	**$10.00**	
Tier 2 Drugs	**$30.00**	
Tier 3 Drugs	**$60.00**	
Tier 4 Drugs	**$60.00**	
Wellness/Clinical Programs		
Preferred Diabetic Supply Program	**Not Included**	
Hi Health Discount Program	**Included**	
HouseCalls Program	**Not Included**	

Visit Us at

www.searveba.com

Staff Education Association Retiree VEBA
Three Gateway Center
Suite 1625
Pittsburgh, PA 15222

1-(866) 520-9174 TOLL FREE