

SUMMARY PLAN DESCRIPTION
DISTRICT COUNCIL 47 HEALTH AND WELFARE FUND
Effective July 1, 2022

Table of Contents

SUMMARY PLAN DESCRIPTION	4
INTRODUCTION and.....	4
GENERAL INFORMATION	4
SUMMARY OF BENEFITS AND INFORMATION ON.....	6
CONTACTS AND ADMINISTRATION	6
SECTION I	9
ELIGIBILITY	9
1. OPTING OUT OF FUND COVERAGE:	9
2. Eligibility: Who is Eligible for Fund Benefits?	10
3. Enrollment: There are three opportunities to enroll for coverage under this Plan: (a) Initial Enrollment (when you are first Eligible), (b) Special Enrollment and (c) Open Enrollment.	
15	
SECTION II	27
MEDICAL BENEFITS COVERAGE	27
SECTION III	28
DENTAL BENEFITS	28
SECTION IV	31
VISION & HEARING BENEFITS	31
SECTION V	33
PRESCRIPTION DRUGS	33
SECTION VI	37
EMPLOYEE ASSISTANCE (“EAP”) BENEFITS.....	37
SECTION VII	39
IMPORTANT FEDERAL LAWS.....	39
What is “balance billing” (sometimes called “surprise billing”)?	46
SECTION VIII	49
COORDINATION OF BENEFITS AND SUBROGATION	49
SECTION IX	55
EXCLUSIONS	55
SECTION X	58
APPEALS PROCESS AND REVIEW OF DENIAL OF CLAIMS	58
SECTION XI	73

GENERAL PLAN PROVISIONS.....	73
SECTION XII	74
HIPAA NOTICE OF PRIVACY PRACTICES	74
SECTION XIII	80
GLOSSARY	80

SUMMARY PLAN DESCRIPTION

INTRODUCTION and GENERAL INFORMATION

This Summary Plan Description ("SPD") provides information about the benefits available from the Fund. Please make sure to read it carefully and to keep it in a safe place for future reference. The information you need to understand your Benefits includes both this SPD and the benefits information supplied by the Providers of your medical, dental, vision, prescription, and counseling Benefits. Health Coverage for medical Benefits, including hospitalization, office visits, emergency room treatment, etc., are described in the information provided to you from Independence Blue Cross. Your other Benefits, including dental, vision, prescription, and counseling Benefits are described in a summary fashion in this SPD and in detail in the material from the dental, vision, prescription and counseling Providers. The Benefit information and the underlying contracts between the Fund and the providers of these Benefits are incorporated by reference into this SPD. If there is a conflict between the Providers' contract and documents and this SPD, the Providers' contract and documents will prevail.

You will want to keep all of this information handy for ready reference, please contact the Fund Office directly if you have any questions regarding your Benefits. If the Trustees change any of the Providers of your benefits, they will provide you with the information you need to access Benefits from the new Provider. The Benefits described in this document are effective July 1, 2022. If a new Provider is selected, the information you receive regarding the new Provider will supersede the information contained in this booklet. In addition, as the Fund is amended from time to time, the Fund Office will send you information explaining the changes. If those later notices describe a Benefit or procedure that is different from what is described here, you should rely on the later information.

IMPORTANT NOTE: The Benefits provided by the Fund are available only to Eligible Employees and their Eligible Dependents. Please read the "Eligibility" section below for a full description of the eligibility requirements.

The Fund's Trustees are proud of the program that the Fund offers. The Trustees, however, may determine that some or all benefits shall be increased, decreased or even eliminated. Please call the Fund Office for any questions about your coverage.

Consistent with the requirements of the Affordable Care Act, the Trustees shall not rescind coverage for Participants and/or their Dependents except in cases involving fraud or an intentional misrepresentation of material facts. In the event of suspected fraud or intentional misrepresentation, the Fund will provide at least 30 days advance notice of an intention to rescind

the coverage, including retroactively, in order to give the affected individuals the opportunity to appeal.

The great majority of our Participants and Dependents use only the benefits to which they are entitled. A few Participants and Dependents, however, attempt to receive benefits to which they are not entitled. If any individual receives benefits to which he/she is not entitled, the Fund can terminate benefits to all family members, subtract the cost of these benefits against other benefits payable to any family member or, in the discretion of the Trustees, initiate legal action to recover the cost of the benefits. The Trustees regret having to take these actions, but they must safeguard the Fund for all Eligible Participants and their Dependents.

Certain terms, like “Eligible,” “Dependent” and “Participant” have a defined meaning when used in this SPD. Those terms will be capitalized throughout the document. See the “Glossary” section of this SPD for the definition of these terms.

IMPORTANT FUND INFORMATION

PLAN NAME: AFSCME District Council 47 Health & Welfare Fund

PLAN SPONSORS: AFSCME District Council 47 and the City of Philadelphia

PLAN TAX ID: 23-197068

TYPE OF PLAN: Tax-exempt VEBA as defined in IRC Section 501(c)(9) and regulations thereunder.

PLAN YEAR: July 1 through June 30

PLAN RECORDS: Except for those records stored remotely pursuant to the requirements of the HIPAA Security Rule, Fund records are maintained at the Fund Office at 1606 Walnut Street, First Floor Rear, Philadelphia PA 19103. Any information regarding your Benefits, and/or your rights under the Fund can be obtained, subject to the limitations set forth in ERISA Section 204 by contacting the Fund Office, in writing.

EFFECTIVE DATE OF FUND: July 1, 1976.

**SUMMARY OF BENEFITS AND INFORMATION ON
CONTACTS AND ADMINISTRATION**

When you need information, please check this booklet first. If you need further help, call the people listed in the following summary:

	YOU SHOULD CONTACT	PLAN BENEFIT
Eligibility Enrollment, COBRA and General Plan Information	AFSCME District Council 47 Health & Welfare Fund, 1606 Walnut Street, 5th floor Philadelphia, PA 19103-5482 Phone: 215-893-3774, 3775, 3776 https://dc47.org/hwfgov/	See the “Eligibility” Rules in this booklet for information on when you become Eligible for benefits, who can be an Eligible Dependent, enrollment rules and other information. You should contact the Fund Office for information about the information you must submit in order to enroll yourself and your dependents for Fund coverage.
Health Coverage	Independence Blue Cross Personal Choice PPO Program Keystone HMO 1-800-ASK-BLUE (1-800-275-2583)	Participants may choose from the following plans: Personal Choice 15/25/70 Personal Choice 20/30/70 Keystone 20/40 Keystone 15 (only available to individuals grandfathered into the K15 plan) Keystone 15/30 For details on prior-authorization, covered benefits, exclusions, coordination of benefits and other details about your hospital and medical benefits, see the applicable Personal Choice or Keystone HMO Booklet at enrollment.

<p>Prescription Drugs</p>	<p>BeneCard PBF 3900 Millenia Boulevard Orlando, FLA 32839</p> <p>Member Services Call Center: 1-888-907-0070</p> <p>Email: member.services@BeneCard PBFpbf.com</p>	<p>Retail (30-Day Supply) Generic: \$10 per prescription Formulary Brand: \$25 per Prescription Non-Formulary Brand: \$40 per prescription</p> <p>RITE-AID Up to 100-day supply at retail: One copayment</p> <p>Mail-Order (Up to 100-Day Supply) Only one copayment is required per prescription.</p> <p>All prescriptions are subject to the Fund’s requirements regarding mandatory generic substitution; step therapy mandatory mail order; prior authorization; and specialty drug management as described below.</p>
<p>Dental Benefits</p>	<p>United Concordia Dental Benefits are administered by United Concordia Companies, Inc., 4401 Deer Path Road, Harrisburg, PA 17110 1-800-332- 0366 www.ucci.com</p>	<p>Dental Benefits payable according to the United Concordia schedule of benefits.</p> <p>Calendar Year Maximum: \$2,500 per covered individual per calendar year after annual deductible of \$25 per covered individual (\$75 per family).</p> <p>Orthodontia payable up to a lifetime maximum of \$2,000</p>

		<p>per covered individual (adult or child).</p> <p>Medically and dentally necessary pediatric dental services not subject to annual maximum.</p>
Vision Benefits	<p>National Vision Administrators, L.L.C 5040 Ritter Road Mechanicsburg, PA 17055 1-800-672-7723 www.e-nva.com</p>	<p>Vision Benefits:</p> <p>Every 12 Months: Eye Exam; Frame; Contact Lenses</p> <p>Medically necessary pediatric vision services are not subject to these limits.</p>
Hearing Aid Benefits	<p>The Fund self-insures this benefit. Submit your paid receipts to the Fund Office within one year of receiving the hearing aid.</p>	<p>Seven Hundred Fifty Dollars (\$750) per ear, once every three years.</p>
Employee Assistance Program	<p>Health Advocate</p>	<p>Up to eight (8) visits per individual (Participant and Dependent) to a Health Advocate counselor at no charge per condition per benefit year in addition to the benefits available through the Fund's HMO and PPO benefits.</p>
Guardian Nurses	<p>You may contact the Guardian Nurses through the Fund Office or the Guardian Nurses may contact you directly</p>	<p>Personalized management of complex or chronic medical conditions; personal medical support and guidance in navigating the health care system.</p>

**SECTION I
ELIGIBILITY**

1. **General:** The Fund can only provide benefits to Eligible Participants and Eligible Dependents who have been enrolled for benefits. When an Employee first becomes Eligible for Benefits, the Fund will send enrollment cards and application forms to the Employee. The Employee must complete all information required by the Fund.

You are eligible to elect enrollment in the Fund for yourself and your eligible dependents when you meet the Fund’s Eligibility rules. **HOWEVER, YOU AND YOUR ELIGIBLE DEPENDENTS WILL NOT HAVE COVERAGE UNDER THE FUND IF YOU DO NOT COMPLETE AND SUBMIT THE REQUIRED ENROLLMENT CARDS, APPLICATION FORM AND DOCUMENTATION. If you did not receive an enrollment card or application form when you became Eligible for Benefits, contact the Fund Office immediately.**

1. **OPTING OUT OF FUND COVERAGE:**

- a. City of Philadelphia and Philadelphia Parking Authority Employees who are represented by AFSCME District Council 47 may choose to opt-out of Fund coverage, provided that you opt out of all coverage, including medical, prescription, dental, vision, and any other benefits offered by the Fund. *(Note that the PPA is responsible for the opt-out payments for PPA employees. Contact the PPA Human Resources Department for required information about how to elect to opt-out of coverage.)*

- i. **City of Philadelphia:**

1. City of Philadelphia Employees will be compensated for opting out in an amount set forth in the collective bargaining agreement between the City and AFSCME District Council 47, payable once annually in a lump sum each December. (Please note that the opt-out payments will be treated like your other taxable wages.)

2. **How to Opt-Out:**

- You may opt-out during the Fund’s annual Open Enrollment period.
- Complete the Fund’s Waiver Form;

- Submit a letter on the letterhead of your spouse’s employer verifying the name of your spouse’s health plan and the effective date of your coverage;
- Submit both the Waiver Form and the letter from your spouse’s employer to the Fund Office at 1606 Walnut Street, 5th Floor, Philadelphia PA 19103.
- Upon receiving your completed waiver application, the Fund will forward the documentation to the City. The City, and not the Fund, is responsible for administering this opt-out benefit. You will not receive the opt-out amount until the City has processed the waiver information.

3. **Duration of Opt-Out:** If you elect to opt-out, or waive, coverage, your waiver will remain in effect unless you elect to re-enroll in the Fund at the next Fund Open Enrollment or you become eligible for Special Enrollment because you experience a “Life Event.” Life events include marriage; divorce; birth or adoption of a child; starting or ending a spouse’s employment; death of a spouse or qualifying dependent; and your retirement. If you experience a life event, you must submit a written request to revoke your opt-out waiver.

ii. **Philadelphia Parking Authority:** Employees should address any questions about opting out to the PPA Human Resources Department.

2. Eligibility: Who is Eligible for Fund Benefits?

a. *You (the Employee) are Eligible for Benefits if:*

- You are an Employee of the City of Philadelphia, the Philadelphia Parking Authority, the First Judicial District of the Commonwealth of Pennsylvania (“FJD”), AFSCME District Council 47 or an Eligible Local, or of the Health and Welfare Fund, and your employer must make a contribution to the Fund on your behalf pursuant to the collective bargaining agreement (“CBA”) between AFSCME District Council 47 and your Employer or pursuant to a Participation Agreement between your Employer and the Fund;
- You have elected the continuation coverage described in the "COBRA" section; or

- You are retired from the City of Philadelphia, the Philadelphia Parking Authority or the First Judicial District and meet all Fund criteria for retiree coverage.
- You and your Dependents will continue to be Eligible for benefits for five years after your retirement or death in active duty if: (a) you have reached age 52 ; and (b) you were employed by one of the Employers listed immediately above for at least ten (10) consecutive years before your retirement and had ten (10) consecutive years of benefits coverage under either the Fund or the City of Philadelphia health plan; or (c) you are deemed totally and permanently disabled;
 - Note: If you are retiree of the Philadelphia Parking Authority, you may also be eligible to purchase additional years of coverage by converting unused days of sick leave. Please contract the Philadelphia Parking Authority for details on this post-retirement benefits purchase.
- You have become Eligible for a service-connected or non-service connected disability pension from the City of Philadelphia, as an Employee of AFSCME DISTRICT COUNCIL47, an Eligible Local, the First Judicial District or the Philadelphia Parking Authority. You will be Eligible to receive five years of post-disability retirement coverage.

b. Dependents are Eligible for Benefits if:

- Your Dependents are Eligible for the same coverage you are enrolled in as of the date you (the Employee) become Eligible for coverage or the date of marriage, birth, adoption or placement for adoption, but only if the required enrollment documentation is submitted to the Fund Office as described under *Enrollment*, later in this section.
- You can be a Dependent if you are the Spouse or Child of a Participant and meet the following requirements. Please note that your Dependents will be enrolled in the same Benefit option that you elect. Your Dependents cannot be enrolled in the Fund if you are not enrolled for coverage.
 - i. **Spouses:** You are Eligible for benefits as the Spouse of a Participant if:
 1. You are the lawfully married Spouse of a Participant. The term Spouse includes:
 - a. Ceremonially married same- and opposite-sex Spouses, provided that your marriage was lawful in the jurisdiction

in which you were married at the time you were married, and you present the required documentation (e.g., marriage certificate);

- b.** Common Law Spouses who meet the requirements established by the Fund. Contact the Fund Office to learn what information must be presented to establish common law spouse status. You can enroll your Common Law Spouse in the Fund only if you submit all of the required documentation to the Fund Office and the Fund determines that ***you and your spouse entered into a valid common law marriage before January 2, 2005.***

IMPORTANT NOTE: If you assert and the Fund determines that you and your Spouse are parties to a valid common law marriage, ***you are legally married for all purposes***, not just for Fund coverage. You will not be able to remove your Common Law Spouse from coverage unless you obtain a divorce decree from a court of competent jurisdiction. This may mean, for example, that your Common Law Spouse could claim a part of your pension. Therefore, you should only claim common law marriage status if you understand that you will be considered married for all purposes.

- 2. **Life Partners (Philadelphia Parking Authority Only):** You may cover your Life Partner if, effective March 1, 2022, the PPA has confirmed acceptance of your Life Partner for benefits coverage. The Fund does not recognize other Life Partners for coverage.
- 3. **Widow/Widower of Active Employee:** You are Eligible for Benefits as the Spouse of a Participant if your Spouse has died and his or her death resulted solely from the performance of the duties of his or her employment with the City of Philadelphia, Philadelphia Parking Authority, AFSCME DISTRICT COUNCIL47, an Eligible Local, or the First Judicial District and not from any misconduct by the Employee. If you were married to your prior

Spouse and had coverage under the Fund at the time of your Spouse's death, your Benefits will continue for five (5) years following your Spouse's death or until your remarriage, whichever comes first.

4. **Widow/Widower of Retiree:** You are Eligible for benefits as the Spouse of a Retired Employee of the City of Philadelphia, Philadelphia Parking Authority, AFSCME DISTRICT COUNCIL47, an Eligible Local, the First Judicial District or the Philadelphia Parking Authority and you and your Spouse were Eligible for post-retirement coverage and your Spouse died during the five-year period described above. You and your Eligible Dependents will continue to be Eligible for coverage for the remaining portion of the five-year period.
5. You have elected the continuation coverage described in the "COBRA" section below.

ii. ***Dependent Children: Eligible Dependent Children include the following:***

1. Children up to age 26 and who are your natural Children, your adopted Children, stepchildren (that is, the Children of your current Spouse for whom you are not the natural parent), and Children for whom you or your Spouse have a valid court order providing you or your Spouse with full physical custody and at least partial legal custody of the child.

In order for your Eligible Dependents to be covered by the Fund, you and your Employer must pay the appropriate contribution for them, as well as for yourself. You must also provide appropriate documentation to the Fund Office.

2. A Dependent Child may also have coverage if:
 - a. You had coverage under the Fund at the time of your parent's death and your parent was an Employee of the City of Philadelphia, Philadelphia Parking Authority, AFSCME DISTRICT COUNCIL47, an Eligible Local, the First Judicial District or the Philadelphia Parking Authority has

died and his or her death resulted solely from the performance of the duties of his or her employment with the City and not from any misconduct by the Employee. The City will continue to provide you Benefits for five years following your parent's death, provided you remain otherwise Eligible for benefits from the Fund.

- b. You were Eligible for Benefits under your Employee parent's post-retirement coverage and the Employee parent died during the five-year period described above. You will be Eligible for coverage during any time remaining in the five-year period.
 - c. Your parent, on account of whose employment you had coverage under the Fund, has died in circumstances other than (a) and (b) above. You will be permitted to continue coverage by paying the entire cost of the premiums until you cease to qualify as a Dependent Child under the terms of this plan or you may elect COBRA continuation coverage.
 - d. You have elected the continuation coverage described in the "COBRA" section below.
 - e. You are covered pursuant to a Qualified Medical Child Support Order (QMSCO).
3. You can be a Dependent Parent if you are the Dependent parent of a Participant. Dependent parents are Eligible only for the Vision and Prescription benefits offered by the Fund.
 4. You have elected continuation coverage under the "COBRA" provisions set forth below.
 5. **Dependent Information Required by the Fund:** If a Participant does not provide the required information, the Fund will be unable to provide coverage for his or her Dependents.
 - a. To enroll a Spouse, you must present a marriage certificate or, for common law Spouses, a properly executed affidavit of common law status provided by the Fund with all

accompanying documentation. ***Consistent with Pennsylvania law, only common law marriages first entered into on or before January 1, 2005, will be considered by the Trustees.***

- b. Philadelphia Parking Authority Only: To enroll your Life Partner, you must provide all required documentation to demonstrate that as of December 9, 2021, the PPA has confirmed acceptance of your Life Partner for benefits coverage. The Fund does not recognize other Life Partners for coverage.
 - c. To enroll Dependent Children, you must present a birth certificate, documentation of adoption or placement for adoption, or court order granting the Participant or the Participant's Spouse legal and physical legal custody of the Child.
 - d. To enroll a Dependent Parent, you must present a copy of your most recent Form 1040 showing that you claimed the parent as a Dependent on your tax return and the parent is a "qualifying relative" as that term is defined in IRC Section 152(d).
- c. Former Employees Whose Grievance Has Been Taken to Arbitration. If you have been discharged and AFSCME District Council 47 is taking the matter to arbitration, and if you have been a Participant in the Fund prior to your discharge, the Fund will provide Benefits for you and your family for a maximum period of eighteen (18) months after your discharge if you are not eligible for other group coverage. Each individual who meets the requirements described above is entitled to this extended coverage only two (2) times during his or her employment. If your case is resolved prior to the end of 18 months, and you are not reinstated, your benefits will be terminated, and you will be able to continue coverage by electing COBRA coverage. See below for a detailed discussion of COBRA coverage.
3. **Enrollment:** There are three opportunities to enroll for coverage under this Plan: (a) Initial Enrollment (when you are first Eligible), (b) Special Enrollment and (c) Open Enrollment.

- a. **Initial Enrollment:** When you (the Employee) first become Eligible for benefits, the Fund will send enrollment cards and application forms to you. The Employee must complete all information required by the Fund. ***If you did not receive an enrollment card or application form when you became Eligible for benefits, contact the Fund office immediately.***

The enrollment package will contain the information on the Health Coverage options (Independent Blue Cross PPO and HMO plans) available under the Fund as well as any applicable payroll deduction required to enroll in the option you select for yourself and your Dependents. Please note that your Dependents will be enrolled in the same Health Coverage option that you choose. **You may also elect to Opt-Out of coverage for yourself and your Dependents as permitted by the Fund's rules.**

- i. **If You Do Not Opt-Out of Benefits but Fail to Enroll in Coverage at Initial Enrollment:** As an Employee, if you do not "opt-out" but do not enroll in the Plan within the required timeframe, you will not be enrolled for **any** medical, prescription, dental, or vision coverage. ***Also, if you do not enroll, you may not enroll your Spouse or any Children.*** If, at a later date, you wish to enroll, you may enroll yourself and any Eligible Dependents only under the Special Enrollment provisions (when applicable) or the Open Enrollment provisions described later in this section.

You must submit all required enrollment information no later than 30 days after the date on which you are Eligible for coverage. If you wish to cover your Spouse and/or Dependent Children, you must enroll them at the same time. If you do not enroll yourself, or if you do not enroll any of your Eligible Dependents during the Initial Enrollment period, you will not be able to enroll them unless you and/or your Eligible Dependent(s) qualify for the Special Enrollment described below section.

- b. **Special Enrollment:** If you opt-out of Fund coverage for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you must execute a waiver of coverage. However, you may be able to enroll yourself and your Dependents in Fund coverage if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). You must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 after the marriage, birth, adoption, or placement for adoption.

You and your Dependents may also enroll in Fund coverage if you (or your Dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You and your Dependents may also enroll in Fund coverage if you (or your Dependents) become Eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your Dependents) is determined to be Eligible for such assistance.

i. **You May Be Eligible for Special Enrollment Under the Circumstances**

Described in Detail Below: You may be able to make some changes during the year if the Fund determines that you have a "Life Event," that is, a qualifying change in your status affecting your benefit needs. The following qualifying changes are the only ones permitted under the Fund's Enrollment Rules:

- Change in legal marital status, including marriage, divorce, legal separation, annulment or death of a Spouse;
- Change in number of Children, including birth, adoption, placement for adoption, or death of a Child;
- Change in employment status or work schedule, including the start or termination of employment by you, your Spouse or any dependent Child, or an increase or decrease in hours of employment by you, your Spouse or any dependent Child, including a switch between part-time and full-time employment, a strike or lock-out, or the start of or return from an unpaid leave of absence;
- Change in Dependent status under the terms of this Fund, including changes due to attainment of age, loss of student status or any other reason provided under the Plan;

- Change of residence or worksite by you, your Spouse or any dependent Child which affects your ability to continue Benefits under the coverages you have chosen;
- Change required under the terms of a Qualified Medical Child Support Order (QMCSO), including a change in your election to provide coverage for the Child specified in the order, or to cancel coverage for the Child if the order requires your former Spouse to provide coverage;
- Change consistent with your right to Special Enrollment;
- Cancellation of your coverage or coverage of your Spouse or any dependent Child who becomes entitled to coverage under Medicaid or Medicare (except for coverage solely under the program for distribution of pediatric vaccines).
- Change in cost.
 - Automatic changes for cost. If the cost of this Fund increases (or decreases) during a plan year, and under the terms of the Fund you are required to make a corresponding change in your payments, the Fund may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elective contributions.
 - Significant changes in cost. If the cost of a benefit package option significantly increases during a plan year, you may either make a corresponding prospective increase in your payments, or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option providing similar coverage.
- Significant changes in coverage.
 - Significant curtailment. If the coverage under the Fund is significantly curtailed or ceases during a plan year, you may revoke your elections under the Fund. In that case, you may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in

coverage provided to Participants under the Fund so as to constitute reduced coverage to Participants generally.

- Addition or elimination of a Benefit option providing similar coverage. If during a plan year the Fund adds a new Benefit option or other coverage option (or eliminates an existing Benefit option or other coverage option) you may elect the newly added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other Benefit options providing similar coverage.
- Changes in Spouse's, former Spouse's or Child's coverage. You may make a change in coverage if it is on account of and corresponds with a change made under a plan of your Spouse, former Spouse or Child for one of the following reasons:
 - If the change is permitted under federal cafeteria plan regulations; or
 - If the plan of the Spouse, former Spouse or Child's employer permits Participants to make an election for a period of coverage that is different from the plan year under this Fund.

ii. Fund rules for making changes to your Benefit coverage(s) during the year:

- Any change you make to your Benefits must be determined by the Fund to be necessary, appropriate to and consistent with the change in status (for example, if mid-year, the Employee and Spouse deliver a newborn child they can add that Child to this Fund, but it would be inconsistent with a birth event to drop the Spouse from coverage at this time); and
- You must notify the Fund in writing within 30 days of the qualifying change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage; and
- If you have a qualifying change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and

actually enrolled for that coverage) can be dropped mid-year from this Fund;
and

- Coverage changes associated with a mid-year qualifying change of status opportunity are effective the first day of the month following the qualifying change provided you submit a completed written enrollment/change form to the Fund Office, except for:
 - Newborns, who are effective on the date of birth;
 - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption and
 - New Spouse, who is effective on the date of marriage.

iii. ***Start of Coverage Following Special Enrollment:*** If a request for enrollment has been submitted on a timely basis, as described above:

- Your Spouse’s coverage will become effective retroactive to the date of the marriage.
- A newborn child is covered under the Health Coverage options for which you, the Employee, are enrolled for the first 31 days immediately following birth. Coverage for the newborn will only continue after the first 31 days if you properly enroll the child within 30 days of the birth.
 - Coverage of a newborn or newly adopted Child who is enrolled within 30 days after birth will become effective as of the date of the Child’s birth.
 - Coverage of a newly adopted Child who is enrolled within 30 days after adoption or placement for adoption will become effective as of the date of the Child’s adoption or placement for adoption, whichever occurs first. A Child is “placed for adoption” with you on the date you first become legally obligated to provide full or partial support of the Child whom you plan to adopt. If a Child is placed for adoption with you, and if the adoption does not become final, coverage of that Child will terminate as of the date you no longer have a legal obligation to support that Child.

- If you enroll yourself and/or your Dependents because of loss of other coverage (including CHIP or Medicaid) or eligibility for a premium assistance, coverage will begin first of the month following the date you lost the other coverage.
 - Individuals enrolled during a Special Enrollment period have the same opportunity to select a medical coverage option at the same costs and the same enrollment requirements that are available to similarly situated Employees at Initial Enrollment.
- c. **Open Enrollment:** Open Enrollment is the annual period during the late fall, usually in November, during which Eligible Employees may add or drop certain Benefits, add or drop Dependents or switch between different medical coverage options offered by the Fund. The Fund Office will notify Employees of the options and costs of each option during an Open Enrollment period.
- i. **Restrictions on Elections During Open Enrollment:**
 1. No Eligible Dependent may be covered unless you are covered.
 2. You and all your Eligible Dependents must be enrolled for the same medical coverage.
 3. All relevant parts of the enrollment form must be completed, and the form must be submitted with the required documentation and received by the Fund Office before the end of the Open Enrollment period for your elections to be effective.
 - ii. **Start of or Changes to Coverage Following Open Enrollment:** If you or your Spouse or Child(ren) are enrolled for the first time during an Open Enrollment period, that person's coverage will begin on the first day of the year following Open Enrollment. In addition, all other changes in or discontinuance of coverage also become effective on the first day of the plan year following Open Enrollment. (The Fund's plan year is January 1 through December 31.).
 - iii. **Failure to Make a New Election During Open Enrollment:** If you have been enrolled for coverage and you fail to make a new election during

the Open Enrollment period, you will be automatically enrolled in the same coverage you were enrolled in during the prior year.

- iv. ***Failure to Enroll Dependents During Open Enrollment:*** If you fail to enroll any of your Eligible Dependents during Open Enrollment, you will not be able to enroll them until the next Open Enrollment, unless your Eligible Dependents qualify for Special Enrollment described in the previous section.

d. **QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs):** This Fund will provide benefits in accordance with a National Medical Support Notice. In this document, the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state’s administrative proceeding) that creates or recognizes the rights of a child, also called the “alternate recipient,” to receive benefits under a group health plan, typically the non-custodial parent’s plan. The QMCSO typically requires that the plan recognize the child as a Dependent even though the child may not meet the plan’s definition of Dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Fund to provide any type or form of Benefit or any option that the Fund does not otherwise provide, or if it requires an Employee who is not covered by the Fund to provide coverage for a child, except as required by a State’s Medicaid-related child support laws. For a State administrative agency order to be a QMCSO, State statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by State law.

If a Court or State administrative agency has issued an order with respect to health care coverage for any of the Employee's children, the Fund or designee will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the Employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the Employee is covered by the Fund, the Fund or designee will notify the parents and each child and advise them of the Fund's procedures that must be followed to provide coverage to the Child(ren).

If the Employee is a Participant in the Fund, the QMCSO may require the Fund to provide coverage for the Employee's Child(ren) and to accept contributions for that coverage from a parent who is not a Participant. The Fund will accept a Special Enrollment of the Child(ren) specified by the QMCSO from either the Employee, retiree or the custodial parent. Coverage of the Child(ren) will become effective as of the date the enrollment is received by the Fund and will be subject to all terms and provisions of the Fund, insofar as is permitted by applicable law.

If the Employee is not a Participant in the Fund at the time the QMCSO is received and the QMCSO orders the Employee to provide coverage for the Child(ren) of the Employee, the Fund will accept a Special Enrollment of the Employee and the Child(ren) specified by the QMCSO. Coverage of the Employee and the Child(ren) will become effective as of the first day of the month following the date the enrollment is received by the Fund Office along with any required contribution.

No coverage will be provided for any Child under a QMCSO unless the applicable Employee contributions for that Child's coverage are paid, and all of the Fund's requirements for coverage of that Child have been satisfied.

Coverage of a Child under a QMCSO will terminate when coverage of the Employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Child's right to elect COBRA continuation coverage if that right applies.

- 1. PAYMENT FOR YOUR COVERAGE:** The Trustees annually determine the payroll deduction you will be required to make on behalf of yourself and your Dependents. Payroll deductions depend on the type of coverage you choose and whether you choose to cover your Dependents. Your Employer will deduct your payroll deductions via

payroll deductions and send to the Fund Office. These contributions are collected on a pre-tax basis (except for those premiums payable on behalf of Philadelphia Parking Authority Life Partners, for whom the Philadelphia Parking Authority is responsible for addressing and reporting the taxability of those premiums).

2. WHEN COVERAGE ENDS (Events Causing Coverage to End):

a. Your (the Employee's) coverage ends on the last day of the month in which the earlier of the following occurs:

- your employment ends; or
- you no longer are Eligible for Fund benefits; or
- you fail to make or fail to authorize your Employer to deduct the required premium contributions required for your coverage; or
- the Fund terminates.

b. Dependent coverage ends on the earliest of:

- the date your (the Participant's) coverage ends; or
- the date your covered Spouse or Child(ren) no longer meets the definition of Spouse or Child(ren); or
- you or your Employer fails to make any the contributions required for coverage;
- Dependents are no longer covered under the terms of the Fund; or
- the Fund terminates.

3. REQUIRED PLAN NOTIFICATION: You, your Spouse, or any of your Children must notify the Fund no later than 60 days after the date of:

- a divorce; or
- a Child reaches the Fund's limiting age; or
- a Child cease to meet the Fund's eligibility requirements

Failure to notify the Fund of the above noted events may jeopardize future COBRA rights.

4. LEAVES OF ABSENCE:

- a. **Family and/or Medical Leave:** If you have completed 12 months of employment, you are entitled by law to up to 12 weeks each year of unpaid Family or Medical Leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a Spouse, child or parent who is seriously ill, or for your own serious illness. Your Employer is responsible for determining and granting the leave and will notify the Fund when you take a leave. *Please check with your Employer's Human Resources Office for further details about use of paid or unpaid time when taking FMLA Leave. For example, your Employer may require that you take unused paid leave prior to taking unpaid leave.*

The Fund will continue Benefits for the Employee on the same basis as prior to the beginning of the leave. You will be responsible for making any required Employee contributions. While you are officially on such a Family or Medical Leave, you can keep Benefit coverages for yourself and your Dependents in effect during that Family or Medical Leave period by continuing to pay any required contributions.

Since you may not be paid while you are on Family or Medical Leave, you may pay your contributions as they come due on the dates you would have been paid or on some other schedule agreed to by you and the Fund, in which case your contributions will be made on an after-tax basis.

Regardless of whether or not you keep your coverage while you are on Family or Medical Leave, if you return to work promptly at the end of that Leave, your Benefit coverage will be reinstated without any additional limits or restrictions imposed on account of your Leave. This is also true for any of your Dependents who were covered by the Fund at the time you took your Leave. Of course, any changes in the Fund's terms, rules or practices that went into effect while you were away on that Leave will apply to you and your Dependents in the same way they apply to all other Employees and their Dependents.

5. **Continuations Coverage if you Temporarily service in the Armed Services**

- a. **General.** The Fund will provide continuation coverage pursuant to the terms of the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), 38 USC 4301 et seq., for all leaves while you are serving in the uniformed services beginning on or after October 13, 1994. The Fund will provide continuation coverage for a period of thirty-six (36) months. As with COBRA

coverage, the Employee must purchase the coverage from the Fund. When your coverage under the Fund terminates because of your reduction in hours due to your military service, you and your Eligible Dependents may also have COBRA rights. See the COBRA Continuation of Coverage section for details about those rights.

If unformed service is less than thirty-one (31) days, you are not required to pay for coverage. This coverage will be funded either by the last Employer for whom you were employed or, if that Employer is no longer functional, by the Fund (provided you continue to pay any applicable Employee contributions).

- b. **Rights Upon Reemployment:** Upon reemployment, you will be entitled to the same Benefits to which you would be entitled had the service in the unformed services not occurred. The coverage will end if you fail to return to covered employment during the time period prescribed by USERRA. If you have a question about your rights under USERRA, please call the Fund Office.

SECTION II MEDICAL BENEFITS COVERAGE

1. **General:** The Fund provides hospital and medical coverage through two different plans offered by Independence Blue Cross. These Benefits are described in the brochures that you received at enrollment from Independence Blue Cross. If you did not receive or misplaced your Independence Blue Cross information booklet, call the Fund Office directly for a replacement at 215/893-3774, 3775 or 3776. If there is a difference between the Independence Blue Cross description of Benefits and the description of Benefits in this Summary Plan Description, the terms in the Independence Blue Cross booklet will control. Also, see the Fund's website: <https://dc47.org/hwfgov/> for detailed descriptions of each of the plans as well as links to the Provider Directory and annual Summary of Benefits Coverage for each plan.

2. You may choose from one of the plans offered under the following:
 - Keystone Health Plan East, a health maintenance organization ("HMO"):
 - Keystone 20/40
 - Keystone 15 (only available to individuals grandfathered into the plan)
 - Keystone 15/30

 - Blue Cross Personal Choice, a preferred provider organization ("PPO"):
 - Personal Choice 15/25/70
 - Personal Choice 20/30/70

3. **Annual Open Enrollment:** You will have the opportunity to change enrollment and add or delete Dependents during the Fund's annual Open Enrollment period. If you do not opt-out of coverage but do not elect coverage or make a change in your coverage, you will automatically be enrolled in the same coverage you had in the preceding year. Please see the Eligibility and Enrollment rules.

4. **Participant Payroll Deduction:** The Trustees annually determine the amount of the Participant payroll deduction. The Payroll deductions are determined each year and are subject to change. You will receive information on what the required payroll deductions are for each plan when you are first Eligible to enroll in the Fund and every Open Enrollment period thereafter.

SECTION III DENTAL BENEFITS

General: The Fund's dental plan provides coverage for preventive, basic and major restorative dental services. Your dental Benefits are available through the Concordia Advantage Network (Concordia Flex) of **United Concordia** ("UCCI"). You should have received a booklet from UCCI that comprehensively describes these Benefits when you became Eligible for Benefits. *(If you did not receive or have misplaced your UCCI dental booklet, please contact the Fund Office at 215/893-3774, 3775 or 3776.) You may call UCCI directly at 1-800-332-0366 or online at UnitedConcordia.com.* A summary of these Benefits is set forth below. The dental Benefits provided are described in the UCCI dental booklet. If there is a difference between the UCCI description of Benefits and the description of Benefits in this Summary Plan Description, the terms in the UCCI booklet will control. You should consult the UCCI booklet for details about your Benefits. These Benefits are subject to change. Please see the Fund's website for a more detailed description of the dental Benefits and a Provider Directory (<https://dc47.org/hwfgov/>).

- You will receive a UCCI identification card when you first become Eligible for Fund coverage. You may call UCCI at 800-332-0366 to request new cards if you lose your card. Show your UCCI identification card when you go to the dentist.

1. UCCI Network Benefits:

a. Benefits and Limits:

- **Benefits:** The Fund provides dental Benefits, based on the UCCI UCR¹, at 100% for preventive and 80% for Basic and Major Restorative Procedures.
- **Deductible and Annual Maximum Benefit:** There is an annual deductible for dental coverage (\$25 – single; \$75 – family), not applied to preventive services. The Fund provides dental Benefits of up to \$2,500 per covered family member annually. The deductible and annual maximum are not

¹ Usual, Customary and Reasonable" Allowance means the fee determined and payable by United Concordia for covered services. The UCR Allowance is set by measuring the following three fees: the "**usual**" fee (that is, the fee which an individual professional provider most frequently charges to the majority of patients for the procedure performed); the "**customary**" fee (that is, the fee determined by UCCI based on charges made by professional providers with similar training and experience in a given geographic area for the procedure performs) and the "reasonable" fee (that is, the fee determined by UCCI considering unusual clinical circumstances, the degree of professional involvement, or the actual cost of equipment and facilities involved in providing the covered service).

imposed for medically necessary pediatric dental treatment. There is a separate lifetime orthodontic limit of \$2,000 for each covered individual.

- UCCI pays Benefits based on an established fee schedule. The fee schedule defines the “Maximum Allowable Charge.”

2. **Benefits of Choosing a UCCI Participating Provider.** While you may visit the dentist of your choice, your dental Benefits will go further if you use a UCCI Participating Provider. There are approximately 700 dentists in the Delaware Valley. You will not have to submit any claims; the UCCI Participating Provider will handle all paperwork. Simply complete the patient information and payment authorization section of the Provider’s claim form, and payment will be made directly to him or her.

a. If you go to a UCCI Participating Provider to receive services where the frequency limit for the procedure has been reached, or if you reach your annual limit, you must pay the Provider, but his charge will not exceed the Maximum Allowable Charge set by UCCI, which will be lower than the amount most Non-Participating Providers will charge. If you go to a Participating Provider to obtain treatment for a procedure not covered by the Fund, you must pay the Provider’s charge for that service.

- To find a Participating Provider, you can call the toll-free number listed above or on-line at www.unitedconcordia.com and select the “Find a Dentist” link. Select the Concordia Advantage Network to find the dentists convenient for you.
- Although not required, UCCI recommends that you seek a predetermination of coverage for any treatment plan with cost over \$200 so that you will know before you receive the services how much the Fund will cover and how much you should expect to pay.

3. **If you use a Non-Participating Provider:** If you go to a Non-Participating Provider who does not participate in the UCCI Network, you must pay the Provider whatever amount he or she charges. You may submit a claim form to the UCCI to receive reimbursement for the charge. The most you will be reimbursed for any procedure is the Maximum Allowable Charge. You will be responsible for any portion of the Provider’s charge that exceeds the Maximum Allowable Charge.

a. To file a Non-Participating Provider claim for Benefits, send a copy of your dental bill along with a written request for reimbursement to: United Concordia Companies, Inc.

4401 Deer Path Road Harrisburg, PA 17110. Be sure to include the Eligible Participant's name, address, and social security number.

4. **Course of Treatment:** A course of treatment is a planned program of one or more services or supplies for the treatment of a dental condition. The course of treatment starts as of the date that a dentist first does something to correct or treat the diagnosed dental condition.
5. **Alternate Treatment:** There are often several ways to treat a dental condition. For example, a filling or a crown can restore a tooth, or a fixed bridge or partial denture can replace missing teeth. United Concordia will authorize treatment for the least expensive procedure; of course, the procedures selected must meet accepted standards of dental treatment. You do not have to accept the less expensive procedure. However, you must pay any additional charges if you choose the more expensive procedure.
6. **Exclusions:** In addition to Exclusions set forth in this SPD, the following treatment and services are not covered under the Fund's dental plan:
 - Treatment by other than a licensed dentist unless performed under the direct supervision of a licensed dentist;
 - Services and supplies not in accordance with accepted standards of dental practice (including experimental services or supplies);
 - Plaque-control programs;
 - Oral hygiene and dietary instructions;
 - Cosmetic services, such as bleaching of teeth;
 - Duplicate or temporary services;
 - Services related to Temporomandibular Joint Dysfunction;
 - Charges to keep a scheduled appointment;
 - Services performed prior to the effective date of coverage;
 - Local anesthesia when billed separately by the dentist.

SECTION IV
VISION & HEARING BENEFITS

1. **General:** The Trustees have selected National Vision Administrators ("NVA") to administer your vision Benefit. Your vision Benefit dollars will go further if you use an NVA Participating Provider. You should have received a booklet from NVA that comprehensively describes your vision Benefits. If you did not receive or misplaced your NVA booklet, please contact the Fund Office at 215/893-3774, 3775 or 3776. A summary of these Benefits is set forth below. The vision Benefits provided are described in the NVA booklet. If there is a difference between the NVA description of Benefits and the description of Benefits in this SPD, the terms in the NVA booklet will control. These Benefits are subject to change. Please see the Fund's website, at <https://dc47.org/hwfgov/> for the NVA booklet.

2. **Accessing NVA Benefits:**
 - a. **Participating Provider:** In order to use your vision Benefits, take the following steps:
 - **Select a NVA Participating Provider.** A Provider locator is available on the NVA web site, through the Interactive Voice Response ("IVR") phone system at (800) 672-7723, or you may speak to a customer service representative to obtain information.
 - **Call the provider to schedule your appointment.** *Notify your Provider that your coverage is administered by NVA and sponsored by AFSCME District Council 47 Health & Welfare Fund, Sponsor #1048.* The Provider will contact NVA to verify your vision care eligibility.
 - **Participating Provider will submit claims on your behalf.** Your Provider will bill NVA for all covered services you receive. NVA, on behalf of your Fund, will reimburse the Provider based on your Fund's allowances.
 - b. **Non-Participating Provider:** Your vision dollars will provide the greatest benefit if you use an NVA Participating Provider. However, if you elect to use a Provider that is not on the panel, the Fund may offer reimbursement of a percentage of the money you spent on covered services. If you use a Non-Participating Provider, your annual maximum Benefit is \$100 per Eligible individual (Employee, Spouse and Child) per year. Obtain a Direct Reimbursement Claim

Form, complete it and attach your receipts and mail it to NVA for processing.
Mail to: NVA, P.O. Box 2187, Clifton, N.J. 07015.

HEARING AID BENEFITS

The Fund provides a limited hearing aid benefit of Seven Hundred Fifty Dollars (\$750) per ear, once every three years. This Benefit can be applied to the purchase or repair of medically necessary hearing aids. In order to receive this Benefit, submit paid receipts for hearing aids and hearing aid repairs to the Fund Office for reimbursement. This Benefit is also available to your parent, if the parent is your dependent for income tax purposes and you submit the required documentation to the Fund.

SECTION V PRESCRIPTION DRUGS

1. **General:** The Fund's prescription plan is administered by BeneCard PBF, Inc. ("BeneCard PBF"). You will receive a plastic BeneCard PBF prescription card from the Fund when you become Eligible for Benefits. You can obtain prescriptions by paying the required copayment and presenting a prescription and the BeneCard PBF card at a BeneCard PBF-participating pharmacy. A link to the BeneCard PBF provider directory is available on the Fund's website and on the BeneCard PBF website. You should have received a booklet from BeneCard PBF that comprehensively describes your prescription benefits. If you do not receive or misplaced your BeneCard PBF booklet, please contact the Fund Office at 215/893-3774, 3775 or 3776 or on the Fund's website at <https://dc47.org/hwfgov/> . You can reach BeneCard directly at 1-888-907-0070 or online at <https://www.benecardpbf.com/PBF/> . A summary of these Benefits is set forth below. The prescription Benefits provided are described in the BeneCard PBF booklet. If there is a difference between the BeneCard PBF description of Benefits and the description of Benefits in this SPD, the terms in the BeneCard PBF booklet will control. These Benefits are subject to change.

In order to protect patients and the Fund, the Trustees have adopted certain restrictions and limitations. Certain medications are not available unless the patient obtains a prior authorization. In addition, under the prescription plan, certain medications are subject to "step therapy," that is, the Fund will first cover your medication for a medical condition with the most cost-effective drug therapy and progress to other more costly or risky therapies only if necessary. Also, there is a "mandatory generic" rule: when a generic drug is available, but you wish to have the brand-name drug instead, you will pay the difference between the brand-name medication and the generic plus the brand-name copayment. You can reach BeneCard PBF directly at 1-888-907-0070 to learn about these limitations.

2. **Copayments:** You will be required to pay the following copayments for prescription medications:
 - a. RETAIL PHARMACY (for up to a 30-day supply):
 - Generic: **\$10 copayment;**
 - Formulary Brand Name: **\$25 copayment;**
 - Non-formulary Brand Name: **\$40 copayment**
 - b. RETAIL PHARMACY (up to a 100-day supply) **RITE AID PHARMACIES ONLY:**

- **One retail copayment, as above**

c. MAIL ORDER (for up to a 100-day supply):

- Generic: **\$10 copayment**
- Formulary Brand Name: **\$25 copayment**
- Non-formulary Brand Name: **\$40 copayment**

3. Mandatory Generic Program: Prescription medications are available under the Fund's "mandatory generic" prescription plan. The Fund will pay benefits for a generic prescription drug, and not for a brand name drug, unless there is no generic equivalent of the prescription drug. If you receive a brand name drug for which there is a generic equivalent, you will be required to pay a brand-name copayment plus the *difference* between the cost of the generic drug and the cost of the brand name drug.

4. Use of the Formulary: BeneCard PBF has negotiated preferred pricing on certain drugs, included on a list called a Formulary. As a result of this preferred pricing (which is often on drugs by different manufacturers for the same medical condition), lower co-payments can be offered on the formulary drugs. Use of these drugs saves both you and the Fund money and their use is encouraged.

You or your physician can obtain a copy of the Formulary by contacting BeneCard PBF at the telephone number and web site shown above.

5. How to Obtain Your Prescription Drugs:

- a. **Participating Pharmacies:** BeneCard PBF has established a network of pharmacies through which you may fill prescriptions. The BeneCard PBF network consists of over 55,000 pharmacies nationally, including chain drugstores like CVS, Rite Aid and Walgreens, as well as pharmacies located in major grocery stores and independent pharmacies. You may contact BeneCard PBF customer service at 1-800-467-2006 or online at <https://www.benecardpbf.com/PBF/> to find a Participating Pharmacy in your area. A link to the directory of BeneCard PBF participating pharmacies appears on the Fund's website <https://dc47.org/hwfgov/>.

- i. Present your identification card and a valid prescription at any Participating Pharmacy for service. The pharmacy is usually able to check eligibility online and may not ask for your ID card, but you should bring it anyway. The Participating Pharmacy will dispense a prescription in a quantity not to exceed a 30-day supply (or 100-day supply, if your prescription is for 100 days and is obtained from a RiteAid Pharmacy) and collect the applicable copayment (as described above). You may be asked to sign a signature log to verify that you picked up the medication. While a pharmacy can usually check eligibility online through BeneCard PBF, if you purchase a prescription at a Participating Pharmacy without your ID card, you might need to pay for the prescription and submit the prescription drug receipt to BeneCard PBF for direct reimbursement.
 - b. ***Non-Participating Pharmacies:*** It is always to your advantage to use a BeneCard PBF Participating Pharmacy. If you purchase a prescription at a Non-Participating Pharmacy, you will have to submit a claim along with the prescription drug receipt to BeneCard PBF for reimbursement. You must submit the receipt(s) no later than one year (365 days) from date of purchase in order to receive reimbursement. Please note any difference in the cost of the prescription and the amount allowed by the Fund is your responsibility.
- 6. ***100-Day's Supply:*** If you are on a maintenance drug, for example, a blood pressure, diabetes, asthma, or similar long-term condition you have two ways to obtain your medication. Note that whichever way you elect to obtain your maintenance medication, you will pay only one thirty (30) day copayment for up to a one-hundred (100) days' supply.
 - a. ***Rite-Aid Pharmacies:*** If you are using a maintenance medication, you can obtain it at any Rite-Aid Pharmacy upon submission of an appropriate prescription from your physician for a single retail copayment.
 - b. ***Mail Order:*** *To have maintenance medications delivered directly to your home,* you will need to obtain a mail order envelope from BeneCard PBF and fill out all required information, including any allergies and relevant medical conditions. Enclose your co-payment for each prescription (see the co-payment information above) and be sure to write your return address on the envelope, including your apartment number. Please contact BeneCard PBF at 1-888-907-0070 or the Fund Office for a mail order form.

- c. **Ordering Refills:** You can refill prescriptions over the telephone at any time. Simply call 1-888-907-0070 and follow the instructions that are given to you over the telephone. You can also order refills online through the BeneCard PBF website at <https://www.benecardpbf.com/PBF/> . When re-ordering your prescription, place your order about two (2) weeks before your medication runs out.

7. Prescription Drugs Benefits Available Only for the Following: Benefits are provided only for those pharmaceuticals (drugs and medicines) that are:

- Approved by the US Food and Drug Administration (FDA) as requiring a prescription;
- FDA approved for the condition, dose, route, duration, and frequency for which they are prescribed;
- Prescribed by a physician or other health care provider authorized by law to prescribe them; and
- Not otherwise specifically excluded under the Fund.

- 8.** In addition to other Exclusions described in this Summary Plan Description, the Trustees may, on the advice of the BeneCard PBF, exclude other prescription drugs from coverage. Please contact the Fund Office or BeneCard PBF for the most up-to-date information on which drugs are not covered by the Fund.

If you wish to appeal the denial of any claim for a prescription medication or for denial of a prior authorization, please see Appeals and Denial of Claims.

SECTION VI
EMPLOYEE ASSISTANCE (“EAP”) BENEFITS

1. **General:** In addition to psychological and psychiatric benefits that are provided by Independence Blue Cross, the Fund also offers an employee assistance plan through Health Advocate. You should have received a booklet from Health Advocate that comprehensively describes your employee assistance plan Benefits. If you do not receive or misplaced your HealthAdvocate booklet, please contact Health Advocate at 1-866-799-2728 or www.HealthAdvocate.com/members or the Fund Office at 215/893-3774, 3775 or 3776. A summary of these Benefits is set forth below. The Benefits provided are described in the Health Advocate booklet. If there is a difference between Health Advocate description of Benefits and the description of Benefits in this SPD, the terms in the Health Advocate booklet will control. These Benefits are subject to change.

2. **Benefits:**

- a. **Counseling and Support:** Health Advocate provides confidential access to a Licensed Professional Counselor (unlimited phone consultations, and up to eight (8) in-person visits per individual – Participant and Dependent - issue annually) or Work/Life Specialist, who can provide short-term assistance with personal, family and work issues, such as: grief, loss, depression; relationship issues, divorce; job stress, burnout, work/life balance; new baby, adoption, eldercare; financial and legal issues, retirement, identity theft; addiction, eating disorders, mental illness. In a crisis, emergency help is available 24/7 at 866.799.2728.

If you are referred to another care provider or additional treatment, Health Advocate will assist you in finding the most qualified clinician and pre-certifying your treatment.

- b. **Health Advocacy Services:** In addition to the counseling and support services described above, Health Advocate can also assist you with unlimited, confidential access to a Personal Health Advocate, typically a registered nurse supported by medical directors and claims specialists. Your Personal Health Advocate can help you and your family:

- Find the right doctors, hospitals and other providers
- Schedule tests and appointments
- Secure second opinions
- Explain Benefits coverage and health conditions
- Research the latest treatments
- Resolve billing and claims issues

- Locate eldercare services
- Make informed decisions

3. **Confidentiality:** Your contact with Health Advocate is completely confidential. Records from this plan are not available to anyone without your written permission. No one will be contacted unless you request it in writing.

SECTION VII IMPORTANT FEDERAL LAWS

CONTINUATION COVERAGE:

If you lose coverage for health Benefits under the Fund, you may be Eligible to continue your health Benefits coverage by purchasing "COBRA" continuation coverage. This coverage is described in detail below. You may also have other health coverage alternatives that may be available to you through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

Your health Benefits coverage under the Fund may be terminated because you have experienced a "qualifying event." This term is described below. The following sections explain that "qualified beneficiaries" have the legal right to continue group health care coverage, generally known as "COBRA Continuation Coverage," for a period of time even after a qualifying event. Under the law, a qualified beneficiary is any Employee, his or her Spouse or dependent child who was covered by the Fund when a qualifying event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered Employee during a period of COBRA Continuation Coverage is also a qualified beneficiary. A person who becomes the new Spouse of an Employee during a period of COBRA Continuation Coverage is not a qualified beneficiary.

Each individual covered by the Fund will have the right to make his or her own decision about continuation coverage.

QUALIFYING EVENTS:

Qualified beneficiaries are entitled to COBRA Continuation Coverage when qualifying events (which are specified in the law and described below) occur, and as a result of the qualifying event, coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Fund. If a covered individual has a qualifying event but does not lose their health care coverage under this Fund, (e.g., Employee continues working even though entitled to Medicare) then COBRA is not yet offered.:

Events that Apply to Employee/Retiree

- You no longer work for an employer that participates in the Fund; or
- Your working hours are reduced so that you no longer meet the eligibility requirements for coverage; or

- Your Benefits were continued until your grievance arbitration was resolved and you were not reinstated provided that not more than 18 months has passed since your termination; or
- You have retired and exhausted your Employer-funded post-retirement Benefits.

Events that Apply to Spouses

- Your Spouse stopped working for an Employer that participates in the Fund, or your Spouse's hours were reduced causing loss of coverage, or your Benefits were terminated after your Spouse's grievance arbitration was resolved, and your Spouse was not reinstated provided that not more than 18 months has passed since his or her termination, or
- Your Spouse dies, or becomes covered by Medicare, or
- You are divorced from your Spouse or have terminated your Life Partnership, or
- Your Spouse has retired and exhausted his or her Employer-funded post-retirement Benefits.

Events that Apply to Dependent Children

- Your parent ceases to be employed by an Employer that participates in the Fund, or your parent's hours are reduced causing loss of coverage, or your Benefits were terminated after your parent's grievance arbitration was resolved and your parent was not reinstated provided no more than 18 months has passed since your parent's termination, or
- Your parent is divorced from or has terminated a Life Partnership with the parent who is employed by an Employer that participates in the Fund, or
- Your parent has retired and exhausted his or her Employer-funded post-retirement Benefits; or
- You cease to be a "Dependent" under the terms of the Fund.

TYPE OF COVERAGE

Generally, you can elect to receive the same type of coverage you had immediately prior to the qualifying event. However, during any Open Enrollment period in which active Employees may

change coverage, you also may change coverage. In addition, your Benefits will change if the Fund's plans change.

Maximum Coverage Period

You may elect to continue coverage up to a maximum period as follows:

- Up to 18 months from the date coverage is lost in the event of the Employee's termination of employment, a reduction in working hours or resolution of an Employee's grievance arbitration provided you were not reinstated during that time; or
- Up to 29 months if the Employee is found by the Social Security Administration to have been disabled within sixty (60) days of the date he or she terminated employment, but only if the disabled person notifies the Fund Office of the determination within 60 days after he or she receives it and before the end of the 18-month coverage period described above; or
- Up to 36 months in all other cases.

If you have elected continuation coverage following a termination of employment, reduction in hours, or resolution of grievance arbitration, and a second qualifying event occurs, your total period of continuation coverage may last up to 36 months from the date coverage would have been lost on account of the Employee's termination of employment or reduction in hours.

NOTE: COBRA Continuation Coverage begins on the date you otherwise would lose your medical coverage.

COST OF COBRA CONTINUATION COVERAGE:

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Fund to end, but you must pay for it. If there is a change in the health coverage provided by the Fund to similarly situated active Employees and their Dependents, that same change will be made in your COBRA Continuation Coverage. The charge for the coverage is equal to the Fund's cost of providing group coverage plus two percent. The two percent charge covers a portion of the Fund's cost to provide you this coverage. If there is an increase or decrease in the Fund's cost, your future premiums will be adjusted accordingly. The Fund's actuary calculates the COBRA rates annually.

NOTIFICATION REQUIREMENTS:

You Must Notify Us: If you are divorced or become covered under Medicare, or one of your Children ceases to qualify as a Dependent under the Fund, or you experience a second qualifying event (as described later in this section) you must notify the Fund Office in writing as soon as possible, but no later than 60 days from the later of: (1) the date of the qualifying event; or (2) the date you would lose coverage due to the qualifying event.

We Will Notify You: The Fund Office will notify you within fourteen (14) days of the date you advise us of one of the above events or of the date your Employer advises us of your termination of employment for any reason, death, entitlement to Medicare, or of your reduction in hours.

ELECTION OF CONTINUATION COVERAGE:

You will have at least sixty (60) days in which to elect continuation coverage. This election period will end on the later of (1) 60 days from the date you would otherwise lose coverage (except for making a COBRA election) or (2) 60 days from the date we mail you notice of your continuation coverage and provide you with an election form.

NOTE: If you incur covered expenses during the election period before you have made an election, your claims will not be processed until the Fund receives your election forms and payment of your first premium.

IF YOU AND/OR ANY OF YOUR ELIGIBLE DEPENDENTS DO NOT CHOOSE COBRA COVERAGE WITHIN 60 DAYS AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS FUND AFTER COVERAGE ENDS.

Grace Periods: Once you elect COBRA, the initial payment for the COBRA Continuation Coverage is due to the Fund Office 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. Under this Fund, after the initial COBRA payment, monthly payments are due on the 1st of the month, but you will have a 30-day grace period to pay the monthly premiums. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Special Enrollment Rights

If you elect COBRA, you have the same Special and Open Enrollment rights as an active Participant. The Special Enrollment rights under state law also allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan

sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed in this section. The Special Enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Notice of Unavailability of COBRA Coverage

In the event the Fund is notified of a qualifying event, but the Fund Office determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, become entitled to Medicare, or if a covered child ceases to be a Dependent under the Fund, the maximum COBRA Continuation period for the affected Spouse and/or Child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below). *Notifying the Fund:* To extend COBRA when a second qualifying event occurs, you must notify the Fund Office in writing within 60 days of a second qualifying event. Failure to notify the Fund in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any Child(ren) born to, adopted by or placed for adoption with you during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

EXTENDED COBRA CONTINUATION COVERAGE IN CERTAIN CASES OF DISABILITY DURING AN 18-MONTH COBRA CONTINUATION PERIOD

If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits, the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare (whichever is sooner). This extension is available only if:

- The Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; and
- You or another family member notify the Fund by sending a written notification to the Fund Office of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member (failure to notify the Fund in a timely fashion may jeopardize an individual's rights to extended COBRA coverage); and that notice is received by the Fund Office before the end of the 18-month COBRA Continuation period. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage 18-month period of COBRA Continuation Coverage is extended because of disability, the Fund may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period. The Fund Office must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

TERMINATION OF COBRA COVERAGE: Your COBRA Continuation Coverage will end when one of the following occurs:

- The last day of the 18, 29 or 36-month period described above
- You fail to pay the premium for your continuation coverage when it is due. However, there is a thirty (30) day grace period before we will actually cut off coverage for failing to pay your premium.
- The date after you elect COBRA on which you first become covered by Medicare.

COORDINATION WITH SUBSIDIZED COVERAGE

If there is a qualifying event but the Fund provides coverage without charge because you remain eligible for Benefits, or on account of your taking a leave of absence pursuant to the

Family and Medical Leave Act of 1993, then COBRA Continuation Coverage does not begin until the date you lose coverage because the subsidized coverage ceases. This rule applies to self-pay coverage as well. (The rules for self-payment are set forth in the Eligibility Section, above.) So, if you elect to receive self-pay coverage, you will be entitled to COBRA Continuation Coverage after your self-pay coverage ends. You will have at least 60 days to make an election to accept or reject COBRA Continuation Coverage beginning with the later of the date you would otherwise lose coverage or the date we provide you with notice of your COBRA rights and an election form. You will not receive coverage unless within forty-five (45) days of the date you elect COBRA, you submit the applicable premium for the period from the date you lost coverage to the date of the payment.

In addition, following retirement, eligible individuals have the opportunity to continue coverage by paying the full required monthly premium until they become eligible for Medicare. Thereafter, individuals may continue coverage by electing the Medicare plan offered through the Fund and remitting the full, required premium.

MASTECTOMIES AND RECONSTRUCTIVE SURGERY

Under a federal law called the Women's Health and Cancer Rights Act of 1998, group health plans such as the Fund that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. Women's Health and Cancer Rights Act of 1988 provides benefits for mastectomy related services reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, as well as prostheses and treatment of physical complications at all stages of mastectomy, including Lymphedemas. This coverage will be provided in a manner determined in consultation with the attending physician and the patient, subject to the Fund's general provisions relating to benefits, precertification and other applicable limitations. The Fund's medical plans include deductibles that can apply to any services you receive from a physician or hospital, including services related to a mastectomy. Please refer to the applicable medical plan Booklet for the details on any applicable copayments or deductibles. You should feel free to contact the Fund with questions about your coverage at 215/893-3774, 3775 or 3776.

BENEFITS FOR MOTHERS AND NEWBORN

Under federal and state law, when you or your Spouse enter the hospital to give birth, the Fund will provide benefits for a hospital stay of at least forty-eight (48) hours following birth if the birth is a normal vaginal delivery. The Fund will provide benefits for a hospital stay of at least ninety-six (96) hours following birth if the birth is by caesarian section. You will still be responsible for any deductibles or copayments required under the medical plan you have selected.

The Fund may provide benefits for a shorter stay if your attending provider, in consultation with you, decides to discharge you earlier than 48 (or 96) hours after you give birth. You may, of course, elect to leave the hospital earlier than 48 or 96 hours after birth.

The Fund:

- Cannot deny you or your child eligibility to enroll or to continue coverage under this Fund to avoid paying for the hospital stays described above;
- Cannot give you or your attending provider any financial or other incentives to encourage you to accept a shorter stay in the hospital than the stays described above;
- Cannot limit the amount it pays your attending provider because the attending provider determines that you should be in the hospital for 48 or 96-hour periods described above;
- Cannot pay lesser benefits or require greater out-of-pocket costs for the 48 or 96-hour hospital stay for the period after birth than it pays for any hospital stay you have prior to the birth.
- May not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

NO SURPRISES ACT:

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan’s network.

“Out-of-network” describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between

what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing.**” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility were in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact [CMS.gov/nosurprises](https://www.cms.gov/nosurprises), or call the Help Desk at 1-800-985-3059 for more information. TTY users can call 1-800-985-3059 .

Visit [CMS.gov/nosurprises](https://www.cms.gov/nosurprises) for more information about your rights under federal law.

SECTION VIII
COORDINATION OF BENEFITS AND SUBROGATION

COORDINATION OF BENEFITS: When you receive health care 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 will provide benefits without regard to the secondary plan. The secondary plan will then consider payment for any remaining balances according to the limitations of its program. If the Fund is determined to be the secondary plan, the Fund will not pay more than it would have paid if there has been no other coverage.

The primary plan will be determined in the following order:

- If the other plan does not include a provision to coordinate benefits, it will be the primary plan.
- If the other plan includes a provision to coordinate benefits, then:
 - The plan covering the patient as the Employee is the primary plan
 - Except for situations where the parents of a child are separated or divorced, the plan of the parent whose date of birth (month, day) falls earlier in the calendar year is the primary plan for that child. If both parents have the same birth date, the plan which covered one of the parents longer shall be primary.

In those situations where the parents are separated or divorced, the primary plan is determined as follows:

- The plan covering the parent with custody of the child is primary;
- 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;
- A court decree may determine the primary plan. You should advise the Fund of any court decree.
- When the determination cannot be made with the above rules, then the plan that has *covered* the patient for the longer period of time will be the primary plan, except that the plan which covers the patient as an active Employee (or a Dependent of such a person) is the primary plan over a plan that covers a patient as a laid-off or retired person (or a dependent of such a person). If either plan does not have this condition, the plan which has been in effect the longer period of time is primary.

- If the other plan does not include a provision to coordinate benefits or if services are provided under a governmental program for which the Employee pays a periodic rate, that program is the primary plan, except when prohibited by law or when the Employee elects Medicare as secondary coverage. The Fund may release to or obtain from any person or organization, any information about coverage, expenses and Benefits which may be necessary to coordinate benefits. The Employee on his/her own behalf and on behalf of their Dependent(s) may be required to furnish information and to take such other action as is necessary to assure the rights of the Fund.

SUBROGATION/REIMBURSEMENT

1. General. If you or one of your Dependents is injured or becomes ill and may have a right of recovery against any third party, and if the Fund has provided coverage for charges incurred as a result of this illness or injury, the Fund will have the right to be reimbursed for any amounts paid for Benefits or incurred as a result of increased premiums arising from the individual's claims from the first dollars paid by the third party, to the extent permitted by applicable state law. **The Fund may permit the Provider or its Subrogation Agent to exercise this right as the Fund's agent. You must fully cooperate with the Fund with regard to subrogation and reimbursement rights.** In this Section, the term "Fund" applies equally to any Provider or to the Fund's Subrogation Agent.

The Fund will provide Benefits on the express and automatic condition that you and your attorney agree to reimburse the Fund for the cost of providing coverage for the claims for which you may recover from a third party. The Fund's rights to subrogation or reimbursement shall not be subject to any reduction for attorney's fees except as may be specifically agreed to by the Fund in writing. The Fund may achieve this reimbursement from a party to whom the Benefits were paid either by direct payment or by offsetting the payment against any other Benefits payable to the Participant or Dependent or payee, or any of them, in the future.

If the Fund has made a payment on behalf of a Participant or Dependent to a Provider of services to that individual in an amount in excess of that amount due under the Fund, the Fund shall be entitled to recover such excess payment, including attorneys' fees expended in connection with such recovery, by proceeding directly against the payee for such amount or against any other individuals to which the Benefits are payable under the Fund. If you or Eligible Dependent becomes ill or injured as a result of a third party's actions or if you are injured on the premises of another person, the Fund is given the broadest rights to recover any medical expenses paid on your behalf, including, but not limited to reimbursement, subrogation, constructive trust and any other applicable federal or state causes of action that may provide legal and/or equitable relief to the Fund. The Fund's rights survive your death and apply to any

recovery subject to these subrogation and reimbursement provisions from a third party that is paid or payable to your estate, survivors, heirs, or any other party.

3. **Participant and Dependent Responsibilities.** If a Dependent is the injured party and receives Benefits pursuant to these rules, the Participant and/or Dependent is responsible to protect the Fund's interests as set forth in this Section. If the Dependent is a plaintiff in an action to recover any monies, damages, etc. related to the accident or injury for which the Fund has paid claims, the Participant and/or Dependent agrees to be a party in that action for the purpose of protecting the Fund's subrogation rights.

4. **Fund Will Advance Payment on an Express and Automatic Condition that the Fund Will Be Reimbursed from Any Third-Party Recovery.** The Fund will generally treat the third party as primarily liable for your medical expenses. However, the Fund will pay Benefits to you with the understanding that payment of these Benefits is expressly and automatically conditioned on the Fund being reimbursed for these Benefits if there is any recovery from that third party including, but not limited to, any recovery from your automobile (including "uninsured motorist coverage" under your policy) or other insurance carrier.

5. **Notice Requirements.** You and your attorney are required to provide the Fund with notice that a third party may be liable for an injury or illness for which the Fund has advanced claims, including the intent to initiate litigation, and must provide the Fund, no less often than quarterly, with notice of the status of the matter. You and your attorney further agree to provide the Fund with full documentation of any expenditures you make with money otherwise payable to the Fund so that the Fund may trace these expenditures and recover an amount equal to its subrogation lien or reimbursement interest.

6. **You Must Cooperate with the Fund's Right to Reimbursement.** You must not do anything that could interfere with the Fund's right to reimbursement from the third party. The Fund may ask you to assign to it your rights against that third party, or your recovery from that third party to the extent of Benefits paid by the Fund.

You must also contact the Fund before you settle the case and may not do so without the prior written consent of the Fund. The Fund may request that you authorize the Fund to sue on your behalf. In addition, as noted above, you and your attorney agree and are required, as a condition of the Fund providing any Benefits for you under this Fund, to hold all money you receive in constructive trust for the Fund, regardless of whether you sign a subrogation agreement.

The Fund can and will deny Benefits to any Participant or Eligible Dependent who acts against the Fund's right to reimbursement from the third party. The Fund also can sue you, your

attorney or any other person to recover the reimbursement owed to it if you or such person receives money from the third party and do not reimburse the Fund. Finally, the Fund can offset the amount that should have been reimbursed to it against other Benefits payable on behalf of the Participant or any Eligible Dependents.

Cooperation with the Fund's Subrogation and Reimbursement provisions includes the timely completion of a Reimbursement Agreement as well as timely and accurate response to the Fund's inquiries relating to the status of any claim subject to the Fund's subrogation and reimbursement provisions.

7. Constructive Trust. You and your attorney agree and are required, as a condition of the Fund providing any Benefits for you, to hold all money you receive in constructive trust for the Fund, regardless of whether you execute a subrogation agreement. This means that you must treat all dollars you receive from the third party as if you are holding them to repay the Fund before you pay anyone else. Your attorney must place these funds in a restricted account and make payment first to the Fund before taking fees or providing payment to you. As noted above, by accepting these Benefits, you and your attorney agree not to dissipate any of the proceeds of the recovery before the Fund's subrogation lien or reimbursement interest is remitted to the Fund to the Fund's satisfaction. You and your attorney further agree to provide the Fund with full documentation of any expenditures you make with money otherwise payable to the Fund so that the Fund may trace these expenditures and recover an amount equal to its subrogation lien or reimbursement interest.

It is the expectation that your attorney will act in a manner consistent with the applicable rules of professional responsibility regarding the Fund's lien. Specifically, the Fund understands that upon receiving funds or other property in which the Fund has an interest, the attorney shall promptly notify the Fund and shall promptly deliver to the Fund any monies due pursuant to the Fund's lien. The Trustees, at their discretion, will report any dereliction in this regard to the appropriate authorities.

8. Fund May Be Subrogated to Your Rights Against a Third Party. At the Fund's discretion, the Fund may choose to be subrogated to your rights against the third party, or to proceed with an action for reimbursement. If the Fund chooses to be subrogated, that means that it will take over your rights against the third party. If the Fund chooses to proceed with an action for reimbursement, that means that it looks to the third party for repayment of expenses it paid on your behalf. The Fund also can proceed with an action against you if you receive money from the third party and do not reimburse the Fund. The Fund's subrogation rights extend to any excess coverage that the Participant or Dependents may have purchased on his or her own. In addition to the above, the Fund may sue you, your attorney, or any other recipient of money from a third-party for imposition of a constructive trust or other legal and/or equitable remedy if you do not reimburse the Fund.

9. **Attorneys' Fees.** At its discretion, and upon receipt of an appropriate, executed Agreement, the Fund may permit a certain percentage of the Fund's recovery to be applied to the claimant's attorney's fees, but shall not be greater than 33 1/3%, unless the Trustees have consented to a higher fee in writing and provided an appropriate, executed Agreement (see below) is signed. You will be responsible for any attorneys' fees above this amount.

10. **Future Medical Expenses.** The Fund's right to reimbursement is an ongoing one. If you have future medical expenses that were the result of the third party's actions, the Fund's right to reimbursement continues.

11. **Workers Compensation Settlements (Lump Sum Commutation).** While you should consult your own attorney about whether to accept a workers' compensation settlement, you should note that any lump sum commutation should be limited to wages only, not medical care for your work-related injury. If you do waive your right to future medical care payments as part of a lump sum commutation, the Fund will not pay Benefits for any of your medical expenses, not just for your work-related injury expenses, until your medical expenses exceed your lump sum commutation.

12. **These Subrogation Rules apply to auto accidents (as well as injuries or illness caused by a third party).** The Fund will only cover medical expenses related to an auto accident on a subrogated basis and only after the maximum liability has been paid by the motor vehicle insurance carrier. In other words, the Fund will consider the payment of medical expenses only after benefits from the automobile insurance carrier have been exhausted. The subrogation rules above also apply if you are injured while repairing your car or by any other contact with your car.

13. **Reimbursement Agreement.** The Reimbursement Agreement is an agreement by which the injured person agrees to reimburse the Fund from any money you recover from another source. If the injured person is a minor, the Reimbursement Agreement must be signed by a person legally authorized to act on behalf of the minor. The Reimbursement Agreement must be on a form approved by the Trustees. It will require the injured person to repay the Fund for all Benefits paid on account of the injury, regardless of whether the recovery is sufficient to fully reimburse the person for his or her losses. The Fund is not responsible for legal fees and expenses incurred in obtaining a recovery from another source, unless the Fund has agreed in writing to assume a share of those fees and expenses. This can be done by an appropriate Agreement (explained below), which must be signed by the injured person (or his/her representative), the injured person's attorney, and by a representative of the Fund.

14. **Representation Agreements.** A Representation Agreement ("Agreement," as used in this Section") is an agreement by which the attorney who represents the injured person also

agrees to represent the interests of the Fund for the purpose of recovering monies the Fund expended in claims for you from a third party. If the Agreement is not signed, the Fund will not be responsible for any attorney's fees or costs incurred by the attorney in making a recovery on behalf of the injured person. Any Agreement signed on behalf of the Fund will have the following terms: (1) the attorney agrees to represent the interests of the Fund and to use his/her best efforts to recover the amounts the Fund has paid in Benefits; (2) the Fund will pay the attorney the lesser of 33 1/3% or the contingency fee percentage agreed to between you and the attorney of the amount the attorney recovers for the Fund; (3) any recovery obtained shall be applied as follows: first, to the Fund (less the agreed-upon deduction for attorney fees and costs); second, to the attorney for his or her agreed-upon fees and costs; and third, to the injured person (this priority shall not be affected by how the recovery is characterized, e.g., damages for pain and suffering, property damage, loss of future earnings, etc.); and (4) the injured person and the Fund each agree to waive any potential conflict that may arise because the attorney is representing both parties.

15. Use of "You" and "Your." Under this Section, "you" and "your" shall refer to the Participant and/or the Eligible Dependent, or the estate, survivors, heirs or any other party entitled to receive a recovery of any monies subject to these subrogation and reimbursement provisions.

SECTION IX EXCLUSIONS

In addition to the exclusions imposed by Independence Blue Cross, United Concordia (“UCCI”), BeneCard PBF, NVA, Health Advocate or other Fund Providers, the Fund will not pay Benefits if the Trustees, in their sole discretion and in consultation with the Fund’s professional advisors, determine that the payment of Benefits is inconsistent with the Fund’s governing documents or with the best interests of the Fund, its Participants and Dependents. In addition, the Fund will not pay Benefits if the claim is subject to any of the exclusions set forth below:

- a. **Medical Necessity:** The Fund will not pay Benefits if the service is not Medically Necessary, as defined in this SPD.
- b. **Lack of Eligibility:** The Fund will not pay Benefits if the service was rendered at a time when the individual was not Eligible for Benefits as described in the “Eligibility” section above.
- c. **False or Misleading Information:** The Fund will not pay Benefits if the service is rendered as a result of the patient’s submission to the Fund or to a Provider of incorrect, false or misleading information, or the Provider is paid as a result of the patient’s submission (or the patient’s Provider’s submission) to the Fund of incorrect, false or misleading information. False or misleading information includes, but is not limited to, failing to inform the Fund of a change in status, for example, a divorce.
- d. **Failure to Comply with Fund Rules:** The Fund may reduce or deny Benefits if the service was rendered when the patient (or the patient’s Provider) failed to comply with rules of the Fund, any Provider, or other administrative and informational requirements of the Fund.
- e. **Outside Employment for Wage or Profit:** The Fund will not pay Benefits if the service is rendered as a result of injury or illness arising from any non-covered employment for wage or profit. For purposes of this paragraph, covered employment means employment for which Contributions are made to the Fund.
- f. **Coordination of Benefits:** The Service is rendered and the patient attempts to make this Fund primary by failing to comply with the requirements of other primary insurance. See the Coordination of Benefit rules summarized in the “Coordination of Benefits and Subrogation” section
- g. **Certain Item Condition or Service Exclusions.**

- i. Personal Comfort Items: The Fund will not pay Benefits if the service is for Personal Comfort items. "Personal Comfort," means a service that does not materially advance medical treatment of the patient's condition but is primarily prescribed or sought for the patient's comfort or convenience (examples of Personal Comfort items include, without limitation, air conditioners, dehumidifiers, electronic controlled thermal therapy, and modifications to home, vehicle, etc.).
 - ii. Child of Non-Spouse Dependent: The Fund will not pay Benefits if the service is for the child of a non-Spouse Dependent, except for the first 30 days following the child's birth.
 - iii. Cosmetic Services: The Fund will not pay Benefits if the service is for cosmetic purposes. A Service is for cosmetic purposes if its purpose is to enhance appearance, rather than to correct a physical deformity caused by a congenital defect, accident, trauma, or disfiguring disease.
- h. Other Coverage.
 - i. Worker's Compensation Claims: The Fund will not pay Benefits if the service is compensable under worker's compensation or similar law.
 - ii. Injury While Self-Employed: A person who is self-employed and otherwise Eligible for coverage under the Fund must obtain liability insurance to provide the coverage that an employee would obtain through worker's compensation insurance. In no event shall the Fund be liable to cover a self-employed person for any Service that arises from an illness or injury incurred in the scope of self-employment.
 - iii. Governmental or Other Coverage: The Fund will not pay Benefits to the extent that the Service is payable by Other Insurance, including government-sponsored insurance.
- i. Miscellaneous.
 - i. Unqualified or Uncertified Provider: The Fund will not pay Benefits if the Service is performed by a Provider that is unqualified, uncertified, or not licensed from the appropriate authority to perform the Service.
 - ii. No responsibility for Claim: The Fund will not pay Benefits if the Participant or Eligible Dependent does not have a legal responsibility to pay for the Service rendered.

iii. Military Service or Act of War: The Fund will not pay Benefits if the Service is rendered as a result of injury or illness from military service or an act of war.

iv. Trustee Discretion. The Trustees, in their sole discretion and in consultation with the Fund's professional advisors, determine whether the payment of Benefits is inconsistent with the Fund's governing documents or with the best interests of the Fund's Participants and Beneficiaries.

SECTION X
APPEALS PROCESS AND REVIEW OF DENIAL OF CLAIMS

REVIEW PROCEDURE (APPEALS PROCESS) IF YOUR CLAIM IS DENIED

You will be notified in writing, either by way of an Explanation of Benefits (EOB) or a letter, if payment of a claim is denied in whole or in part. The written denial notice will explain the reason(s) for the denial with reference to the Fund provisions upon which the denial was based.

The notice of denial of the claim will be provided by Independence Blue Cross, BeneCard, United Concordia, or National Vision Administrators, or Health Advocate depending on the type of Service you received. You have the right to request an appeal (review) of any denied claim. You will be told what additional information is required for the appeal and why it is needed. The denial notice will indicate how you may proceed to appeal a denied claim. Your request for appeal review (also called reconsideration) must be made in writing, except for “urgent claims,” which can be submitted by phone or fax.

For medical, prescription, dental, vision and employee assistance claims, refer to the booklet you received from each of these vendors for information on how and when to file an initial appeal. Submit your appeal as quickly as possible but, in no event later than 180 days after the receipt of the denial of your claim:

- **MEDICAL CLAIMS:**

- Independence Blue Cross
 - Participant Appeals Department
 - P.O. Box 41820
 - Philadelphia, PA, 19101-1820
 - Toll Free Phone: 1-888-671-5276 (TTY: 711)
 - Toll Free Fax: 1-888-671-5274 or
 - Fax: 215-988-6558

- **PRESCRIPTION APPEALS: If you wish to appeal the denial of a prior authorization or an initial denial of benefits:**

- BeneCard PBF: 1-888-907-0070
 - Prior Authorizations: BeneCard PBF Prior Authorization Department by phone at 609-219-0400, or in writing to: BeneCard PBF Prior Authorization Department, 5040 Ritter Road, Mechanicsburg, PA 17055.

- For appeals beyond the initial claims adjudication you may file a claim for appeal with the Trustees of the AFSCME District Council 47 Health & Welfare Fund, 1606 Walnut Street, 5th floor, Philadelphia, PA 19103-5482, PHONE: 215-546-9880; FAX: 215-545-7052.

DENTAL APPEALS:

- United Concordia (UCCI, Inc.), www.ucci.com, Customer Service:
1-800-332-0366

VISION APPEALS:

- National Vision Administrators: 1 800 672 7723

HEARING AIDE APPEALS:

- Trustees of the AFSCME District Council 47 Health & Welfare Fund, 1606 Walnut Street, 5th floor, Philadelphia, PA 19103-5482, PHONE: 215-546-9880; FAX: 215-545-7052.

Q. What are the rules for claims submission to the Fund?

A. Please note that for medical, dental, vision, initial prescription and employee assistance claims, you should submit your appeal to the provider listed above. All claims for payment of Benefits from the Fund must be submitted within one year from the date the Service was rendered or they will not be processed.

Q. I have a complex health condition and need my wife or personal representative to help me work through the claims. Can the Fund accommodate this?

A. Yes. You may designate an “authorized representative” to act on your behalf with respect to processing claims or appealing the denial of a claim. Contact the Fund Office for the appropriate form for designating your authorized representative. After you have properly designated an “authorized representative,” the Fund will communicate directly with your authorized representative unless you tell the Fund on your authorization form that you would like the Fund to continue to communicate directly with you. (If you have an “urgent care claim,” the health professional with knowledge of your medical condition may act as your authorized representative without an executed authorization form from you.).

Q. How does the Fund categorize claims?

A. There are four types of claims:

- **Post-Service Claim:** If you have already received the service or treatment, the claim is a “post-service” claim.
- **Concurrent Claims:** Once you begin a course of treatment, your health professional may determine that you need a continuing course of treatment. These are called “concurrent claims.”
- **Pre-Service Claim:** Certain Services and procedures require prior authorization. These claims are called “pre-service claims.”
- **Urgent Care Claim:** If a physician believes the treatment must be provided immediately, the claim is an “urgent care” claim.

The different types of claims, and the time limits for processing these claims, are described below.

Q. What is an “urgent care” claim and how long does the Fund have to respond? Are there special rules that apply?

A. An urgent care claim is a claim for treatment that the treating physician believes must be provided immediately or the patient’s health or life could be jeopardized or the patient will suffer severe pain that cannot otherwise be managed. Your claim must be certified as an “urgent care” claim by a physician.

If your claim includes all of the information the Fund needs to process your claim, you will receive a response as soon as possible but no later than 72 hours after your request for review is received. If your claim does not include all of the information needed, you will be contacted within 24 hours and told what information you need to submit to support your claim. You will have up to 48 hours to submit the requested information. You will receive a response, including the reason for the decision as soon as possible but no later than 48 hours after you submit the required information or the expiration of the period you were given to provide additional information. The Fund may initially provide a response orally, including by telephone, if the situation so warrants.

Q. What is a “concurrent care” claim and how long does the Fund have to respond? Are there special rules that apply?

A. A concurrent care claim arises when the Fund has approved an ongoing course of treatment to be provided over a period of time or a number of treatments. For example, a concurrent care claim is one for additional doses or an extended course of treatment with a medication than has initially been authorized. If the Fund determines that the course of treatment is going to be reduced or terminated, it must notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the Benefits are reduced or terminated. If your concurrent care claim is for “urgent care” and you notify the Fund, at least 24 hours before the expiration of the period or number of treatments, the Fund will notify you within 24 hours of the receipt of your claim. If the request is made less than 24 hours prior to the end of the course of treatment, the Fund will notify you of its decision within 72 hours of receipt of the claim. If the concurrent care claim is not an urgent care claim, the Fund will treat it as a pre-Service claim or post-Service claim and will process it according to the applicable deadlines described below.

Q. What is a “pre-service” claim and how long does the Fund have to respond? Are there special rules that apply?

A. A pre-service claim must be submitted when the Fund requires advance approval or certification prior to receiving medical treatment or Services. With respect to a prior authorization for a medication, BeneCard will make the initial determination. If BeneCard denies your claim at this point, you or your Provider may submit your appeal for the denial of prior authorization to the Fund. The Fund will provide a response not later than 15 days after it receives your request, unless it cannot respond because you (or your Provider) have not submitted all of the information it needs to process the claim or for other reasons beyond its control. If the delay is caused by circumstances beyond its control, the Fund shall notify you in advance of the expiration of the first 15-day period that an additional 15 days are required. If you (or your Provider) have not submitted the information needed to process your claim, the Fund will inform you of the specific information needed to process your claim. At that point, consideration of your claim will be suspended. You will have 45 days to submit this information. After you submit the required information, your claim will be processed during the balance of time remaining before consideration of your claim was suspended.

Q. What is a “post-service” claim and how long does the Fund have to respond? Are there special rules that apply?

A. A post-service claim is a claim for Benefits for treatment or Services that you have already received. Post-Service claims may be submitted directly by the Provider to the Fund. The Fund

will provide a response not later than 30 days after it receives your request, unless it cannot do so because you (or your Provider) have not submitted all of the information needed to process the claim or for other reasons beyond the Fund's control. If the delay is caused by circumstances beyond the control of the Fund you will be notified in advance of the expiration of the first 30-day period that an additional 15 days are required. If you (or your Provider) have not submitted the information needed to process your claim, the Fund will inform you of the specific information needed to process your claim. At that point, consideration of your claim will be suspended. You will have 45 days to submit this information. After you submit the required information, consideration of your claim will resume, and it will be processed within the balance of time remaining before consideration of your claim was suspended.

Q. What information will the Fund provide if my claim is denied?

A. If your claim is denied, you will receive a written notice that will include the following information, regardless of whether your claim is processed and denied by the Fund. In the case of an urgent claim, the information may initially be provided orally but will be followed with written confirmation no later than three days after the original decision is rendered. The information will include:

- (1) The specific reasons for the denial (for example, you were not Eligible for Benefits at the time you applied for Benefits);
- (2) The specific plan provisions under which your claim was denied;
- (3) If an internal rule, guideline or protocol was relied upon to make the decision, you will be provided with the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;
- (4) If the decision turned on medical necessity or whether a treatment was Experimental, you will be provided with either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or a statement that it will be provided to you free of charge upon request;
- (5) A description and explanation of the information you must submit in order to perfect your claim;
- (6) A description of the procedures you must follow to appeal the denial of your claim to the Board of Trustees.

Q. What can I do if I disagree with the Fund's decision on a claim?

A. If you are dissatisfied with the denial of your claim, or of a portion of your claim, you may appeal to the Board of Trustees. You must submit your written request for review to the Board of Trustees no later than 180 days after the denial or partial denial of your claim. Your request for review must include the reasons for your request for review. If you fail to appeal your claim, you waive your right to dispute the Fund's determination on this claim.

IMPORTANT NOTE: Appeal of the denial of an urgent care claim may initially be submitted by telephone or email.

You may also request an "external review," as detailed in the following pages.

Q. Does the Fund have to continue coverage for my claim while my appeal is pending?

A. The Fund is required to provide continued coverage pending the outcome of an appeal, provided that you remain Eligible for Benefits. However, if your appeal is regarding the Fund's decision to rescind coverage, the Fund will not continue coverage during the pendency of this appeal.

Q. What are my rights on appeal?

A. Your rights when you request a review of the denial of a claim:

(1) Your claim will be considered by the Board of Trustees. The Board of Trustees does not participate in the processing and denial of claims at the initial stage. The Board of Trustees will not defer to the original decision of the Fund staff who originally denied your claim. You have the right to appeal in person, by telephone, or by email and at least one Trustee will participate in the hearing on appeal.

(2) In support of your request for review, you are permitted to submit written comments, documents, records, and other information relevant to your request for review. The Board of Trustees will review this information in making a determination about your request for review.

(3) At your request and free of charge, you will be provided reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

(4) If consideration of your request for review requires that the Board of Trustees make a medical judgment (for example, if the Trustees must consider whether a prescription drug was medically appropriate or Experimental), the Trustees shall consult with an appropriate health care professional. If the Trustees consult medical experts with respect to your request for review, they will provide you the identification of these experts. The medical expert consulted

by the Board of Trustees on appeal shall be different from any medical professional consulted with respect to the original claim for Benefits.

Q. If the Trustees deny my claim, what information will the Fund provide to me?

A. If the Board of Trustees denies your appeal of the denial of a claim, you will be provided with the following information:

- (1) The specific reasons for their determination;
- (2) The plan provisions on which the Trustees based their determination;
- (3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for Benefits;
- (4) If an internal rule, guideline, or protocol was relied upon to make the decision, the Board of Trustees will provide either the rule, guideline, or protocol itself or an explanation that the rule, guideline, or protocol was relied on and that a copy will be available to you at no charge upon your request;
- (5) If the decision turned on medical necessity or whether a treatment was Experimental, the Board of Trustees will provide either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will provide the explanation to you free of charge upon request;
- (6) Whether there are other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.
- (7) You have the right to bring an action against the Fund under Section 502(a) ERISA, as amended, after you have exhausted all levels of appeal required under this claim procedure.

Q. When Will the Board of Trustees Provide a Decision on Appeal?

A. It depends on the type of claim:

- (1) Urgent Care Claims: The Board of Trustees will provide a response no later than 72 hours after the Fund receives your appeal of the denial of a claim.
- (2) Pre-Service Claims: The Board of Trustees will provide a response no later than 30 days after the Fund receives your appeal of the denial of a claim.

(3) **Post-Service Claims:** The Board of Trustees will generally provide a response to an appeal after the regular meeting of the Board of Trustees that follows the submission of your request for appeal. If your request for appeal was filed less than 30 days before the meeting, the Board of Trustees may defer consideration of the appeal until the next regular meeting. If, due to special circumstances (for example, that the Board believes that a hearing would be appropriate), the Board of Trustees will provide a response no later than following the third meeting after your request for appeal was submitted. If the Board of Trustees requires an extension due to special circumstances, the Board of Trustees will provide you with a description of the special circumstances and the date on which a determination will be made before the extension of time begins. The Board of Trustees will provide you with a response no later than five days after the decision is made.

IMPORTANT NOTE: If you (or your Provider) have not submitted the information needed for the Board of Trustees to consider your appeal, you will be informed of the specific information needed to process your claim. At that point, the Fund’s consideration of your claim will be suspended. After you submit the required information, the Board of Trustees will resume consideration of your appeal within the balance of time remaining before consideration of your appeal was suspended. During the period that the Board of Trustees was awaiting the requested information, the deadlines for rendering a decision will be suspended.

Q. What happens if the Board of Trustees fails to make a decision within the time deadlines for my type of claim?

A. If the Board of Trustees fail to act within the timelines set forth above or fails to provide you with the information described above, your request for review is deemed denied. This means that you will be considered to have exhausted the Fund’s review procedures and may proceed to act against the Fund in federal district court, should you so choose.

Q. What if I wish to have my claim evaluated by an independent party following an adverse benefit decision by the Fund?

A. If you have received an adverse benefit determination from the Fund, you (or your authorized representative) may request an “external review” of the Fund’s final decision. This is a review of the Fund’s denial of a payment or the Fund’s refusal to authorize care that you have sought. The external review will be performed by an “independent review organization” engaged by the Fund.

Q. What is an “independent review organization”?

A. An “independent review organization” (“IRO”) uses qualified individuals to undertake a review process, independent of all affected parties, to determine whether a health care service is Medically Necessary and appropriate or Experimental/Investigational. Under federal law, the IRO must be properly accredited; not be owned by or have material professional, financial, or familial relationships with the Fund or its personnel.

Q. Who pays the fees to the IRO for the external review?

A. The Fund is responsible for paying the IRO’s fees.

Q. Can I request an external review for any type of Fund adverse determination?

A. No. The external review can be requested only for adverse benefit determinations that involve:

- Medical necessity;
- Appropriateness;
- Health care setting;
- Level of care;
- Effectiveness of a covered Benefit;
- Whether a treatment is experimental or investigational; or
- Any other matter that involves medical judgment.

Q. If the IRO reverses the Fund’s adverse determination, does the Fund have to cover my claim?

A. Yes. The IRO’s determination is binding on the Fund. It is binding on you only to the extent that other remedies are not available under state or federal law (for example, you are still permitted to sue the Fund under ERISA Section 502(a)(1)(B)) in the event the IRO upholds the Fund’s denial of your claim.

Q. Are there different kinds of external review, depending on the urgency of my claim?

A. Yes. There is a standard external review and, for urgent cases, an expedited (faster than usual) external review.

Q. How do I request a standard external review?

A. You may submit a standard external review request by mail or fax no later than four months after you receive the final internal adverse benefit determination notice. To request an external review, a person must provide the information listed below. For your convenience, the Fund will provide you with a form on which to make your request. Using the form will also help ensure that you submit all information needed to consider your request for external review:

- Name;
- Address;
- Phone;
- Email address;
- Patient’s signature if person filing the appeal is not the patient; and
- A brief description of the reason you disagree with the Fund’s denial decision. In addition, you may also submit documents to support the claim, such as physicians’ letters, reports, bills, medical records, and explanation of Benefits (EOB); letters sent to the Fund or to your Providers about the denied claim; and letters received from the Fund or your Providers regarding your claim.

Q. What address should I use to submit my External Review Request?

You may mail a request for external review to:

By Postal Mail:

Administrator Michael Walsh

AFSCME DISTRICT COUNCIL47 Health & Welfare Fund

1606 Walnut Street

Philadelphia, PA 19103

PHONE: 215/893-3782

FUND FAX: **215/545-7052**

Q. What happens after I submit my request?

Within five business days of receiving your request, the Fund will turn over to the IRO all documents and information used to make the final internal adverse benefit determination. If the Fund fails to timely provide the documents and information, the IRO will suspend the review and shall reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify the claimant and the Fund.

After the IRO receives the documentation from the Fund, the IRO will timely notify you in writing of acceptance for external review eligibility. You will be able to submit, in writing, within ten business days following the date of receipt of the notice, information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Q. Is the IRO required to share the information I submit to the IRO with the Fund?

A. Yes. Upon receipt of any information submitted by the claimant, the IRO will, within one business day, forward the information to the Fund. Upon receipt of any such information, the Fund may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. However, the Fund's reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Fund must provide written notice of its decision to the claimant and to the IRO, at which time, the IRO will terminate the external review.

Q. Does the IRO accept the Fund's decision or make its own determination about my claim?

A. For both a standard and an expedited external review, the IRO will review all of the information and documents timely received, will review the claim "de novo," that is, the IRO takes a completely fresh look at your claim, and will not be bound by any decisions or conclusions reached during the Fund's internal claims and/or appeals process. In addition to

the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- (1) The claimant's medical records;
- (2) The attending health care professional's recommendation;
- (3) Reports from appropriate health care professionals and other documents submitted by the Fund, issuer, claimant, or the claimant's treating provider;
- (4) The terms of the Fund to ensure that the IRO's decision is not contrary to the terms of the Fund, unless the terms are inconsistent with applicable law;
- (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- (6) Any applicable clinical review criteria developed and used by the Fund, unless the criteria are inconsistent with the terms of the Fund or with applicable law; and
- (7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

Q. When will I receive the determination of the IRO?

A. The IRO will provide you with written notice of the final external review decision as soon as possible, but no later than 45 days after the examiner receives the request for an external review.

Q. What will be included in the decision of the IRO?

A. The written decision of the IRO for both the standard and expedited external review will include the following information. (If in response to a request for an expedited external review the IRO provides an initial oral response, this information will not be included in the oral response. However, the IRO will provide it in the written response that will follow.) The IRO response will include:

- (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

- (2) The date the IRO received the assignment to conduct the external review and the date of the decision;
- (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- (5) A statement that the determination is binding on the Fund except to the extent that other remedies may be available under State or federal law to either the Fund or to the claimant;
- (6) A statement that judicial review may be available to the claimant;
- (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

Q. When can I request an “expedited” external review?

A. You may request an “expedited” external review when:

The patient has asked for an expedited internal appeal and an expedited external review at the same time, and the timeframe for an expedited internal appeal (72 hours) would place the person’s life, health, or ability to regain maximum function in danger.

OR

The patient has completed an internal appeal with the Fund and the decision was not in his or her favor, and:

- The timeframe for a standard external review (45 days) would place the person’s life, health, or ability to regain maximum function in danger, or
- The decision is about admission, care availability, continued stay, or emergency health care services where the person has not been discharged from the facility.

Q. What information must I submit in order to request an “expedited” external review?

A. You must include the following information:

- Name and Address;
- Phone;

- Email address;
- Why the request is urgent;
- Patient's signature if the person filing the appeal is not the patient; and
- A brief description of the reason you disagree with the Fund's denial decision.

Q. Do I have to submit my request for an expedited external review in writing?

A. No. A patient may also request an expedited review by calling (215) 893-3710. The 72-hour timeframe for an expedited request begins when the Fund receives a written request (e.g., via fax) or when a phone call ends.

Q. Where do I submit my request for an expedited review?

By Postal Mail:

AFSCME DISTRICT COUNCIL47 Health & Welfare Fund

1606 Walnut Street

Philadelphia, PA 19103

By Phone: (215) 893-3710

By Fax: (215) 545-7052

Q. When will I receive the IRO's determination in my expedited external review?

A. The Fund will provide the IRO with all documents and information used to make the internal adverse benefit decision as expeditiously as possible. The IRO will give the claimant and the Fund the external review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request. The IRO may give the external review decision orally, but it must be followed up by a written version of the decision within 48 hours of the oral notification.

Q. Upon a final determination by the Fund, will I receive any information in addition to the information described above?

Yes. You will receive a statement that you may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the Pennsylvania Department of Insurance.

Q. Are there other ways to appeal an adverse determination of the Fund?

A. No. The procedures specified in this section shall be the sole and exclusive procedures available to any individual who is dissatisfied with an Eligibility determination, Benefit award or denial, or any other action by the Fund.

Q. Do the Trustees have the authority to make determinations of my appeal?

A. Yes. The Trustees shall have full and exclusive discretionary authority to determine all questions regarding all such issues, including Coverage and Eligibility. Note that the Trustees may delegate to the medical network provider, as a “named fiduciary,” to determine claims on appeal. The Trustees shall have full and exclusive discretionary authority to construe and interpret all Fund provisions, including ambiguous provisions, and to construe and interpret all rules and regulations and procedures of the Fund and all plans. In addition, the Trustees shall have full and exclusive discretionary authority to determine the relevant facts, and to apply the facts to the law and to the terms of the Fund. Any such determination or construction made by the Trustees shall be binding upon all parties and is entitled to the maximum deference permitted by law. No such determination or construction shall be subject to the grievance or arbitration procedures established in any Collective Bargaining Agreement.

IMPORTANT NOTE: Actions Brought Under This Fund. No action of any kind shall be brought in any forum with respect to any claim under this Fund unless the individual has exhausted the Claim Procedures described above. Any such litigation that challenges a claim review decision must be filed within **one (1) calendar year** of the claimant’s actual or constructive receipt of the claim review decision that the claimant intends to challenge. Receipt of the Trustees’ decision may be determined to occur on (a) the actual date of receipt of the Claim Review Decision by the aggrieved party, as reflected either by a USPS “return receipt” card or UPS delivery receipt; or, if these documents are not available, (b) three days following the Funds’ mailing of the Claim Review Decision, as documented in the Funds’ records. The Trustees reserve the right to adopt such policies and procedures as may be necessary to implement this section.

SECTION XI GENERAL PLAN PROVISIONS

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain Benefits until after you have completed this Fund's appeal process. No lawsuit may be started more than one year after the time a proof of claim must be given.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities for the Fund, the Trustees, and other Fund fiduciaries and individuals to whom responsibility for the administration of the Fund has been delegated, have discretionary authority to interpret the terms of the Fund and to determine eligibility and entitlement to Benefits in accordance with the terms of the Fund. Any interpretation or determination made under that discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

FACILITY OF PAYMENT

If the Fund or its designee determines that you cannot submit a claim or prove that you or your Dependent paid any or all of the charges for health care services that are covered by the Fund because you are incompetent, incapacitated or in a coma, the Fund may, at its discretion, pay Benefits directly to the Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Benefits will completely discharge the Fund's obligations to the extent of that payment. Neither the Fund, nor any other designee of the Fund will be required to see to the application of the money so paid.

SECTION XII

HIPAA NOTICE OF PRIVACY PRACTICES

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

We are providing this Notice from the AFSCME District Council 47 Health & Welfare Fund (referred to in this Notice as the “Fund”) in order to inform you about the way that your health information may be used by the Fund. A federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), provides your health information with important protection.

The Fund is required by federal law to maintain the privacy of your protected health information (“PHI”). The Fund is also required by federal law to provide you with this description of the privacy policies and practices adopted by the Fund. The Fund must follow these policies and practices, but as permitted by law, the Fund reserves the right to amend or modify these privacy policies and practices.

Changes in our policies and practices may be required by changes in federal and state laws and regulations and the Trustees reserve the right to make changes to this Notice to reflect these required changes and as well as other changes, provided that the changes are consistent with applicable federal law.. Regardless of the reason for the change, we will provide you with notice of any material changes within 60 days of the date the change is adopted.

Under HIPAA, how can the Fund use my protected health information (“PHI”)? The Fund can use your PHI to facilitate your treatment, to make or obtain payment for your treatment and for health plan operations, including administration, oversight, and other legal purposes.

How may the Fund use my protected health information (“PHI”) with respect to payment for my treatment? The Fund may use your PHI for the broad range of actions needed to make sure that the Fund can make payment for the services received by you and your family. The Fund may use your PHI for making payment to providers for services or treatment you received, for making arrangements for payment through one of the Networks of providers through which the Fund provides Benefits to you, as well as for coordinating payment to providers through other health plans under the Fund’s coordination of Benefits rule. For example, the Fund provides participants with access to a Network of providers outside of this immediate geographic area. The Fund may provide your PHI to the Network and directly to the provider in order to ensure that the provider receives the appropriate payment for the services that have been provided to you.

How does HIPAA permit the Fund to use my protected health information (“PHI”) with respect to “health care operations”? The Fund may use your PHI for a broad range of actions required to assess the quality of the Fund’s plan of Benefits as well as for its administration and operations. These activities include, but are not limited to, ensuring that participants or their beneficiaries are Eligible for Benefits prior to making payment; taking corrective action to recoup overpayments and assessing health plan performance; reviewing the Fund’s plan of Benefits and determining whether a reduction in costs is possible; continuing case management and coordination of care; commissioning and reviewing actuarial studies relating to the cost of Benefits and management studies relating to the operation and administration of the plan; resolving internal grievances; and undertaking medical review, legal, and auditing functions. For example, the Fund may use PHI to determine the most cost-effective manner of providing vision Benefits to its participants and beneficiaries.

May the Fund use my protected health information (“PHI”) for purposes besides payment and health care operations? Yes. HIPAA permits the Fund to use your PHI for a number of other purposes, including informing you of treatment alternatives or other health-related Benefits that may be of interest to you.

Because I am always on the road, my Spouse often calls to find out the status of my health claims and to get other information about me or my Benefits. Can the Fund release information relating to payment of my claims to my Spouse? The Fund will provide claims payment and other information to your Spouse after receiving an authorization from you.

May I call the Fund to get information about my Children’s health claims? The Fund will provide a minor Child’s parent, guardian (or person standing *in loco parentis* with respect to the Child) with payment information about the Child’s claim. The Fund will carefully consider your written request for information other than claims payment information and will respond as permitted by these privacy policies and applicable state law.

IMPORTANT NOTE: If your Child is not a minor, the Fund generally cannot provide you with the Child’s PHI, even if the Child is still covered under this Fund as your Dependent.

Does HIPAA permit the Fund to disclose my protected health information (“PHI”) to my Employer or insurer? Under HIPAA, the Fund generally cannot disclose your PHI to your Employer without your written authorization. It is important to note, however, that HIPAA does permit that the Fund disclose your PHI without your authorization to workers’ compensation insurers, state administrators, or others involved in the workers’ compensation systems to the extent the disclosure is required by state or other law.

May the Fund release my protected health information (“PHI”) to the Fund’s plan sponsor?

HIPAA does permit the Fund to disclose information to the “plan sponsor” for administrative functions. Here, the “plan sponsor” is the Fund’s Board of Trustees. The Fund may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids or modify, amend, or terminate the plan.

May the Fund release my protected health information (“PHI”) to law enforcement or other governmental entities?

Your PHI may be disclosed to law enforcement agencies, without your authorization or permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting. The Fund may not disclose your PHI if you are the subject of an investigation that does not arise out of or is directly related to your receipt of health care or public Benefits. In addition, the Fund may disclose your PHI in the course of a judicial or administrative proceeding if the Fund receives a court order, subpoena, discovery request or other lawful process. Before releasing this information, the Fund will make reasonable efforts either to notify you or to obtain an order protecting your PHI.

Would the Fund release my protected health information (“PHI”) if my health or safety or public health or safety would be jeopardized if it did not?

If the Fund has a good faith belief that your health or safety or public health or safety would be jeopardized if it did not disclose the information, the Fund will do so, after consideration of appropriate legal and ethical standards.

Must the Fund have an authorization to release my protected health information (“PHI”)?

Yes, in many circumstances. For example, the following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of PHI;

Any other disclosure or use of your PHI for any other purpose not described in this notice requires your written authorization. This means that if you want your friend, relative, or union representative to check on the status of a claim you submitted or to advise when or if payment will be made, you must sign an authorization form and submit it to the Fund Office. If you change your mind after authorizing a use or disclosure of your PHI, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to the Fund of your decision to revoke the authorization.

Under what other circumstances may the Fund release my PHI without my authorization? The Fund may release your PHI without your authorization under the following circumstances, in addition to the other reasons set forth in this Notice:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigation; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud.).
- To organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.
- If you are in the Armed Forces and your PHI is needed by military command authorities. The Fund may also disclose your PHI for the conduct of national security and intelligence activities and for other specialized government functions such as protective services for the President, Medical suitability determinations, correctional institutions and other law enforcement custodial situations.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For medical research subject to conditions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

- To disclose proof of immunization to schools in States that have school entry or similar laws.

May the Fund use or disclose my genetic information for underwriting purposes? No. The Fund is prohibited from using or disclosing genetic information for underwriting purposes.

Do I have the rights under the federal privacy standards? Your rights to information under HIPAA include:

- the right to request restrictions on the use and disclosure of your PHI. The Fund will carefully consider, although is not required to honor, your request for restrictions;
- the right to restrict confidential communications concerning your medical conditions or treatment if you believe that disclosure of this information could endanger you (this means, for example, that you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential). The Fund will attempt to honor reasonable requests;
- the right to opt out of receiving fundraising communications prepared the Fund;
- the right to inspect and copy your PHI. The Fund may charge a reasonable fee for copying, assembling and postage;
- the right to an electronic copy of electronic medical records. The Fund will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format;
- the right to get notice of a breach of any of your unsecured PHI;
- the right to amend or submit corrections to your PHI. If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, for example, you do not include the reason you wish to correct your records or if the records were not created by the Fund;
- the right to receive an accounting of how and to whom your PHI has been disclosed if it was disclosed for reasons other than payment or health care operations. Your written request for information must be submitted to the Fund and should state the period of time for which you are requesting an accounting;
- the right to file a complaint that your privacy rights have been violated to the Fund and to the Secretary of U.S. Department of Health & Human Services.

IMPORTANT NOTE: you will not be penalized or otherwise retaliated against for filing a complaint;

- the right to receive a printed copy of this notice. In addition, this Notice is posted on the Fund's website, <https://dc47.org/hwfgov/> .

Complaints? Comments? Requests? The Fund has designated Michael Walsh, Administrator as the Privacy Officer. If you wish to request information that you have a right to receive, want to file a complaint with the Fund or if you have any comments or questions regarding this notice, contact Mr. Walsh. The Fund can assess reasonable charges for copying and assembling documents you request as well as for postage.

SECTION XIII GLOSSARY

The following words and phrases shall have the following meanings when used in this Summary Plan Description unless their context clearly indicates otherwise. These words are capitalized throughout the text of the SPD.

Administrator. The person or persons appointed by the Trustees pursuant to the Trust Agreement to perform certain administrative or managerial duties for the Fund. The Administrator is not the Plan Administrator as that term is defined in ERISA § 3(16).

Benefits. The dollar amounts that the Fund will pay under the terms of the plan of benefits. The Trustees establish the level of Benefits in their sole discretion.

Benefit Coverage. Coverage provided under the Plan for Eligible Participants or Dependents.

Benefit Period. A time period established by the Fund during which a Participant or his or her Dependent may be Eligible for Benefits under the Plan.

Benefit Year. A year-long period established by the Fund for tracking the payment of Benefits. The Benefit Year begins on January 1 and ends on December 31.

Child. May include the following individuals who are under age 26 and are:

- (a) A natural or adopted child of a Participant;
- (b) A stepchild, that is, the child of the Participant's Spouse;
- (c) A child placed in the custody or guardianship of a Participant or the Participant's Spouse by court order, regardless of whether that order requires the provision of health benefits.
- (d) A child who has been placed with the Participant for adoption. The term "placed for adoption," means the assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation. The Participant must provide the Fund with written updates about the progress of the adoption process at least once every six months.

(e) , a Disabled Child is a Child who has been determined to be disabled by the Social Security Administration; who is not able to earn a living because of the disability, whose disability began prior to the date on which the Child would have lost Benefit Coverage because of age (age 26); and who is financially dependent on the Participant for support and maintenance as evidenced by, *inter alia*, documentation showing that the Participant claims the Disabled Child as a dependent for federal income tax purposes.

Code. The Internal Revenue Code of 1986, as amended, and the rules and regulation and guidance promulgated thereunder.

Collective Bargaining Agreement. An agreement between an Employer and AFSCME District Council 47 or a Local Union representing Employees, which agreement governs the terms and conditions of employment, including Contributions to the Fund for Employees covered by the agreement.

Common Law Spouse. An individual who is validly a Participant's Spouse pursuant to common law and not pursuant to ceremonial marriage in accordance with the laws of the state in which the Participant and Spouse reside; provided that both the Participant and the Common Law Spouse have executed properly an affidavit of common law marriage required by the Fund. **The Fund will not recognize any common law marriage entered into in Pennsylvania after January 1, 2005.**

Contribution. A payment made or required to be made by an Employer to the Fund pursuant to the terms of a Collective Bargaining Agreement, Participation Agreement or other written document as provided under the Fund's policies and procedures. A Contribution shall be considered as a "plan asset" and shall include those Contributions that have both been paid to the Fund and those that are due and owing to the Fund. In the event an Employer fails to pay any Contribution or other payment when due, such failure to pay promptly shall be a violation of such Employer's obligations hereunder. The Trustees shall treat unpaid delinquent Contributions as "plan assets" held in trust by the Employer on behalf of the Fund.

Copayment. A charge for Services for which a Participant or Dependent is responsible and that is collected by a Provider.

Deductible. A charge for Services for which a Participant or Dependent is responsible, and that is deducted from Benefits paid by the Fund after the Services have been rendered.

Dependent. A "Dependent" may include: your Spouse and your Child, as defined in this Plan.

Disability (Disabled). A condition caused by an injury or illness as a result of which a Participant is completely unable to perform any work for wage or profit, any occupation, or any employment. A Participant is not Disabled if he or she is engaging in any work for wage or profit, any occupation, or any employment, even if he or she cannot perform his or her usual job.

Eligible (Eligibility). An Employee or his or her Dependent is Eligible for Benefits when the Employer has made the Contributions required by the Collective Bargaining Agreement and the Employee has met the requirements set forth in the Fund's Plan Documents. To the extent permitted under the Fund's Plan Documents, the Fund will provide Benefits for a Participant for periods for which Contributions were remitted, provided that appropriate documentation supporting the claims is submitted to the Fund.

Eligible Local: A local union of AFSCME District Council 47 that makes contributions to the Fund in order to cover its employees for benefits. ("Eligible Local").

Employee. An Employee includes any of the following individuals:

- (a) A common law Employee who is performing bargaining unit work as a member of the bargaining unit with respect to which unit an Employer is required to make a Contribution to the Fund pursuant to a Collective Bargaining Agreement with the Union, regardless of whether the individual is a full-time, part-time or casual Employee.
- (b) A common law Employee who is engaged by or who is an Employee of the Union or any Local Union that Union or Local Union is required to make Contributions to the Fund pursuant to a participation or other appropriate written agreement.
- (c) A common law Employee who is engaged by or who is an Employee of the Fund or AFSCME District Council 47 and the Fund or District Council is required to make Contributions to the Fund pursuant to participation or other appropriate written agreement.
- (d) A common law Employee who had been employed pursuant to one of the Subparagraphs set forth above and who is now making self-payments under rules established by the Trustees and who meets the requirements set forth in the Fund's Plan Documents.

Employer. "Employer" includes any of the following entities:

(a) The City of Philadelphia, the Philadelphia Parking Authority, the First Judicial District, or a or party employing Employees, which is party to a Collective Bargaining Agreement between an Employer and the District Council or a Local Union, which Collective Bargaining Agreement provides for payment to the Fund. Further, an “Employer” is a person that has been accepted by the Fund as a contributing Employer and is or was obligated to make Contributions to the Fund. By making contributions to the Fund, an Employer agrees to make Contributions as required by the Fund’s Plan Documents.

(b) The Fund, the District Council or related entity that, for purposes related to its engagement or employment of Employees who are Participants in the Fund that is required to make Contributions to the Fund on behalf of Employees.

Experimental/Investigative - A drug, biological product, device, medical treatment or procedure, or diagnostic test is “experimental or investigative” if it meets any of the following criteria:

- A. Is the subject of ongoing clinical trials;
- B. Is the research, experimental, study or investigational arm of an on-going clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person’s particular condition;
- D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition; or
- E. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug, biological product, device, medical treatment or procedure, or diagnostic test is **not** considered Experimental/Investigative if it meets all of the criteria listed below:

- A. When required, the drug, biological product, device, medical treatment or procedure, or diagnostic test must have final approval from the appropriate governmental regulatory bodies (e.g., FDA).
- B. Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.
- C. Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test leads to measurable improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

D. Reliable Evidence clearly demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

E. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.

F. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, device, medical treatment or procedure or diagnostic test is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

Family. (Family Members). A Participant and all of his or her Eligible Dependents.

Fund. The AFSCME District Council 47 Health and Welfare Fund, as amended from time to time, and its successors. The Fund is a governmental plan as that term is defined in ERISA Section 3(32).

Lifetime. A Participant or Dependent's Lifetime while covered under this Plan.

Local Union. A local union affiliated with AFSCME District Council 47.

Medically Necessary. Services, Treatment and Items (collectively referred to as "Service") that meet the following criteria: health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Network. The individuals, organization, or organizations with which the Fund contracts to provide Services to Participants and Dependents at advantageous rates.

Network Providers. The Physicians, Hospitals and other Providers of health Services to Participants and Dependents who are affiliated with a Network.

Non-Network Providers. The Physicians, Hospitals and other Providers of health Services to Participants and Beneficiaries who are not affiliated with the Network.

Other Insurance. “Other Insurance” includes any of the following types of coverage:

(a) Any group insurance coverage, including any plan covering individuals as Employees of an Employer or as members of any other group that provides Hospital or medical care benefits or Services on an insured or a prepayment basis;

(i) “Other insurance” does **not** include the coverage of a Spouse or Dependent under a “health savings account” as that term is defined under Code Section 223 and regulations thereunder. If (a) all of the plans covering the Spouse are high-deductible health plans or the Spouse elects a high-deductible health plan offered by the Spouse’s employer and (b) the Spouse intends to contribute to a “health savings account” as that term is defined in the applicable federal law and regulations, this Plan cannot coordinate benefits with or provide any reimbursement for the primary high-deductible health plan’s deductible.

(b) Any coverage under a labor-management Trustee plan or other welfare plan, Employer plan, Employer organization plan, or other arrangement for benefits for individuals or a group, whether insured, partially insured, self-insured, non-insured, or otherwise;

(c) Any coverage under any governmental program, including, but not limited to, worker’s compensation, occupational disease, or similar programs; provided, however, that such coverage shall not be deemed Other Insurance for purposes of this Plan if applicable law mandates that the Plan provide Primary coverage;

(d) Any Other Insurance, private or otherwise, carried by the Participant or an Eligible Dependent of a Participant, including, but not limited to, motor vehicle coverage (including fault, no-fault, financial responsibility, catastrophic, liability, collision or other coverage).

Participant. An Employee who may be Eligible for Benefits for him or herself and his or her Dependents under the terms of the Plan.

Participation Agreement. An agreement between the Fund and an Employer, which agreement sets forth the terms and conditions governing the participation of that Employer’s Employees in this Plan.

Patient. A Participant or Eligible Dependent receiving medical care.

Provider. A person or organization that provides health care Services.

Qualified Beneficiary. An individual who was covered by the Plan on the day before a Qualifying Event occurred and who is either an Employee, the Employee's Spouse or former Spouse, or the Employee's Dependent Child.

Qualifying Event. Events that cause an individual to lose Coverage under the Plan and may trigger an individual's right to elect Coverage under COBRA.

Qualified Medical Child Support Order (QMCSO). A court or administrative order requiring the Fund to provide Benefit Coverage for a Dependent, which order the Trustees have determined complies with ERISA § 609(a).

Service(s). Any medical care, treatment, Hospitalization, or item provided to a Participant or Eligible Dependent.

Spouse. Your Spouse is the person to whom you are legally married under the laws of the state or country in which you were married.

Trustees. Those persons, including Employer Trustees and Employee Trustees appointed by AFSCME District Council 47 or the City of Philadelphia, respectively, to administer the Fund.

B. Construction.

1. The masculine gender, where appearing in this SPD, shall be deemed to include the feminine gender, unless the context clearly indicates otherwise.
2. The singular shall be deemed to include the plural, and the plural the singular, as the context may require.