RETIREE HEALTH AND WELFARE BENEFITS FOR MEMBERS AGE 65 OR MEDICARE ELIGIBLE

Dear Retiree:

This letter is being sent to you because you have submitted your Notification of Retirement to the District. If you retire in June, your current prescription, dental and vision coverage will end on August 31st. If you retire any other time during the course of the school term, your prescription, dental and vision benefits will terminate upon us being notified by the District.

As a retiree, you may be eligible to continue your prescription drug coverage by enrolling in the Philadelphia Federation of Teachers Health and Welfare Fund Retiree Program. You may remain in this program for your lifetime, as long as you maintain continuous coverage with the Fund, but you must enroll within 2 months of your retirement.

Please review the Retirement page at pfthw.org for useful benefits information. You may also contact the Fund to speak with one of our coordinators to discuss your benefit options.

(I) Definition of Eligibility for the Retiree Program:

a. Those who retire under a State Early Retirement Plan (30 years of service or more) – no age requirement;
b. A person who has retired from a PFT bargaining unit and is at least 65 years of age.
c. Approved PSERS Disability Retirement and/or the Health and Welfare Fund's Long Term Disability benefit.
d. A person who has retired from a PFT bargaining unit and is at least age 55 with a combination of age and years of service that equal 65 or more.

(II) Below is a summary of the Retiree Plan with Independence Blue Cross Select Option (PDP Plan):

RETIREE – AGE 65 or Older – or- Medicare Enrolled due to disability **Premium is $140.00 per month; Payable every 6 months for a total of $840.00.**
Both Retail and Mail Order provide a 90-day supply at $60.00 for brand and $15.00 for generic **Both Retail and Mail Order provide a 30-day supply at $40.00 for brand and $10.00 for generic**

(III) Enrollment

a. **After you make the first payment when you enroll, you will be billed $840.00 twice a year**:
   Payment due dates:
   January 2nd for March 1st - August 31st
   July 1st for September 1st - February 28th
b. Enrollment after these deadlines may result in a Medicare imposed late enrollment penalty.

RETIREE HEALTH AND WELFARE BENEFITS FOR MEMBERS AGE 65 OR MEDICARE ELIGIBLE

(IV) Two Important Notes for Retirees on Medicare:

1. Medicare guidelines forbid simultaneous enrollment in both an individual Medicare Advantage Plan, (including Medical only Plans) and our Medicare Part D Drug Plan. Medicare will automatically discontinue Medical coverage for Advantage Plan members who enroll in our Part D Drug Plan. For more information concerning this, call the Fund Advocate Line at 215-600-4119.

2. The Affordable Care Act of 2010 implemented a new income-related premium (IRMAA) on beneficiaries' enrolled in Part D plans. This income-related adjustment is calculated and administered directly by CMS and will be deducted from the member's Social Security check. Annual income is determined by tax returns from the previous year.

(V) COBRA

a. In addition to the retiree packet, a letter from the Health & Welfare Fund office will also be sent separately to you and your dependents shortly regarding continuation of prescription, dental and vision through COBRA. **No one on Medicare should take COBRA because a Medicare Part D penalty may apply.**

(VI) PFT Health & Welfare Fund Retiree Dental Plan - Retirees and eligible dependents may enroll. An application will be in the retiree packet.

Individual	$31.93 per month – **billed by United Concordia quarterly** ($95.79)
Two People	$58.16 per month – **billed by United Concordia quarterly** ($174.48)
Family	$75.55 per month – **billed by United Concordia quarterly** ($226.65)

RETIREE HEALTH AND WELFARE BENEFITS FOR MEMBERS AGE 65 OR MEDICARE ELIGIBLE

STEPS TO FOLLOW TO CONTINUE THE HEALTH AND WELFARE FUND

Independence Blue Cross Select Option (PDP) Medicare Part D Drug Plan and United Concordia Dental Plan

Retiree Plan (for the Retiree only): Return Everything to retireeinfo@pfthw.org

1. Complete the Retiree Benefits Application form to enroll.
2. Provide a copy of your Personal Choice, Keystone or Medicare card.
3. Provide a copy of your PSERS Statement or Retirement Estimate showing years of service.
4. Visit pfthw.org to set up your online account for payment.
5. Complete the dental application and return to **United Concordia** directly.
6. Email items #1 - #3 to retireeinfo@pfthw.org

COBRA

1. You will sign and return the acceptance letter when it is mailed to you and include the first month's payment. Be sure to list each family member to be covered along with their social security number.
2. When your completed application and payment are received, the Fund office will send you a fee schedule.

If you have any additional questions, you may visit our website or call our office. We are pleased to assist you at this important time in your life.

Sincerely,

LeShawna Coleman
Chief Trustee

11/2025

PHILADELPHIA FEDERATION OF TEACHERS HEALTH AND WELFARE FUND RETIREE BENEFIT APPLICATION

Last Name	First	M.I.	Social Security #

Home Address	City	State/Zip	Phone#

Date of Birth

__/__/__

Please submit a copy of your medical/Medicare card Members are permitted to have prescription coverage from **ONLY ONE SOURCE**

Female ☐
Male ☐

Date retired from School District of Philadelphia ____/____/_____

Work location from which you retired. _____

Personal Email Address (REQUIRED)

_____ **I give permission to use this email address for billing and other Fund communications.**

The data furnished by me on this application is accurate to the best of my knowledge.

_____ ____/____/_____

(Signature) (Date)

*Submit this application with a copy of your last statement of account from the Public School Employees Retirement system (PSERS) or a copy of your Disability Retirement Approval Letter. Your statement must show how many years of service you have. If you cannot locate either of these forms, please request a copy from PSERS at 215-443-3495.

Rev.11/2025

RETIREMENT PRESCRIPTION APPLICATION

Your retirement prescription benefit will become effective depending on the following event:
a) Your retirement date, from which you will have 2 months from the retirement date to apply
b) Or within 2 months of the conclusion of COBRA benefits

PFT HEALTH AND WELFARE FUND – RETIREMENT PRESCRIPTION PLAN

Last Name, First Name, M.I.	Social Security #	Phone #
Home Address	City, State and Zip Code	

Coverage start date, please check one of the following options:

1. ☐ I elect coverage effective January 1st through February 28th totaling $280 and $840.00 for coverage effective March 1st through August 31st totaling $1,120.
2. ☐ I elect coverage effective February 1st through February 28th totaling $140 and $840.00 for coverage effective March 1st through August 31st totaling $980.
3. ☐ I elect coverage effective March 1st through August 31st totaling $840.
4. ☐ I elect coverage effective April 1st through August 31st totaling $700.
5. ☐ I elect coverage effective May 1st through August 31st totaling $560.
6. ☐ I elect coverage effective June 1st through August 31st totaling $420 and $840.00 for coverage effective September 1st through February 28th totaling $1,260.
7. ☐ I elect coverage effective July 1st through August 31st totaling $280 and $840.00 for coverage effective September 1st through February 28th totaling $1,120.
8. ☐ I elect coverage effective August 1st through August 31st totaling $140 and $840.00 for coverage effective September 1st through August 31st totaling $980.
9. ☐ I elect coverage effective September 1st through February 28th totaling $840.
10. ☐ I elect coverage effective October 1st through February 28th totaling $700.
11. ☐ I elect coverage effective November 1st through February 28th totaling $560.
12. ☐ I elect coverage effective December 1st through February 28th totaling $420 and $840.00 for coverage effective March 1st through August 31st totaling $1,260.

Please pay online at pfthw.org

Subsequent payments will be due bi-yearly on January 2nd and July 2nd. Late payments will NOT be accepted. If I fail to make timely payments, I understand that I will be permanently terminated from the prescription plan.

Signature_____ Date____ / / ____

The Affordable Care Act 2010 implemented a new income-related premium on beneficiaries enrolled in Part D plans. This income-related adjustment is calculated and administered directly by CMS and will be deducted from member's Social Security check. Annual income is determined by tax returns from the previous year

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For Office Use Only

Date Receive / / Date of Payment / / Amount $

11/2025

PHILADELPHIA FEDERATION OF TEACHERS

Health and Welfare Fund

1816 Chestnut Street

Philadelphia, PA 19103

215.561.2722

ARTHUR G. STEINBERG
PFT President

LESHAWNA COLEMAN
Chief Trustee

Dear Retiree:

The Philadelphia Federation of Teachers Health and Welfare Fund is pleased to send you a complete description of the United Concordia Retiree Dental Plan. We trust that you will find this new booklet helpful and informative.

We wish you the best of health and happiness during your retirement.

Sincerely,

LESHAWNA COLEMAN

Chief Trustee

Rates Effective: 1/1/2025

Single • $31.93/Monthly $95.79/Quarterly

Two People • $58.16/Monthly $174.48/Quarterly

Family • $75.55/Monthly $226.65/Quarterly

This booklet describes the principal features of your program. It is an attempt to explain the benefits available to you as clearly and briefly as possible. Complete terms of the program are set forth in your United Concordia Group Dental Agreement. Final interpretation of any specific provision is governed by reference to that Agreement.

GENERAL INFORMATION

DEPENDENTS ELIGIBLE FOR ENROLLMENT

Your spouse and all unmarried children under 26 years of age are eligible for enrollment.

CHANGES IN YOUR ADDRESS OR FAMILY STATUS

It is important that you notify our office promptly of any change in your address or your family status - Including marriage, divorce, birth or adoption of a child, marriage of dependent children, death of spouse or child. Change forms and application cards should be given directly to the United Concordia Plan Office.

HOW BENEFITS ARE RECEIVED

United Concordia Plan (Dentist's Charges)

Present your United Concordia Identification Card at the time services are provided by a network dentist. The dentist will submit a claim form directly to United Concordia on your behalf. The payment will be sent to the dentist and United Concordia will notify you of the final disposition of the claim.

A non-participating dentist, in most cases, will submit a claim to United Concordia on your behalf. However, if they will not submit a claim, it will be your responsibility to do so within one year from the date of services. Request an itemized bill which shows:

1. Patient’s name and address
2. Date of service
3. Type of service and diagnosis
4. Itemized charges
5. Dentist's complete name and address

Then add the subscriber's name and identification numbers (as shown on your identification card), and the patient's date of birth. If you need assistance, contact United Concordia at 1-866-646-7913.

Claim submissions are forwarded to:

United Concordia Companies, Inc. Dental Claims

P. O. Box 69421

Harrisburg, PA 17106

When services are performed by non-participating dentists, the payment is made directly to the subscriber.

TERMINATION OF COVERAGE

When your eligibility terminates, all benefits of this program will end.

THE GROUP DENTAL PROGRAM IS NOT AVAILABLE ON A DIRECT BILLING BASIS.

UNITED CONCORDIA GROUP DENTAL PROGRAM

CONCORDIA FLEX

Our group dental program consists of the services listed below.

PAYMENT OF BENEFITS

MAC -Maximum Allowable Charge or the maximum dollar amount a dental program will pay.

Payment for services performed by United Concordia Participating Dentists (those dentists with whom United Concordia has a contract with respect to payment for services) will be made to the dentist on the basis of a percentage of the MAC allowance (as specified below) or the amount charged, whichever Is less.

A participating dentist must accept United Concordia's allowance as payment in full for covered services. You are responsible for any coinsurances, deductibles and amounts exceeding the maximum (if applicable under your program) or any service not covered by United Concordia. The sum of your payment and the United Concordia payment will be accepted as payment in full provided that your payment is made to the participating Professional Provider within 60 days of notification by United Concordia. If your payment is not made within 60 days, the participating Professional Dentist may bill you the difference between the charge and the MAC allowance.

Payment for covered services performed by Non-Participating Dentists will be made to you on the basis of a percentage of the MAC allowance (as specified below) or the amount charged, whichever is less.
Non-participating dentists are not obligated to accept the MAC allowance as payment-in-full. Such payment will constitute full discharge of United Concordia's responsibility under the Program. You are responsible for payment of the remaining charge.

Payment under the program is limited to a maximum of $1,500 per person for all services rendered in any calendar year.

The Basic Program	**80%MAC**
Diagnostic Services	**80%MAC**
Preventive Services	**80%MAC**
Minor Restorations	**80%MAC**
General Services	**80%MAC**
Oral Surgery	**50%MAC**
Prosthetics and Crown, Inlay and Onlay Restorations	**50%MAC**
Periodontics	**50%MAC**

Benefits will be provided for eligible dental services when billed *by* the dentist in charge of the case. This professional care can be performed anywhere unless otherwise Indicated.

You are entitled to a payment for the following covered services you receive from a dentist provided they are deemed dentally necessary by United Concordia:

THE BASIC PROGRAM

1. Diagnostic Services:
   A. Routine oral examinations, but not more than once in any period of 6 consecutive months.
   B. Dental X-rays:
      Full mouth x-rays, but not more than once in any period of 36 consecutive months.
      Bitewing x-rays but not more than once in any period of 6 consecutive months.
      Periapical x-rays as required.

1. Preventive Services:
   a. Routine prophylaxis (including cleaning, scaling and polishing of teeth), but not more than once in any period of 6 consecutive months.
   b. Topical fluoride application for dependent children under 19 years of age, but not more than once in any period of 6 consecutive months.
   c. Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under 19 years of age.
2. Minor restorations: Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.
3. General Services:
   A. Repair of broken partial or full removable dentures.
   B. Palliative emergency treatment of an acute condition requiring immediate care.
   C. Simple extractions
   D. Endodontics, including pulpotomy, direct pulp capping and root canal treatment.
   E. Administration of anesthesia in connection with covered services when rendered by or under the direct supervision of a dentist other than the surgeon, assistant surgeon or attending dentist
   F. Inpatient consultations if the condition requires it and the dentist in charge of the case requests the consultation. You are limited to one consultation per consultant during any one inpatient stay.

ORAL SURGERY

1. Surgical removal of teeth.
2. Surgical removal of maxillary or mandibular intrabony cysts.
3. Procedures performed for the preparation of the mouth for dentures.
4. Apicoectomy (dental root resection)
5. Services of a dentist who actively assists the operating surgeon in the performance of oral surgery when the condition of the patient or the type of surgery performed requires assistance. Surgical assistance is not covered when performed by a dentist who himself performs and bills for another surgical procedure during the same operative session.

Limitations on Oral Surgery

1. If more than one oral surgical procedure is performed by the same dentist during the same operative session, United Concordia shall pay 1000% of the MAC allowance for the highest paying procedure and no allowance for additional procedures except where United Concordia deems that an additional allowance is warranted.

PROSTHETIC AND CROWN, INLAY AND ONLAY RESTORATIONS

Coverage for prosthetics. crowns, inlays and onlays may be limited to the least expensive but adequate treatment plan consistent with established dental standards. A more expensive treatment plan than that covered under this dental program may be selected with the understanding that the subscriber will be responsible for paying the difference in cost between the treatment received and the United Concordia allowance. (Refer to Alternate Treatment Section.)

1. Initial insertions of bridges (including pontics and abutment crowns, inlays and onlays).
2. Initial insertion of partial or full dentures (including any adjustments during the 6-month period following insertion).
3. Replacement of an existing partial or full denture or bridge by a new denture or by a new bridge, but only if satisfactory evidence is presented that:
   A. The existing denture or bridge was inserted at least 5 years prior to the replacement; and
   B. The existing denture or bridge is not serviceable and cannot be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable.
4. Single unconnected crowns, inlays and onlays (none of which is part of a bridge or are splinted together).
5. Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least 5 years have elapsed since the date of the insertion of the existing crown, inlay or onlay, and only if the existing crown, inlay or onlay is unserviceable and cannot be made serviceable.
6. The addition of teeth to an existing partial denture or to a bridge, but only if satisfactory evidence is presented that the addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge was inserted.
7. Relining or rebasing of dentures more than 6-months after the insertion of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months.
8. Repair of broken crowns, Inlays, onlays and bridges.

Exclusions and Limitations on Prosthetics and Crown, Inlay and Onlay Restorations:

1. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the MAC allowance for such procedure will be made toward a more elaborate or precision attachment denture or bridge that the subscriber and dentist may choose to use, and the balance of the cost is your responsibility.
2. If the personalized dentures, bridges or crown, inlay and onlay restorations or specialized techniques as opposed to standard procedures are chosen, payment of the applicable percentage of the MAC allowance for the standard covered services will be made toward such treatment and the balance of the cost is your responsibility.
3. Payment will be made for crown, inlay and onlay restorations only if the tooth cannot be restored with another material, such as amalgam. However, if the tooth can be restored with another material, payment of the applicable percentage of the MAC allowance for that procedure will be made toward the charge for the restoration selected. The balance of the treatment charge is your responsibility.
4. Any denture or bridge replacement made necessary by reason of loss or theft or subscriber alteration of a denture or bridge shall not be considered a covered service.
5. No payment will be made for any crown, inlay or onlay restoration or for any denture or bridge and the fitting thereof which was prescribed while the subscriber was not covered under this Program or for which the restorative treatment was initiated or the denture or bridge prescribed while you were covered under this Program and which is finally inserted more than 30 days after termination of coverage.
6. No payment will be made for precious metal dentures. Payment of the applicable percentage of the MAC allowance for a nonprecious metal denture will be made toward the charge for the precious metal denture selected by the subscriber and dentist. The balance of the treatment charge is your responsibility.
7. No payment will be made until services are completed. Crowns, inlays, onlays, bridges and dentures shall be considered completed on the date they are finally inserted.

PERIODONTAL SERVICES

1. Diagnosis and treatment planning including periodontal examination.
2. Nonsurgical periodontal therapy including periodontal scaling and root planning and special periodontal appliances.
3. Surgical periodontal therapy.
4. Maintenance - post treatment preventive periodontal procedures (periodontal prophylaxis).

Limitation on Periodontal Services:

1. Post treatment preventive periodontal procedures are limited to 4 in any period of 12 consecutive months. This maximum shall be reduced by the number of routine prophylaxis received during that 12-month period so that the total number of prophylaxis for a given 12-month period, including both routine and periodontal prophylaxis, shall not exceed 4.

PREDETERMINATION

Predetermination is used by United Concordia to determine eligibility of the subscriber and to review the treatment plan to determine the extent of coverage. This assures both the subscriber and the dentist that the particular service that will be performed is a covered service. However, approval by United Concordia of the treatment plan during the predetermination process does not necessarily constitute acceptance by United Concordia of liability for the services involved in the treatment plan. For example: If the patient's coverage is terminated before the planned treatment is completed, United Concordia will not be liable for any services provided after the date of such termination.

Predetermination is required for:

- All treatment plans of $300 or more;
- The extraction of six or more teeth;
- Prosthetics and Crown, Inlay and Onlay Restorations; Periodontics.

ALTERNATE TREATMENT

Frequently your dentist can choose from several alternate methods of treating a particular dental problem. For example, a tooth can be restored with either a crown or a filling. Missing teeth can be replaced with either a fixed bridge or a partial denture. In cases where alternate methods of treatment are possible, United Concordia will make payment based on its allowance for the less expensive procedure provided that the less expensive procedure meets accepted standards of dental treatment. Whenever this alternate treatment provision is applied, a United Concordia Dental Advisor reviews the claim.

United Concordia's decision on the allowance it will pay does not commit you to the less expensive procedure. You may decide to have the more costly treatment and to be responsible for the additional charges beyond those for the treatment paid by United Concordia.

WHAT IS NOT COVERED

Except as specifically provided in this booklet, you are not covered for services, supplies or charges that:

- Are not prescribed by or performed by or under the direct supervision of a dentist;
- Are not medically or dentally necessary as determined by United Concordia;
- Are experimental or investigative in nature;
- Are for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- The cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law;
- Are provided by any governmental unit;
- You would have no legal obligation to pay in the absence of this or any similar coverage;
- Are received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
- Are performed prior to the effective date;
- Are incurred after your termination date unless otherwise indicated.
- Are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;
- Do not meet accepted standards of dental practice;
- Are for unusual procedures and techniques;
- Are not billed by the dentist;
- Are performed by a dentist who in any case is compensated by the facility for similar covered services performed for patients;

You are not covered for:

- Telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form;
- Services which are cosmetic in nature, including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Duplicate and temporary devices, appliances, and services;
- Services related to the diagnosis and treatment of temporomandibular joint dysfunctions;
- Sealants;
- Plaque control programs and for oral hygiene and dietary instructions;
- Implantology and related services;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration for ma/alignment of the teeth;
- Local anesthesia when billed for separately by a dentist;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable by The Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- Any other dental service or treatment except as provided by this booklet;
- Orthodontics.

Payment for services are limited as follows:

- If dental care is transferred from one dentist to that of another dentist during the course of treatment, or if more than one dentist performs covered services for one dental procedure, United Concordia shall be liable for not more than the amount it would have been liable for had but one dentist performed the service.
- In all cases involving covered services in which the dentist and subscriber select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental conditions concerned, payment under this Program will be based on the charge allowed for the lesser procedure.
- A contract between subscriber and dentist, prior to the effective date of coverage under this program, is not invalidated by a subsequent contract made between United Concordia and/or subscriber and/or dentist. You will be liable for any difference due to the dentist under such a contract after the United Concordia liability had been satisfied.
- Any additional treatment that is necessitated because of lack of cooperation with the dentist or non-compliance with prescribed dental care that results in additional liability will be your responsibility.

COORDINATION OF BENEFITS
United Concordia Program

In addition to this program's broad scope of benefits the program has a Coordination of Benefits provision. The purpose of this provision is to conserve funds associated with health care. Coordination of benefits is applicable only when you, your spouse or your dependent(s) are eligible for benefits under more than one group health plan.

When you receive services that are also *covered* under another plan, a determination is made as to which plan is "primary" and which plan is "secondary". The primary plan considers the services without regard to the secondary plan. The secondary plan will then consider the balances on covered services according to the limitations of its programs.

If this plan is determined to be the secondary plan, payment for covered services will not exceed the difference between the primary plan's payment and the charge. However, United Concordia will not pay more than it would have, had there been no other coverage.

The primary plan will be determined in the following order:

1. If the other plan does not include a provision to coordinate benefits, it will be the primary plan.
2. If the other plan does include a provision to coordinate benefits, then:
   A. The plan covering the patient as the employee/subscriber is the primary plan.
   B. In those situations, where the parents are separated or divorced, the primary plan is determined as follows:
      i. the plan covering the parent with custody of the child is primary
      ii. if the parent with custody of the child has remarried, the stepparent's plan will pay for covered services before the plan of the parent without custody
      iii. a court decree may determine the primary plan
   C. When the determination cannot be made with the above rules, then the plan that has covered the patient for the longer period of time is the primary plan.

THE GROUP DENTAL PROGRAM IS NOT AVAILABLE ON A DIRECT BILLING BASIS.

CLAIM APPEAL PROCEDURES

If your claim has been denied in whole or in part, you will be notified by United Concordia. This rejection letter will set forth the specific reasons for such denial. If you wish to appeal this decision, you may write to your company's employee benefits department or directly to the address which appears on the rejection letter (marked to the attention of the person who signed the letter, if any).

First, however, it is important for you to understand the reasons for the denial of benefits in order to decide whether you want to appeal and request that the claim be reviewed again. You should examine your group agreement, which is on file with your employer. The group agreement Is a legal document setting forth the full terms and conditions of your professional coverages and excluded services. You may also request an explanation of the rejection decision by calling 1-866-646-7913,

You may appeal a denial of benefits within 60 days of the date of the rejection by sending a letter stating why you think your claim should not have been denied, including a copy of the denial letter and any additional claim information. Be sure to include in your letter your group number, your identification number, claim number, if any, your employer's name and the date of services for which benefits were denied.

Upon receipt of your letter and any additional information you provide, your records will be reviewed; and the results of this review will be sent to you normally within 60 days. In unusual cases, as when review of your claim requires examination by qualified medical personnel, including consulting physicians, the review may take longer than 60 days.

UNITED CONCORDIA

America's Premier Dental Insurer

ENROLLMENT/CHANGE FORM

For *New Enrollment,* please complete all sections of this form. If you are enrolling for employee-only coverage, you do not need to fill in the *Dependent Information* section. **For** enrollment *Change,* please complete the *Type of Activity* and only the applicable changes along with the employee name and PFT Health & Welfare ID#.

SECTION A: GENERAL INFORMATION

1. TYPE OF PROGRAM

☐ Concordia Flex - **PPO**

Return Address:
United Concordia Companies
Direct Pay
PO Box 69423
Harrisburg, PA 17106-9423

2. TYPE OF ACTIVITY

☐ **New Enrollment**

☐ **Change** ***(Please Specify}***

- ☐ Change Address
- ☐ Only Change Name
- ☐ Add Dependent(s)

Cancel Coverage for:

- ☐ Enrollee
- ☐ Spouse
- ☐ Dependents

☐ ***Death Certificate attached (If applicable}***

- ☐ **Continue Coverage for:**
  - ☐ Spouse of a deceased member
  - ☐ Child of a deceased member

3. GROUP INFORMATION

Group Name: **PFT Health & Welfare Fund**

Group Number: **099209**

Effective Date

__ / __ / ____

SECTION B: EMPLOYEE INFORMATION

Employee Name: (Last, First, Middle Initial)

PFT Health & Welfare ID#: (This# can be found on your current Capital Rx Card)

Date of Birth: __ / __ / ____

Home Address: City: State: Zip Code:

SECTION C: DEPENDENT INFORMATION

Social Security Number	Relationship	Last Name	First Name	Sex	Date of Birth
	Spouse				__ / __ / ____
	Dependent A				__ / __ / ____
	Dependent B				__ / __ / ____
	Dependent C				__ / __ / ____

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any Insurance company or other person, files an application for Insurance containing any materially false Information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent Insurance act which is a crime.

Employee Signature

Phone

Date __ / __ / ____

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Philadelphia Federation of Teachers

Effective 07/01/1993
Revised 05/01/2025

Group Number# 0132

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination once every calendar year and lenses and frames every two calendar years. Members/Spouse/Dependents are eligible for multiple benefits with prior approval.

At the time of your appointment, simply indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please call the fund office at 215-561-2722.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 01320001 and enter in your search parameters. It's that easy!

Schedule of Vision Benefits

Benefit Frequency	*Participating Provider*	*Non-Participating Provider*
Examination **Once Every Calendar Year**	▪ **Up to $25**	**Reimbursed Amount** ▪ **N/A**
Lenses **Once Every Two Calendar Years**	**Standard Glass or Plastic**	
▪ **Single Vision** ▪ **Bifocal** ▪ **Trifocal** ▪ **Lenticular**	▪ **Up to $27 or Up to $28** ▪ **Up to $38 or Up to $39** ▪ **Up to $47 or Up to $48** ▪ **Up to $64**	▪ **N/A** ▪ **N/A** ▪ **N/A** ▪ **N/A**
Frame **Once Every Two Calendar Years**	**Wholesale Allowance** ▪ **Up to $24***	▪ **N/A**

*Provider will charge the difference between the wholesale cost and the plan allowance plus 20%.

**Pre-approval from NVA required.

Patients receive discounts at NVA providers. Patients are responsible for the charges (payable to the PFT fund office plus a $6.69 handling fee).

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $75 Polarized
- $30 Blended Bifocal (Segment)
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $12 Fashion Gradient
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $55 High Index
- $12 Ultraviolet Coating

$25 Polycarbonate (Single Vision)
$30 Polycarbonate (Multi-Focal)
$10 Scratch-Resistant Coating (Standard
$65 Transitions Single Vision (Standard)
$70 Transitions Multi-Focal (Standard)
$10 Solid Tint
$40 AR Coating – Tier 1
$50 AR Coating – Tier 2
$65 AR Coating – Tier 3
$80 AR Coating – Tier 4

20% discount AR Coating – Tier 5
$50 Progressive Tier -1
$80 Progressive – Tier 2
$100 Progressive – Tier 3
$120 Progressive – Tier 4
$140 Progressive – Tier 5
$165 Progressive – Tier 6
$190 Progressive – Tier 7
20% discount Progressive – Tier 8
$39 Retinal Screening

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's wholesale cost, whichever is less. Options not listed will be priced by NVA providers at their wholesale cost. Fixed prices are available in-network only. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Nominate a non-participating provider to join the NVA network

Examinations*:* The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Hearing Discount: You will receive up to up to 60% savings at participating provider locations through NationsHearing®.

At NVA, We Work Only for Our Clients.

Exclusions / Limitations*:* No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.