for members of District 1199C,
National Union of Hospital
and Health Care Employees,
AFSCME, AFL-CIO

Benefit Highlights





The Benefit Fund for Hospital and Health Care Employees—Philadelphia and Vicinity

About This Guide

This Guide is considered a Summary of Material Modifications (or SMM) for the Medical, Dental, Life Insurance, and Accidental Death & Dismemberment (AD&D) Insurance plans. The detailed Health and Welfare Benefits Handbook is currently under revision and temporarily unavailable. Contact the Benefit Fund office at 215-735-5720 or 800-531-1199 if you cannot access the website or would like to receive a copy of the Handbook when it becomes available.

Taken together, this Guide, enrollment or schedule of benefit information provided by the carriers (if any), the individual Benefit Descriptions, and the description in the Health and Welfare Benefits Handbook now under revision, are considered your Summary Plan Description, as required by the Employee Retirement Income Security Act of 1974 (ERISA).

This brochure provides highlights of your benefits; it is not a complete description. Complete information may be found in the Plan contracts or Plan documents. In case of any question about Plan provisions, the official Plan documents and/or contracts will govern over this brochure or any other enrollment communication material. The Fund reserves the right to change the benefit plans at any time for any reason, subject to collective bargaining if applicable.

What's Inside

Eligibility and When Coverage Begins

Who's Eligible for What

To be eligible for benefits, you must be a member in Wage Class I, II, or III, and your employer must be making contributions to the Fund for your employment as the result of a collective bargaining agreement.

NOTE: *You also are considered a member if you are a Disabled Member, a Pensioner, a member who is covered for certain benefits through extended coverage, or a person who is covered by direct payment under COBRA.*

See your Health and Welfare Benefits Handbook for detailed information about eligibility.

The chart below shows how each Wage Class is defined and outlines the benefits provided to each Wage Class:

WAGE CLASS DEFINED

Wage Class I	Wage Class II	Wage Class III
Full-time working members and part-time working members whose average weekly earnings are at least as much as the lowest-paid full-time working member covered by the applicable collective bargaining agreement.	Part-time working members whose average weekly earnings are at least 60% of the lowest average weekly wage paid to full-time workers covered by the applicable collective bargaining agreement.	Part-time working members whose average weekly earnings are less than 60% of the lowest average weekly wage paid to full-time workers covered by the applicable collective bargaining agreement.

BENEFITS PROVIDED TO EACH WAGE CLASS*

	Wage Class I	Wage Class II	Wage Class III
Medical	Member and dependents	Member and dependents	Member only (no dependents)
Dental	Member and dependents	No coverage	No coverage
Prescription Drug Plan	Member and dependents	No coverage	No coverage
Disability	Member only	Member only	Member only
Death and AD&D	Member only	Member only	Member only

* To receive coverage, dependents must meet any applicable eligibility requirements.

When You Become Eligible for Coverage

You are covered for benefits 30 days after you pass your probationary period—provided the Fund receives contributions on your behalf from your employer. To appear as eligible in the Fund computer system, two requirements must be met:

- the Fund Office must receive your enrollment form—along with any required documents such as marriage certificate, birth certificate, or adoption court orders—**within 30 days of the date you become eligible** and enter the data into the Fund's computer system (it takes about two weeks for your form to be entered); and
- the Fund Office must receive and record the first employer contributions made on your behalf.

Questions About Eligibility or When Your Coverage Begins? Call the Fund Office at (215) 735-5720 or (800) 531-1199.

There is always a lag time between the time you become eligible and the time you appear as eligible in the computer system and can receive your ID card(s). This is because your employer is not required to make the first contribution until 30 days after the end of the month in which you pass your probationary period. Once the Fund Office receives the contribution, it takes about two weeks to enter it into the system and an additional two weeks for your ID card(s) to be generated and mailed.

How to File Your Enrollment Form

You must complete a Benefit Fund Enrollment Form and return it to the Fund Office within 30 days of the date you become eligible.

To request an enrollment form, visit www.1199cfunds.org, or call the Benefit Fund Office at (215) 735-5720 or (800) 531-1199. Fill out the form completely. Incomplete forms will be returned to you, which will delay the enrollment process.

Be sure to fill out the enrollment form completely, including your exact date of hire and beneficiary information. If your spouse and children will be covered, include:

- your spouse's Social Security number and information about any coverage your spouse has at work (put this information on the Benefit Fund Enrollment Form), and
- a copy of your marriage certificate and/or your children's birth certificate/adoption papers.

Keep Your Records Up to Date

To keep your coverage up to date as required by plan rules, contact the Fund Office for the appropriate form(s) if:

- you move,
- your marital status changes,
- you acquire a new dependent through birth or adoption,
- your covered spouse or dependent dies,
- your child reaches the limiting age, or
- there is a change in the employment status of you or your spouse that results in a change in eligibility for health coverage.

See "Changing Your Coverage" in your Health and Welfare Benefits Handbook for a full list of events that require you to notify the Fund Office. Changes must be made within 30 days of the event.

Late Enrollment

If you do not enroll within 30 days of the date you are eligible, or you do not add newly eligible dependents within 30 days—and later apply for coverage—retroactive coverage is not guaranteed. If you notify the Benefit Fund Office more than 30 days from the date you or your dependents are eligible, coverage will be provided but it will not be retroactive for more than 30 days.

Medical coverage for you or your dependents will not be made retroactive for more than 30 days prior to the date the Fund receives notification.

Qualified Change In Status

The benefits you choose when you enroll will stay in effect for the entire calendar year, unless you experience a qualified change of status recognized by the plan.

Special Enrollment Event

Note: all references to dependent coverage below apply to Wage Class I and Wage Class II only.

By law, under special circumstances, you, your spouse, or your children may enroll in the health care plans at any time during the year if:

- You waived coverage for yourself or your eligible dependents because you or your dependents had other health care coverage and eligibility for that coverage is lost due to divorce, legal separation, death, termination of employment, reduction in hours, or exhaustion of the COBRA coverage period under another plan. In this case, you may enroll yourself and your eligible dependents who lost coverage provided you enroll within 31 days after the loss of coverage.

- You acquire a new dependent through marriage, birth, adoption or placement for adoption. In this case, you may enroll yourself, your spouse and your newly acquired dependents provided you enroll within 31 days after the event.

In addition, you, your spouse, or your child(ren) may enroll in the following situations—provided you request the change and provide appropriate documentation within 60 days of the event:

- You or your dependent lost Medicaid or Children's Health Insurance Plan (CHIP) coverage because you or your dependent are no longer eligible for that coverage; or

- You or a dependent become eligible for a premium assistance subsidy under Medicaid or CHIP.

If you are not currently enrolled, you may enroll in a 1199C medical plan if you request the change within the time period allowed.

Your Health Care Plans

Aetna QPOS Medical Plan…Pays More When You "Go 1199C"

The Aetna QPOS Medical Plan covers most 1199C members. Members who live outside the QPOS plan's service area are covered by the Aetna Preferred Provider Organization (PPO) Plan (Out-of-Area Medical Plan), described later in this booklet.

You must complete a Benefit Fund Enrollment Form and choose a Primary Care Physician (PCP) for yourself and each covered family member (if applicable) before your POS Plan coverage takes effect. **If you do not select an Aetna Primary Care Physician as required, benefits will be paid at the lowest level and you will pay significantly more money for your health care.**

Maximize Your Benefits: Go 1199C! To receive maximum benefits, choose an Aetna PCP who admits to one of the hospitals listed on Aetna DocFind (go to www.aetna.com/docfind/home.do). You'll save money because the plan's benefits encourage greater use of 1199C facilities to help keep our members working.

The medical plan has 3 benefit levels that are designed to encourage you to use 1199C providers:

- **Referred Care to 1199C Facilities/Providers**—You receive maximum benefits when you use 1199C hospitals (listed on Page 6 of this booklet) and 1199C-related providers. When you go through your PCP, the plan pays 100% of most eligible expenses (you pay a copay for doctors' office visits and certain other services), and the Benefit Fund reimburses your costs for inpatient hospital copays ($250) and outpatient surgery copays ($100). **Your out-of-pocket costs are lowest when you "Go 1199C."**

- **Referred Care to Aetna Providers**—Your PCP or PCP-referred specialist admits you to non-1199C facilities or you are referred to non-1199C-related providers. **This can result in significant out of pocket costs to you.** The Plan pays 100% of most eligible expenses, after you pay a $200 annual deductible ($400 for spouse or family coverage), in addition to a $1,000 copay for inpatient admissions ($500 per day in New Jersey with a maximum of $1,000 per admission), a $500 copay for outpatient surgery, and a copay for

- **Self-Referred Care**—You do not receive care from your PCP or you receive care without a referral from your PCP. **When you choose this way to receive care, your out-of-pocket costs are highest** because you pay a $500 deductible ($1,500 per family) plus 30% of the cost of most eligible expenses. In addition to your deductible and coinsurance, you also pay any amount above the plan's maximum allowance if you choose providers who are not participating providers.

See the "Summary of Benefits" in the Medical section of your Health and Welfare Benefits Handbook for a detailed overview of covered medical services.

1199C Panel Providers—Hospitals Designated for Maximum Benefits	
Pennsylvania 1199C Hospitals	
Children's Hospital of Philadelphia 34th Street and Civic Center Boulevard, Philadelphia, PA	**Taylor Hospital** 175 East Chester Pike, Ridley Park, PA
Crozer Chester Medical Center 1 Medical Center Boulevard, Upland, PA	**Temple University Hospital** 3401 North Broad Street, Philadelphia, PA
Girard Medical Center 801 West Girard Avenue, Philadelphia, PA	**Temple University Hospital-Episcopal Campus** 100 East Lehigh Avenue, Philadelphia, PA
Hahnemann University Hospital Broad and Vine Streets, Philadelphia, PA	**Thomas Jefferson University Hospital** 111 South 11th Street, Philadelphia, PA
Presbyterian Medical Center of the University of Pennsylvania Health System 51 North 39th Street, Philadelphia, PA	**Wills Community Surgical Services Center of Center City, Inc.** 840 Walnut Street, Philadelphia PA
St. Joseph Medical Center 1601 West Girard Avenue, Philadelphia, PA	**Wills Eye Hospital** 840 Walnut Street, Philadelphia PA
New Jersey Hospitals	
Summit Surgical Center 110 Carnie Boulevard, Voorhees, NJ*	**Virtua West Jersey Health System-Marlton** 750 Route 73 South, Marlton, NJ*
Virtua West Jersey Health System-Berlin Townsend Avenue and White Horse Pike, Berlin, NJ*	**Virtua West Jersey Health System-Voorhees** 101 Carnie Boulevard, Voorhees, NJ*
Virtua West Jersey Health System-Camden 1000 Atlantic Avenue, Camden, NJ*	**Virtua-Memorial Hospital Burlington** 175 Madison Avenue, Mount Holly, NJ*
Virtua West Jersey Health System-Marlton 90 Brick Road, Marlton, NJ*	
Delaware Hospitals	
All surgical centers*	**Christiana Care Health Services** 200 Hygeia Drive, Newark, DE
Alfred I. DuPont Hospital 1600 Rockland Road, Wilmington, DE	**Christiana Care Health Services** 4755 Ogletown-Stanton Road, Newark, DE
BayHealth Medical Center 21 West Clarke Avenue, Milford, DE	**Nanticoke Memorial Hospital** 801 Middleford Road, Seaford, DE
BayHealth Medical Center 640 South State Street, Dover, DE	**St. Francis Hospital-Wilmington** 7th & Clayton Streets, Wilmington, DE
Beebe Medical Center 424 Savannah Road, Lewes, DE	**Smyrna-Clayton Medical Services** 401 North Carter Road, Smyrna, DE
Christiana Care Health Services 501 West 14th Street, Wilmington, DE	**Veterans Administration Medical Center/Wilmington** 1601 Kirkwood Highway, Wilmington, DE

*These are additional hospitals designated by the Benefit Fund, although they do not employ 1199C members.

Understand Your Benefits Before You Receive Care!

Be sure to read the detailed description of the Medical Plan in your Health and Welfare Benefits Handbook before you receive care. You can find the most up to date information online at www.1199cfunds.org. Contact the Benefit Fund Office at (215) 735-5720 or (800) 531-1199 or Member Services at (800) 533-2195 if you have any questions about whether or not a medical service is covered, or about the plan's benefits for a specific service.

Aetna Preferred Provider Organization (PPO) Plan (Out-of-Area Medical Plan)

If you do not live in the area serviced by the Aetna QPOS Medical Plan, you and your eligible family members will be covered by the Aetna PPO Medical Plan (Out-of-Area Plan). The Out-of-Area Plan medical plan provides comprehensive coverage for wellness and preventive care, hospital and doctors' charges, mental health/substance abuse treatment, and certain vision expenses. (Prescription Drug expenses are covered by a separate program that is described later in this booklet.)

To find a Network Doctor or Hospital visit www.aetna.com/docfind/home.do. When you are asked to "Select a Plan," choose Open Choice PPO under Aetna Standard Plans in the drop-down menu. You can also call Aetna Member Services at 1-888-502-3862.

The Out-of-Area Medical Plan is a PPO ("Preferred Provider Organization") Plan which gives you the freedom to use the doctors and hospitals of your choice. Under the plan, there are two levels of benefits, based on whether you use certain "Preferred" providers carefully chosen by Aetna.

- **Preferred Care**—You may use the doctors and hospitals of your choice but you receive maximum benefits when you use providers in the PPO network. When you use preferred providers, there is no deductible, and the Plan pays 100% of the cost for most services. There are copays for some services, such as doctors' visits and inpatient hospital stays—but the Benefit Fund will reimburse you for most of these copays (see "Summary of Benefits" in the Medical Plan section of your Health and Welfare Benefits Handbook). **You may need to file claim forms.**

- **Non-Preferred Care**—When you use non-preferred providers, you pay more of your expenses. Generally, the Plan pays 70% and you pay 30% plus a $300 deductible ($600 per family). In addition to your deductible, copays and coinsurance, you also pay any amount above the plan's maximum allowance.

Prescription Drug Plan

Wage Class II and III members are not eligible for Prescription Drug Plan coverage.

Benefits for prescription drugs are provided through Express Scripts. There are two ways to receive prescription drugs under the plan:

- **Retail Pharmacies**—For medications that you will take for 34 days or less (such as an antibiotic), use a participating Express Scripts retail pharmacy.
- **Mail Order**—For medications that you take on an ongoing basis (longer than 34 days), such as high blood pressure medication, and for **all refills**, you **must** use the mail-order program.

If you or your covered dependent MUST take a brand-name drug that is medically necessary and prescribed by a licensed physician, you should submit a request for waiver of the generic requirement to the Benefit Fund Office.

How the Prescription Drug Plan Works

The Prescription Drug Plan divides prescription drugs into two categories (or groups):

- Brand-name drugs, and
- Generic drugs.

Under the Express Scripts Prescription Drug Plan, at a retail pharmacy, you pay a $10 copayment
for generic drugs and a $20 copayment for brand-name drugs. The brand-name copay applies even if a generic is not available. For mail order prescriptions and all refills, you pay a $20 copayment for generic drugs and a $40 copayment for brand-name drugs.

About Generic Drugs

A generic drug is a prescription drug that is basically a "copy" of a brand-name drug, and is chemically equal to a brand-name drug, contains the same active ingredients, and must pass similar testing requirements as the brand-name form. Yet, the generic form costs significantly less than the brand-name drug.

No benefits will be paid for prescriptions filled at pharmacies that do not participate in the Express Scripts program. In addition, no benefits will be paid for prescriptions that are for more than a 34-day supply if filled at a retail pharmacy.

Bring Your ID Card

You must show your Express Scripts ID card whenever you receive prescriptions. If you forget your ID card, you must pay the full cost of the prescription (not the Express Scripts discounted rate). After you submit a claim form and receipt toExpress Scripts, you will be reimbursed for the cost of the generic form (if available) at the Express Scripts discounted rate. You are responsible for any charges above that amount. This means that you will pay more for each prescription if you forget your ID card—so be sure to keep it with you.

Your Dental Care Plan

Wage Class II and III members are not eligible for Dental Plan coverage.

Managed Dental Care Plan

Regular, professional dental care is not only essential to good health, but it also can prevent serious and/or costly problems. That's why the Fund offers dental coverage that provides benefits for preventive, basic restorative, major, and orthodontic dental services.

Available to most 1199C members, the Managed Dental Plan covers services that are rendered at an Approved Dental Facility (ADF). Some members are covered by the Out-of-Area Dental Plan described under "Out-of-Area Dental Plan" on the next page.

To participate in the Managed Dental Plan, you must complete an enrollment form to pre-select an Approved Dental Facility. **If you do not select an Approved Dental Facility, you will be assigned to the Approved Dental Facility nearest your home, as reflected in the Fund's records.**

To find an Approved Dental Facility call the Benefit Fund Office (weekdays 8 a.m.– 6 p.m. Eastern time) at 215-735-5720 in Philadelphia, or 800-531-1199 outside Philadelphia.

How the Plan Works

- When you need dental services, contact your selected or assigned Approved Dental Facility.
- When you need a specialist, including oral surgeons, periodontists, and endodontists, your general dentist (also called "primary" dentist) must refer you in writing.
- If you need orthodontic treatment, you can use any orthodontic facility in the Approved Dental Facility listing. A written referral is not required.
- You can change your Approved Dental Facility at any time by calling the Fund office or Dominion Dental Services.

What the Plan Pays

- **When you use general dentists at your Approved Dental Facility**—You pay a fixed dollar copayment based on a specific list of services.
- **When you use specialist dentists after receiving written referral from your general dentist**—You generally pay approximately 75% of the Usual, Customary, and Reasonable (UCR) charge for covered services. Different percentages may apply to specific procedures. (See "Dental Plan Schedules" in your Health and Welfare Benefits Handbook.)
- **Annual Maximum Benefit**—There is no maximum benefit limit for eligible dental expenses.
- **Orthodontia Copayment**—For orthodontia, your copay varies based on the services required. See "Orthodontics" in the "Dental Plan Schedules" section in your Health and Welfare Benefits Handbook.

You and your eligible dependents must use an Approved Dental Facility to receive benefits! No benefits will be paid for visits to non-approved dental facilities.

Out-of-Area Dental Plan

You and your eligible dependents are covered under the Out-of-Area Dental Plan if you are a Wage Class I member and:

- you are employed by Burlington Woods Convalescent Home, or
- you are covered by the Out-of-Area Medical Plan.

Burlington Woods Members may choose between the Out-of-Area Dental Plan and the Managed Dental Care Plan described on the previous page.

How the Plan Works

- When you receive dental care, you pay the full cost and then submit a claim to the Benefit Fund for payment—unless your dentist is willing to bill the Benefit Fund and then bill you for any charges that exceed the Fund's payment.
- Prior Approval is required for services expected to cost more than $200. You, your dentist, or dental specialist should file a statement of certification with the Fund before dental or orthodontic treatment begins if the treatment is expected to cost $200 or more.
- You are responsible for any charges above the UCR amount. (See the "Dental Plan Schedules" section in your Health and Welfare Benefits Handbook.)

What the Plan Pays

Preventive and diagnostic services are covered at 100% of the Usual, Customary, and Reasonable (UCR) charge. For most other services, you pay a fixed copayment. Your copayment varies depending upon whether services are performed by a general dentist or a specialist, such as a periodontist, endodontist, or pedodontist (children's dentist).

- You pay a fixed copayment for most basic restorative and major services performed by a general dentist. (See the "Dental Plan Schedules" section of your Health and Welfare Benefits Handbook.)
- You pay approximately 75% of Usual, Customary, and Reasonable charges for most specialist services.
- Your copayment for orthodontia services will vary with the services required.

Lifetime Maximum Orthodontia Benefit for Orthodontia Services—is $2,500 for each eligible member and/or dependent. This maximum lifetime limit is separate from the Annual Maximum Benefit for general dental services.

Disability Benefits

If you become disabled, the plan will replace 2/3 of your average weekly earnings, up to a maximum weekly benefit, as determined by the plan. "Average weekly earnings" means the average of your gross weekly earnings during the last eight calendar weeks immediately prior to the pay period in which your disability begins.

You are considered disabled if you are unable to engage in the regular duties of your occupation due to an injury or illness (including pregnancy).

You may receive up to 26 weeks of disability benefits as long as you remain disabled. You may not receive benefits for more than 26 weeks in any 52-week period for any reason. The date you are eligible to receive benefits depends on the reason for your disability:

- **Illness**—Benefits begin as of the eighth day that you are disabled as certified by your physician.
- **Accident**—Benefits begin as of the first day that you are disabled as certified by your physician.
- **Maternity**—Special rules apply for Maternity disability. See the Disability section of your Health and Welfare Benefits Handbook for details.

Note: Members who work in New Jersey are covered under Private Plan Disability Income Benefits. Please see your Health and Welfare Benefits Handbook for a detailed explanation of the plan.

You Must Initiate the Disability Claims Process

If you become disabled, you are required to call the Benefit Fund Office to start the claims process no later than 48 hours after your doctor informs you that you are disabled, and in no case longer than five working days after the onset of your disability. **If you do not call, the Benefit Fund Office will assume your disability began on the date your claim is received.**

When you call, a Benefit Fund representative will request information from you to start your disability claim. Make sure you have your doctor's name, address, and telephone number handy when you call the Fund Office.

Disability Management Process

The Fund has retained a professional disability management firm to review and manage certain types of disability claims. Part of the disability management process may require you to supply further information or to be examined by an independent medical consultant. If you refuse to comply with information requests, provide proof of disability, or be examined, the Fund may deny disability benefits.

Death and AD&D Benefits

Death Benefits

Death and Accidental Death and Dismemberment (AD&D) benefits are provided for Wage Class I, II, and III members, but not their dependents.

If you die while covered under the plan, your beneficiary will receive a death benefit. You may name anyone you wish as your beneficiary. If you name more than one beneficiary and you do not specify the amount each beneficiary is to receive, your beneficiaries will receive equal shares of your benefit. You may change your beneficiary at any time by completing an Enrollment Change Form and filing it with the Fund Office.

You must complete a Benefit Fund Enrollment Form to elect a beneficiary.

The amount of your death benefit depends on your Wage Class and the length of time you have been covered under the plan:

Length of Coverage	Wage Class I	Wage Class II	Wage Class III
Less than one year	$1,250	$1,250	$1,250
One or more years	Your annual pay up to $15,000	$2,500	$1,250

If there is a lapse in coverage of more than 30 days for any reason, the death benefit will be re-established at the first-year level of $1,250 for a period of one year from the date coverage is reinstated.

Accidental Death and Dismemberment (AD&D) Benefits

Accidental Death and Dismemberment (AD&D) coverage is in addition to your death benefit. This plan provides coverage for you against two types of loss—accidental death and accidental dismemberment. This plan considers dismemberment to be loss of a limb or eyesight.

The plan pays a benefit to you if you suffer certain serious and accidental losses, such as a limb or your eyesight, and pays a benefit to your beneficiary if you die as the result of a covered accident. The plan's benefits are as follows:

Loss	Benefit Payable
Life	Same as death benefit
Both hands, both feet, sight of both eyes, one hand and one foot, one hand and sight of one eye, or one foot and sight of one eye	Same as death benefit
One hand, one foot, or sight of one eye	50% of death benefit

AD&D benefits are payable for off-the-job accidents only.

Important Info

THE BENEFIT FUND

In Philadelphia 215-735-5720

Outside Philadelphia 1-800-531-1199

AETNA MEDICAL PLANS

Aetna Member Services 1-800-533-2195

Physician/Hospital Information ..... www.aetna.com/docfind/home.do

Aetna Behavioral Health 1-800-424-5679

Pre-certification (for self-referred care) 1-800-245-1206

EXPRESS SCRIPTS, INC. (prescription drug coverage)

Member Helpline 1-800-711-0917

DOMINION DENTAL SERVICES, INC. (dental network management)

In Pennsylvania and New Jersey ..... 1-888-518-5338 (toll-free)
1-703-518-5338

Notes