

**Public Service Enterprise Group Incorporated
Postretirement Supplemental Health Benefits Plan
Summary Plan Description**

Public Service Enterprise Group Incorporated

October 2005

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Every effort has been made to provide you with clear, accurate, understandable information about the Public Service Enterprise Group Incorporated Postretirement Supplemental Health Benefits Plan. This summary is based on information in the legal plan documents that govern the Plan. If there is a difference between the legal documents and this summary, decisions about participation, benefits payable, and the administration of the Plan will always be made according to the provisions in the legal documents.

Also, this is a description of the Plan under current law. Because laws are subject to change, the Plan also may change.

While Public Service Enterprise Group Incorporated intends to continue the Postretirement Supplemental Health Benefits Plan described in this summary, it reserves the right to end, suspend, or amend the Plan at any time, in whole or in part. Should this happen, you will be notified.

10/10/2005

Introduction

Public Service Enterprise Group Incorporated (“PSEG”) and its participating affiliate companies (each an “Employer”) offer the Postretirement Supplemental Health Benefits Plan (the “Plan”) to help you save money now as an active employee for medical expenses and health insurance premiums you or your survivor will incur during your retirement. The Plan is a voluntary employees’ beneficiary association and also is referred to as the VEBA Plan. When you leave the Company, you can use the value of your account to pay eligible health care expenses for you and your family. You can contribute between \$50 and \$5,000 to the Postretirement Supplemental Health Benefits Plan Account (the “Plan Account”) each year on an after-tax basis. Your balance earns tax-free interest.

Additional Resources

- To enroll in the Postretirement Supplemental Health Benefits Plan, or if you have questions about the Plan, call 1-800-571-0400 and follow the voice recognition prompts to speak with a Benefits Express™ representative. Representatives are available Monday through Friday during normal working hours.
- To help you plan for retirement, visit the *Retirement Planning* section of *Your Benefits Desktop*. To access *Your Benefits Desktop*, go to www.pseg.com/benefits.

Who Is Eligible

Employees

You are eligible to participate in the Plan if you are an active permanent employee of a participating Employer, who is scheduled to work at least 20 hours per week.

You are *not* eligible for benefits under the Plan if you are:

- A temporary, summer, or seasonal employee;
- A vacation or illness replacement;
- Employed for an anticipated limited duration or a special project; or
- A leased employee.

Dependents

Your spouse or certified same-sex domestic partner and dependent children will be considered participants after your death if you have a balance remaining in the Plan Account that is not paid as a death benefit.

Your children are eligible if they are unmarried and depend on you for support. Eligibility lasts:

- Until the end of the calendar year in which they reach age 25; or
- Until any age, if they are unable to care for themselves because of a mental, physical, or developmental disability.

Your dependent may qualify as a domestic partner if:

- You and your same-sex domestic partner live in NJ and you have already registered and obtained a Certificate of Domestic Partnership from your local government.
- You and your same-sex domestic partner live outside NJ in a county where a Certificate of Domestic Partnership is available from your local government and you have obtained the certificate.

Retirees

You are eligible to use the value of your account if you are a retiree who contributed to the Plan while actively employed or if your Employer made contributions on your behalf. You are not eligible to make contributions to the Plan as a retiree.

How to Enroll

You enroll in the Plan by completing the Postretirement Supplemental Health Benefits Plan Enrollment/Change Form. Your participation begins as soon as administratively possible after Benefits Express receives your form—generally, the following pay period.

The Postretirement Supplemental Health Benefits Plan Enrollment/Change Form is available on the *Forms* section of *Your Benefits Desktop* or by calling Benefits Express.

If you do not enroll when you first become eligible, you can join the Plan and begin making contributions at any time during the year.

Contributing to the Plan

You can contribute from \$50 up to \$5,000 a year to the Plan. You can start or stop contributing or change the amount of your contribution at any time.

Your contributions are deducted from your pay after all Federal, State, and local taxes have been withheld. The Plan does not provide for pre-tax contributions.

Employer Contribution

On January 1, 1999, your Employer began making a \$75 contribution into a Postretirement Supplemental Health Benefits Account to all employees who had 25 or more years of service with the Company. If you have 25 or more years of service on the January 1 of each year, your Employer may make an annual contribution of \$75 to an account for you, even if you are not making voluntary contributions. This contribution is not made once you retire.

If You're a Participant in Benefits 2000

If as of December 31, 2005 you are at least age 55 or have worked for your Employer for at least five years, you will receive \$300 per year from PSEG deposited into a Postretirement Supplemental Health Benefits Plan account in your name. These contributions are made to your account each January that you continue to work for your Employer, beginning January 2006.

If you are currently contributing to an account, Employer contributions are added to your existing account. If you are not currently contributing to an account, PSEG will open an account in your name.

The account balance will earn interest. The total amount in your account at retirement is available to you and/or your spouse and dependents. The unused account balance upon your death is available for use by your surviving spouse and eligible dependents.

If you leave your Employer prior to becoming eligible to retire, which means you are not at least age 55 or do not have at least five years of service, you forfeit the \$300 per year your Employer has contributed to your account and the interest earned on those amounts. Your contributions to the account, and the interest earned on your contributions, will continue to be available.

Investing Your Account

At the end of each month, your contributions will be forwarded to the Trustee of the VEBA. The VEBA Trust is the funding vehicle for the Plan. The Trustee invests contributions in vehicles such as government-backed funds and other money-market type investments. Earnings on your contributions are credited to your Plan Account and remain tax-free when used for health care expenses not covered by another plan. This means you will not have to pay taxes on earnings when they are credited to your account, or when you use the money in your Plan Account for health care expenses after you leave the Company.

While the Plan cannot guarantee that the value of your savings will increase through earnings generated by the VEBA, there is a high probability that your account balance will grow over time.

Changing Your Coverage

You may start or stop contributing to the Postretirement Supplemental Health Benefits Plan at any time. You also may change your contribution amount at any time by filling out the Postretirement Supplemental Health Benefits Plan Enrollment/Change Form.

How the Plan Works

While you are an active employee, you make after-tax contributions to the Plan. Once you retire or terminate employment, you can begin to receive benefits from your Plan Account. There is no time limit for using the value of your account. If you die before all funds are used, the value of your account will be distributed to your survivors, if any (see [If You Die](#) on page 8).

Receiving Reimbursement from the Plan Account

To use the money in your Plan Account, you will need to estimate once a year how much you will need for the coming year:

- After your termination or retirement, you complete a VEBA Distribution Form, which is included in the Distribution Kit you will receive, indicating how much you want taken from your Plan Account, if anything, for the current year. This decision remains in effect for the full plan year, from January 1 through December 31. Each year thereafter, you will receive a VEBA Distribution Form in an annual mailing sent out in November.
- If you retire, you may choose to:
 - Allocate money from your Plan Account to pay your medical premium contribution for health care coverage through the Company;
 - Allocate money from your Plan Account to a Retiree Health Expense Reimbursement Account for out-of-pocket expenses you anticipate during the following year; or
 - Do a combination of both.

There is no time limit on the use of the funds in your Plan Account.

- If you terminate employment before you are eligible for retirement, you may choose to:
 - Allocate money from your Plan Account to a Retiree Health Expense Reimbursement Account for out-of-pocket expenses you anticipate during the following year.
 - Pay COBRA premiums.

There is no time limit on the use of the funds in your Plan Account.

***Money Allocated to Pay Health Care Insurance Premiums
(Available to Retirees and COBRA Participants Only)***

Retiree

A deduction will be taken from your pension check to pay your contribution toward your health care insurance premium for coverage through the Company. You can elect to have your VEBA account balance to be allocated to pay for your health care insurance premiums. At the end of the calendar year, in the month of December, you will receive a separate check from your VEBA account; which will be the lesser of your remaining VEBA balance of your annual health care insurance premium amount. This check will not be subject to any income taxes.

COBRA

You can elect to have your VEBA account balance to be allocated to pay for your COBRA health care insurance premiums. At the end of the calendar year, in the month of December, you will receive a separate check from your VEBA account; which will be the lesser of your remaining VEBA balance or your annual health care insurance premium amount. This check will not be subject to any income taxes.

Money Allocated to a Retiree Health Expense Reimbursement Account

You may allocate money from your Plan Account to a Retiree Health Expense Reimbursement Account. You may use this account to reimburse yourself for eligible health care expenses (other than Plan premiums).

Claiming Benefits from the Retiree Health Expense Reimbursement Account

Any time you have eligible expenses you first pay your bill(s), then submit a VEBA Claim Form to the account for reimbursement. You are reimbursed for the eligible portion of the claim, up to the amount you decided to set aside in the Retiree Health Expense Reimbursement Account.

If an expense is covered by any other medical or dental coverage you have, including Medicare, you must submit a claim for reimbursement to that plan or program before submitting a claim for reimbursement to your Retiree Health Expense Reimbursement Account—even if all or a portion will be applied to any deductible. Once you receive your Explanation of Benefits (EOB) statement from the claims administrator, forward the original EOB along with a VEBA Claim Form to the Retiree Health Expense Reimbursement Account claims administrator for reimbursement.

If you or your eligible dependents are covered under more than one medical, dental, or vision plan, you must submit an EOB statement from each program.

If an expense is ineligible under all programs in which you or your dependents participate, or if you have reached the program's benefit limit, you can submit an original bill, statement, receipt, or other proof that the service was provided, and indicate the reason it is ineligible.

Claims submitted to your Retiree Health Expense Reimbursement Account will be reimbursed for the amount of the claim—not to exceed the amount you have elected to place in the account, less any previous reimbursement. For example, suppose you have allocated \$500 to be placed in your Retiree Health Expense Reimbursement Account from your Plan Account and you have only claimed \$200 in eligible expenses for the year. If you submit a \$350 eligible expense for reimbursement, you will receive a check for \$300, since this is the amount available in your account.

Money in this account will continue to be paid for eligible expenses until exhausted and will not be forfeited. If you wish to allocate additional money to your VEBA account for out-of-pocket expenses for the following year or request your VEBA account balance to be allocated to pay for your PSEG health care insurance premiums, you may do so during annual enrollment.

The Postretirement Supplemental Health Claim Form is available on the *Forms* section of *Your Benefits Desktop* under *Forms—Retirement Planning* or by calling Benefits Express.

Eligible Expenses from the Retiree Health Expense Reimbursement Account

After you retire, you can use the money you allocate each year to your Retiree Health Expense Reimbursement Account for many expenses, including:

- Medical deductibles, copayments, coinsurance amounts, and other expenses not reimbursed under your retiree medical plan;
- Copayments, coinsurance, and other expenses not reimbursed under any dental benefits plan (including braces for adults);
- Copayments, coinsurance, and other expenses not reimbursed under any vision benefits plan (including radial keratotomy; eye laser surgery);
- Unreimbursed expenses after “coordination of benefits” with another plan, if applicable;
- Hearing aids, batteries, and exams;
- Routine physical exams not covered under your retiree medical plan;
- Prescription drug copayments, coinsurance, or uncovered expenses;
- Psychoanalysis and psychiatric therapy;
- Learning disability counseling by a licensed professional;
- Therapeutic treatment for drug or alcohol addiction, including meals, and lodging if necessary;
- Prescribed weight loss programs required to cure a specific ailment substantiated by a physician (such as heart disease or high blood pressure);
- Certain over-the-counter drugs (see the box to the right);

For a complete list of eligible expenses as defined by the IRS, link to the IRS website through the *External Links* section of *Your Benefits Desktop*. As a guide, the IRS maintains Publication 502; which is a general listing of eligible health care expenses. However, not all services listed in Publication 502 are eligible for reimbursement under the Retiree Health Expense Reimbursement Account. For information about the eligibility of a specific expense, call the claims administrator (see [page 9](#)).

Examples of eligible OTC drugs used primarily for medical care include antacids, allergy medicines, pain relievers, and cold medicines. Ineligible drugs used primarily for general health include dietary supplements, vitamins, toothpaste and other toiletries, and cosmetics. In addition, drugs that have both a medical and general health purpose will require a medical note from your physician stating a specific medical condition and the drug recommended to treat the condition. This includes weight-loss drugs for obesity and joint supplements for arthritis.

- Smoking-cessation programs for a specific ailment or for general health and well-being; and
- Documented transportation expenses such as parking fees and tolls that are essential to medical care.

Ineligible Expenses from the Retiree Health Expense Reimbursement Account

You cannot use the Retiree Health Expense Reimbursement Account to reimburse yourself for certain expenses. Ineligible expenses include, but are not limited to:

- Expenses not recognized by the IRS as legitimate Federal income tax deductions, including:
 - Medical expenses for general health purposes, but not for prevention or correction of a specific ailment;
 - Funeral or burial expenses;
 - Health club dues, YMCA and YWCA dues, or the cost for steam baths;
 - Membership fees and costs for weight loss programs for general health and well-being;
 - Contraceptives that do not require a prescription;
 - Household and domestic help, even if prescribed or recommended by a physician;
 - Cosmetic procedures performed solely to improve appearance, including surgery and teeth-bleaching materials and treatments;
 - Electrolysis for hair removal; and
 - Premiums for automobile, life, disability, health (medical, dental, etc.), or any insurance policies.
- Expenses originally paid for with before-tax dollars, such as from a spouse's reimbursement account;
- Marriage and family counseling;
- Custodial care;
- Over-the-counter health supplies such as health and beauty aids, and similar products;
- Service contracts or warranties (such as for eye glasses or contact lenses);
- Health plan premiums, including individual health insurance policies, Medicare, or plans of another employer;
- Any expenses that are paid by another medical, dental, vision, or health care plan—either you or your spouse's; and
- Undocumented services such as mileage on a private car.

If a Claim Is Denied

Your Employer makes every effort to resolve disagreements quickly and informally. However, the Plan has formal procedures in place should you need to appeal a Plan decision.

If a claim for benefits is denied in whole or in part, you, your beneficiary, or your representative will receive written notification within 90 days of when the Plan Administrator receives the claim (subject to extension under special circumstances). The notification will include the reason(s) for denial with reference to the specific Plan provisions on which the denial is based, a description of any additional information needed to process the claim, and an explanation of the claim review procedure. Should this happen, or if you believe the amount of your benefit payment is wrong, you may contact the Plan Administrator to review the reason for the denial. You may also appeal the Plan Administrator's final decision to the Employee Benefits Committee.

Within 60 days of receiving your initial denial, you may submit a written request, asking that the Employee Benefits Committee reconsider your claim. ***You must exhaust all levels of appeal available through the Plan Administrator before contacting the Employee Benefits Committee.***

Your request should be sent to:

Public Service Enterprise Group, Inc.
Secretary—Employee Benefits Committee
80 Park Plaza, T-21F
P.O. Box 1171
Newark, NJ 07101-1171

If you believe there is an error in your benefit amount, your request for reconsideration must include the reason(s) you think there is an error, and, whenever possible, copies of any documents or records that support your appeal. You, your beneficiary, or your representative has the right to review pertinent documents affecting your claim and to submit additional information or comments.

Your claim will be thoroughly reconsidered after your request is received. Within 60 days of when you send your appeal to the Employee Benefits Committee (subject to extension under special circumstances), you will receive a written response to your appeal. This response will explain the reason(s) for the decision, and refer to the specific Plan provisions that are the basis for the decision. The decision of the Employee Benefits Committee following this review is final.

Situations Affecting Your Benefits

If You Are on a Leave of Absence

You may continue to contribute to your account while you are on a paid leave of absence. You cannot continue to contribute while you are on an unpaid leave.

If You Become Disabled

If you become disabled and terminate your employment, you may use your account balance to pay for qualified medical expenses.

If You Terminate Employment

If you have money in a Plan Account and terminate employment before you are eligible for retirement, you can use the money in your Plan Account through the Retiree Health Expense Reimbursement Account for eligible expenses as if you were retired (including the cost of COBRA coverage).

If You Die

If you die with money remaining in your Plan Account, whether you are actively employed, retired, or terminated, your family may be able to use the money.

- If you are actively employed and married or have a certified same-sex domestic partner or eligible dependent children, you can elect to have the value of your Plan Account paid as a lump-sum death benefit to your surviving spouse, certified same-sex domestic partner, or eligible dependent children or to have the money available to your survivor(s) for eligible health care premiums or expenses, in accordance with the provisions of the Plan. This election is made when you enroll. The choice you make at the time you enroll may not be changed in the future. All or a portion of the death benefit payable from the Plan Account may be excluded from taxable income. You may wish to consult your tax advisor.
- **If you are retired and married or have a certified same-sex domestic partner or eligible dependents at the time of your death**, your spouse, certified same-sex domestic partner, or dependents can use all the money in your Plan Account for eligible expenses.

If your spouse or certified same-sex domestic partner dies and there is still money in the account or if you are single but have eligible dependent children, your eligible dependent children can use the money in the Plan Account until your account balance is exhausted.

- **If you have no eligible dependents at the time of your death**, the money in your Plan Account is paid to your estate.

If you are married or have a certified same-sex domestic partner, your spouse or certified same-sex domestic partner is automatically your beneficiary. If your spouse, or certified same-sex domestic partner dies before you, your dependent children are your beneficiaries. After your death, your spouse, certified same-sex domestic partner, or dependent children can use the Plan in the same way you do. During the fall enrollment period, they need to make a decision about how much they will need for the coming year. That amount is then set aside as a Retiree Health Expense Reimbursement Account. Or, if your spouse, certified same-sex domestic partner, or dependent children have health care coverage through an Employer, their premiums can be paid directly from your Plan Account. If you have no eligible dependents at the time of your death, your death benefit is paid to your estate.

When Coverage Ends

Coverage under the Plan ends at different times.

Coverage for you ends:

- If you use all the money in your Plan Account; or
- If you die.

Coverage for your surviving spouse or certified same-sex domestic partner ends:

- When he or she dies; or
- When he or she uses all the money in the Plan Account.

Coverage for your eligible dependents ends:

- When they use all the money in the account.

Administrative Information

Plan Name and Number

Public Service Enterprise Group Incorporated Postretirement Supplemental Health Benefits Plan—539

Plan Type

The Postretirement Supplemental Health Benefits Plan is a “welfare benefit plan.”

Employer Identification Number

22-2625848

Claims Administrator

SHPS
P.O. Box 14646
Lexington, KY 40512

Plan Sponsor and Administrator

The Postretirement Supplemental Health Benefits Plan is sponsored and administered by Public Service Enterprise Group Incorporated and its participating affiliate companies. You can contact the Plan Administrator at:

Public Service Enterprise Group, Inc.
Corporate Benefits
80 Park Plaza, T-21F
P.O. Box 1171
Newark, NJ 07101-1171
973-430-7000

Plan Trustee

The Bank of New York
1 Wall Street
New York, NY 10286

Agent for Service of Legal Process

Legal process concerning the Plan may be served on the Corporate Secretary at the following address. In addition, legal process may be served on the Plan Trustee or Plan Administrator.

Public Service Enterprise Group, Inc.
Corporate Benefits
80 Park Plaza, T-4B
P.O. Box 1171
Newark, NJ 07101-1171

Plan Year

The records for the Plan are kept on a calendar year basis; that is January 1 through December 31.

Plan Funding

Employee contributions are required for coverage. Employers generally do not make contributions to the Plan. However, your Employer may make a \$75 annual contribution to an account if you have worked for an Employer for at least 25 years.

Plan Amendment or Termination

PSEG and its participating affiliate companies expect to continue the Postretirement Supplemental Health Benefits Plan. However, they reserve the right, subject to contracts to which they are party, to amend, modify, or terminate the Plan. The decision to do so may be due to changes in Federal or State laws, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974 (ERISA), or any other reason.

PSEG and its participating affiliate companies specifically reserve the right to alter, amend, increase, decrease, or terminate such benefits to the full extent permitted by law at any time, in their sole discretion. If PSEG and its participating affiliate companies change or end the Plan, they may decide to set up a different plan providing similar, lesser, or identical benefits. A Plan change may transfer Plan assets and debts to another plan or split a plan into two or more parts subject to ERISA and tax rules governing VEBA trusts.

If the Plan is amended, claims incurred before the change are paid under the former provisions. Generally, if the Plan should ever be terminated, benefits will be paid for services rendered up to the termination date. Expenses incurred after the termination date will not be eligible. The amount and form of any final benefit you or your beneficiary receives will depend on the terms of the Plan's legal document and the trust document. You should note that there are specific tax law rules governing termination of a VEBA trust, which do not permit any monies held by the VEBA to be used for any purpose other than the payment of certain specified welfare benefits. So, no part of your account can ever revert to your Employer or be refunded.

After all benefits have been paid and other requirements of the law have been met, any remaining Plan assets will be used to purchase similar benefits from an insured carrier or other provider, or transferred to another welfare benefit trust providing similar benefits, in accordance with the requirements of ERISA and the tax laws governing VEBA trusts.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants shall be entitled to:

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all Plan documents. These may include insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports.
- Obtain copies of all Plan documents and other Plan information by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.
- Review a summary of the Plan's annual financial report. The Plan Administrator is required by law to make available to each participant a copy of this summary annual report. The summaries are available on the *Documents & Publications* section of *Your Benefits Desktop*.

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 the Postretirement Supplemental Health Benefits Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one—including your employer, your union, or any other person—may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your ERISA rights.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request materials from the Plan Administrator 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 ignored—in whole or in part after a final review—you may file suit in a State or Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

If you file suit, 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 frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.