

**1199C Hospitals
Designated for Maximum Benefits**

Pennsylvania Hospitals		New Jersey Hospitals
<ul style="list-style-type: none"> • Chestnut Hill Rehabilitation Hospital • Children’s Hospital of Philadelphia • Crozer Chester Medical Center • Episcopal Hospital • Girard Medical Center • Hahnemann University Hospital • Jefferson Institute for Neurosciences 	<ul style="list-style-type: none"> • Northeastern Hospital • Penn Presbyterian Medical Center • St. Joseph’s Hospital • Taylor Hospital • Temple Children’s Hospital • Temple University Hospital • Thomas Jefferson University Hospital • Wills Eye Hospital 	<ul style="list-style-type: none"> • Summit Surgical Center* • William B. Kessler Memorial Hospital • Virtua West Jersey Hospitals (Berlin, Camden, Marlton, and Voorhees)*
		Delaware Hospitals
		<ul style="list-style-type: none"> • All Delaware hospitals*

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

Understand Your Benefits Before You Receive Care!

Be sure to read the detailed description of the Medical Plan in your Health and Welfare Benefits Handbook before you receive care. Contact the Benefit Fund Office or Member Services if you have any questions about whether or not a medical service is covered, or about the plan’s benefits for a specific service.

Maximize Your Benefits: Go 1199C!

To receive maximum benefits, choose a Keystone PCP who admits to one of the hospitals listed in the front of the Keystone Doctor and Hospital Directory. You’ll save money because the plan’s benefits encourage greater use of 1199C facilities to help keep our members working.

Personal Choice Preferred Provider Organization (PPO) Plan—(Out-of-Area Medical Plan)

To find a Network Doctor or Hospital visit www.bcbs.com. Or call BlueCard Access at 1-800-810-2583 (or call collect at 1-804-673-1177).

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

The Personal Choice Plan is a PPO ("Preferred Provider Organization") Plan that gives you the freedom to use the doctors and hospitals of your choice. Under the plan, there are two levels of benefits, based on whether you use certain "Preferred" providers carefully chosen by Independence Blue Cross.

Understand Your Benefits Before You Receive Care! Be sure to read the detailed description of the Medical Plan in your Health and Welfare Benefits Handbook before you receive care. Contact the Benefit Fund Office or Member Services if you have any questions about whether or not a medical service is covered, or about the plan's benefits for a specific service.

- **In-Network Care**—You may use the doctors and hospitals of your choice, but you receive maximum benefits when you use providers in the PPO network. When you stay "in-network," there is no deductible and the plan pays 100% of the cost for most services. There are copays for some services, such as doctors' visits and inpatient hospital stays—but the Benefit Fund will reimburse you for most of these copays (see "Summary of Benefits" in the Personal Choice Out-of-Area Medical Plan section of your Health and Welfare Benefits Handbook). You may need to file claim forms.
- **Out-of-Network Care**—When you go Out-of-Network, you pay more of your expenses. Generally, the plan pays 70% and you pay 30% plus a \$300 deductible (\$600 per family). In addition to your deductible, copays, and coinsurance, you also pay any amount above the plan's maximum allowance.

Prescription Drug Plan

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

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

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

How the Plan Works

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

- Brand name drugs, and
- Generic drugs.

Under the Medco Health Prescription Drug Plan, you pay a \$5 copayment for generic drugs and a \$10 copayment for brand-name drugs. The brand-name copay applies even if a generic is not available.

If there is a generic form of your medication and you request the brand-name form, you will pay the difference in cost between the generic cost and the brand-name cost.

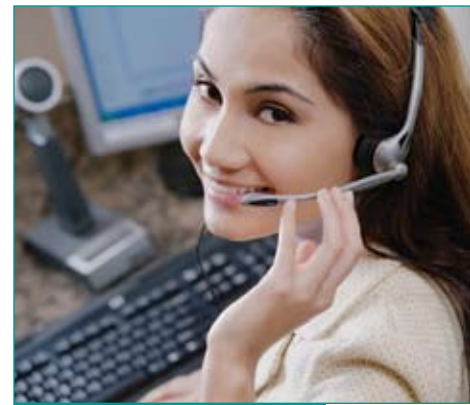
About Generic Drugs

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

Bring Your ID Card

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

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



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

Your Dental Care Plan

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

Managed Dental Care Plan

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

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

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

How the Plan Works

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



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

What the Plan Pays

When you use general dentists at your Approved Dental Facility—You pay a fixed dollar copayment based on a specific list of services.

When you use specialist dentists after receiving written referral from your general dentist—You generally pay approximately 75% of the Usual, Customary, and Reasonable (UCR) charge for covered services. Different percentages may apply to specific procedures. (See “Dental Plan Schedules” in your Health and Welfare Benefits Handbook.)

Annual Maximum Benefit—There is no maximum benefit limit for eligible dental expenses.

Orthodontia Copayment—For orthodontia, your copay varies based on the services required. See “Orthodontics” in the “Dental Plan Schedules” section in your Health and Welfare Benefits Handbook.

Out-of-Area Dental Plan

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

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

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

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

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

How the Plan Works

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

What the Plan Pays

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

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

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

Disability Benefits

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

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

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

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

You Must Initiate the Disability Claims Process

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

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

Disability Management Process

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



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

Death and AD&D Benefits

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

Death Benefits

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

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

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

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

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

Accidental Death and Dismemberment (AD&D) Benefits

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

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

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

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

Camp and Scholarship Benefits

You must be a Wage Class I member for your dependent children to be eligible to participate in either the Camp or Scholarship program. See your *Health and Welfare Benefits Handbook* for more detailed eligibility requirements.

Applications for both the Camp and Scholarship programs are available at the Fund Office beginning December 30. All applications must be post-marked no later than March 15 for the coming year.

Camp Program

The camp program is a two-week overnight stay at a camp approved by the American Camping Association (ACA). You must complete an application form and you and your child must attend a personal interview with camp personnel. There is a \$10 registration fee, which will be refunded to you if your child is not accepted into the program.

Campers are selected based on available funding, seniority in the Fund, acceptance by the camp, and prior use of this benefit.

Only one child per family may go through the Camp program in a given year (except in the case of twins).

Scholarship Program

The Thomas Breslin Scholarship program provides scholarships to members' children who are in post-secondary schools. If your child meets the scholarship requirements, he or she may apply for an award each year for up to four years, provided you are eligible for Wage Class I benefits.

Once you have completed and returned the initial form, you will receive an official scholarship application. Your child and a representative from the school your child plans to attend must complete this application and return it to the Benefit Fund Office by the deadline designated by the Fund.

Scholarship awards are paid in equal installments each semester (or trimester) of the academic year. The maximum scholarship award is for eight semesters (or 12 semesters if the school is on a trimester schedule). The summer semester is not eligible for this award.

Neither the Camp benefits nor the Scholarship benefits are guaranteed benefits since funding is limited. The Fund's decisions for selection are final.



Important Telephone Numbers

THE BENEFIT FUND

In Philadelphia215-735-5720
Outside Philadelphia 1-800-531-1199

KEYSTONE HEALTH PLAN EAST

Keystone Member Services215-567-3550 or 1-800-253-3854
Physician/Hospital Information 1-800-ASK-BLUE
Davis Vision
(vision care providers under
Keystone Health Plan East) 1-888-393-2583
Magellan Behavioral Health
(mental health/substance abuse
under Magellan Behavioral Health) 1-800-688-1911
Pre-certification (for self-referred care) 1-800-227-3116

AMERIHEALTH PA

Provider Information 1-800-275-2583

INDEPENDENCE BLUE CROSS

Physician/Hospital Information
(BlueCard Access) 1-800-810-2583
1-804-673-1177 (collect)
Pre-certification (for self-referred care) Call the number on the back of
your Personal Choice ID card

DOMINION DENTAL SERVICES, INC. (dental network management)

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

